



# **Building the Blocks for Nutrition-Sensitive Social Protection Systems in Asia**

Informing Design, Prompting Implementation



**World Food Programme**

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**World Food Programme**

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# Acronyms

ASEAN	Association of Southeast Asian Nations
BBC	BISP's Beneficiary Committee (Pakistan)
BCC	Behavioural Change Communication
BISP	Benazir Income Support Programme (Pakistan)
CCT	Conditional Cash Transfers
CMAM	Community Management of Acute Malnutrition
CNW	Community Nutrition Workers
CoD	Cost of Diet
CT	Cash Transfers
DHS	Demographic and Health Survey
FFA	Food for Assets
FFV	Fresh Food Vouchers
GAIN	Global Alliance for Improved Nutrition
GFD	General Food Distributions
IFPRI	International Food Policy Research Institute
ILO	International Labour Organization
ISPP	Income Support for the Poorest Programme (Bangladesh)
KAP	Knowledge, attitudes and practices on nutrition
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD-W	Minimum Dietary Diversity of Women
MDD-IYCF	Minimum Dietary Diversity of Children
MICS	Multiple Indicator Cluster Survey
MNP	Micronutrient Powder
NNS	National Nutrition Survey
PFM	Public Financial Management
PF4C	Public Finance for Children (UNICEF)
PLW	Pregnant and Lactating Women
PSNP	Productive Safety Net Programme (Ethiopia)
PSSN	Productive Social Safety Net (Tanzania)
SAARC	Asian Association for Regional Cooperation
SNF	Specialized Nutritious Food
SPF	Social Protection Floors
SSN	Social Safety Nets
SP	Social Protection
SUN	Scaling Up Nutrition Movement
ToC	Theory of Change
VGD	Vulnerable Group Development Programme (Bangladesh)
WASH	Water, Sanitation and Hygiene
WeT	Waseela-e-Talem (Pakistan)



# 1. Introduction

*The potential of nutrition-sensitive programmes to improve nutrition outcomes is clear, but it has yet to be unleashed.*

The 2013 Lancet Nutrition Series





## 1.1. The Rationale

This document offers a rationale for scaling up effective nutrition-sensitive social protection (SP) interventions to reduce the global burden of child and maternal malnutrition in Asia – South and South-East Asia in particular. It brings together two fields that are usually approached separately: nutrition and SP. Its purpose is to inform practitioners from both fields (from all kind of stakeholders, not only WFP's) during the design and implementation of SP programmes by using a nutrition lens. Today, most social protection programmes in Asia were not designed to address malnutrition. However, their impact on nutrition can be maximized by considering alternative nutrition-sensitive actions for the most vulnerable populations, tailored to the nutrition needs specific to each group.

The complexities around the prevention and management of all forms of malnutrition often lead SP practitioners to overlook its causes and the potential solutions within their programmes. While evidence about the impact of social transfers (see Glossary for a definition of the term) on domains such as education, poverty alleviation and food security is well documented, its impact on malnutrition is still mixed and scant (Bastagli et al., 2016). Yet thanks to a new generation of nutrition-sensitive interventions – particularly since the launch of the 2013 Lancet Series on Maternal and Child Nutrition – these two fields have started exploring existing synergies and pursuing opportunities for an enhanced impact on nutrition.

It builds upon the findings of research carried out by WFP from March to December 2016 on the scope of the nutritional dimension within the SP systems in selected countries across South and South-East Asia. The selected countries – Pakistan, Bangladesh, The Philippines and Indonesia – share similar social economic backgrounds and poverty and undernutrition trends. In Pakistan, for example, there is a stunting prevalence of 44 percent, in Bangladesh, 41 percent, Indonesia, 37 percent, and The Philippines, 30 percent. Social exclusion, a high frequency of natural disasters, social conflicts and

accelerated migration are also factors present in the selected countries.

Findings from the selected countries in the region were triangulated with the results from discussions held by WFP's Nutrition Division and the International Food Policy Research Institute (IFPRI) in Rome on the conceptualization of WFP's nutrition-sensitive programming. This document cannot be understood separately from that work, which resulted in the corporate guidelines for 'unlocking WFP's potential for nutrition-sensitive programming' (see WFP, 2017). While both documents complement each other – this one from a sectoral and policy perspective while the other from a corporate and programme centred perspective –, this one nonetheless explores the pathways to nutrition within the broader national SP systems in Asia specifically, taking into account the social, economic, cultural and political determinants of undernutrition in this region.

The sections presented next reflect on current issues, such as innovations and challenges for future programmes and practical implications for existing programmes in Asia. Primarily the document stresses the importance of the adequate identification of the main nutritional problems in each country, the population groups and geographical areas affected by them, as well as the incorporation of tailored objectives, actions and nutritional monitoring indicators in the different phases of a programme cycle. Overall, it explores how to address the design and operational aspects of national policies and programmes that are faced by practitioners, programme managers and policymakers dealing with SP and nutrition.

## 1.2. How to Read it?

This is an informative document that provides the main principles for those working in any of these two related topics – SP and nutrition – in Asia rather than a prescriptive, 'how-to' guide. The reader will not find here exhaustive lists and recommendations, but valuable information on the key design and operational aspects that

are common to nutrition and SP when applying a shared lens – the nutrition-sensitive lens – to protecting the most vulnerable populations against shocks that are detrimental to their health.

Illustrated by examples from the region and beyond, it is not directed to WFP staff alone, but to anybody working in social policy related to either social protection or nutrition. For readers willing to delve into more detailed information, additional resources have been added as annexes at the end of the document. Those findings and

background information serve as the supporting evidence for the recommendations presented throughout this document.

A glossary of terms is provided in Annex 1. Evidence provided by the literature on relevant aspects for SP and nutrition can be found in Annex 2. For those not familiar with the Asia region, a general overview on poverty, food insecurity and malnutrition is presented in Annex 3; which is followed by a series of case studies from selected countries in Asia in Annex 4.





## 2. Setting up the Nutrition-Sensitive Lens



It has not been until recently that nutrition-sensitive SP has been moved to the top of the development agenda. Two important events have been at the centre of the latest progress in this field. First, the launch of the influential 2013 Lancet Series on Maternal and Child Nutrition.<sup>1</sup> Second, the Global Forum on Nutrition-Sensitive SP that took place in Moscow in September 2015. Several global initiatives such as the Scaling Up Nutrition (SUN) movement, or the Copenhagen Consensus (Behrman et al., 2004; Hoddinot et al., 2013), preceded these and helped lay the necessary foundations.

Underpinned by a growing trend toward making SP programmes more nutrition-sensitive, there is also a global push for developing complementary or alternative methods to the traditional food-based approaches for the prevention and treatment of malnutrition. One such intervention is cash transfer programmes (CTs), where poor and vulnerable households, which might also include children at risk of undernutrition during periods of food insecurity or during emergencies, receive social benefits in cash. As it is shown in the following sections, CTs may have an impact on nutrition outcomes in three different ways: i) by addressing the underlying causes of malnutrition, such as poverty, food insecurity, and lack of access to education or to health care; ii) by working toward nutrition-related objectives, as defined by the programme's Theory of Change (ToC), such as cash transfers conditional to attendance to or upon receipt of some health services; or iii) by using SP programmes as a delivery channel for additional nutrition-specific interventions, such as improving access to specialized

nutritious foods (SNF) and behaviour change communication (BCC).

In order to improve nutrition through SP programmes, it is necessary to understand how the drivers of malnutrition work and relate to social transfers. Such an analysis is provided in the beginning of this section, exploring the available evidence on the links between CT and nutrition and the pathways toward the latter. This is followed by an overview of a common aspect to both types of programmes: the life-cycle approach.

## 2.1. The Social Transfers Pathways to Nutrition

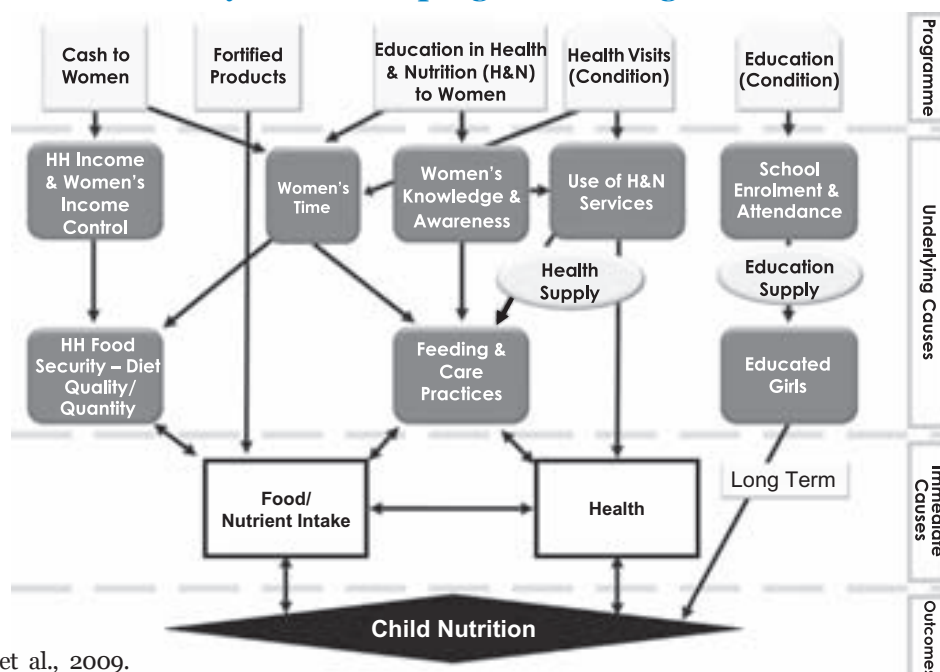
There is a great deal of evidence on the variety of immediate contributors to nutrition, whereas research that identifies solutions to the underlying causes of malnutrition is more recent. As a result of the successful results obtained by conditional cash transfers (CCTs) in Latin America – e.g. Mexico's PROGRESA – Leroy, Ruel and Verhofstadt (2009) developed a programme impact model and synthesised evidence on the pathways through which CCTs may improve child nutrition (see Figure 2.1). The authors found that CCT programmes significantly improved child anthropometry, but had very little impact on micronutrient status. Conversely, they found an enormous knowledge gap around the specific mechanisms by which CCT programmes improve nutrition. They concluded that in order to reach their full potential the programmes needed to have a better defined set of nutrition actions grounded in programme theory.

The nutrition pathways framework developed by UNICEF (de Groot et al., 2015) and adapted by the Research on Food Assistance for Nutritional Impact/REFANI (Fenn, 2015), considers three main pathways through which CTs may impact the underlying determinants of child nutrition by making additional financial resources available in a household (see Figure A.4.2 in Annex 4). The three pathways are i) livelihoods and food security, ii) health, and iii) care. The authors

<sup>1</sup> In a series of four papers, the publication starts by examining the prevalence and consequences of nutritional conditions during the life course from adolescence (for girls) through pregnancy to childhood and discusses the implications for adult health. A second paper covers the evidence supporting nutrition-specific interventions and the health outcomes and cost of increasing their population coverage. A third paper examines nutrition-sensitive interventions and approaches and their potential to improve nutrition. The fourth paper discusses the features of an enabling environment that are needed to provide support for nutrition programmes, and how they can be favourably influenced.



**Figure 2.1. Mechanisms by which CCT programmes might affect nutritional status**



Source: Leroy et al., 2009.

stress the importance of carrying out an in-depth analysis of the drivers of malnutrition in order to incorporate the appropriate nutrition outcomes within the SP programmes.

New thinking and accumulating evidence suggests that cash or food transfers alone are inadequate to achieve nutritional outcomes. This body of evidence is at the origin of a joint global effort by the social development and nutrition sectors to address a population's vulnerabilities in a more comprehensive way. Some of these key aspects are related to the interactions between income and diets and its relevance for poverty and nutritional analysis; the concepts of food and nutrition security; the central role of dietary diversity; and the importance of caring practices and environment for nutrition (see Annex 2 for details).

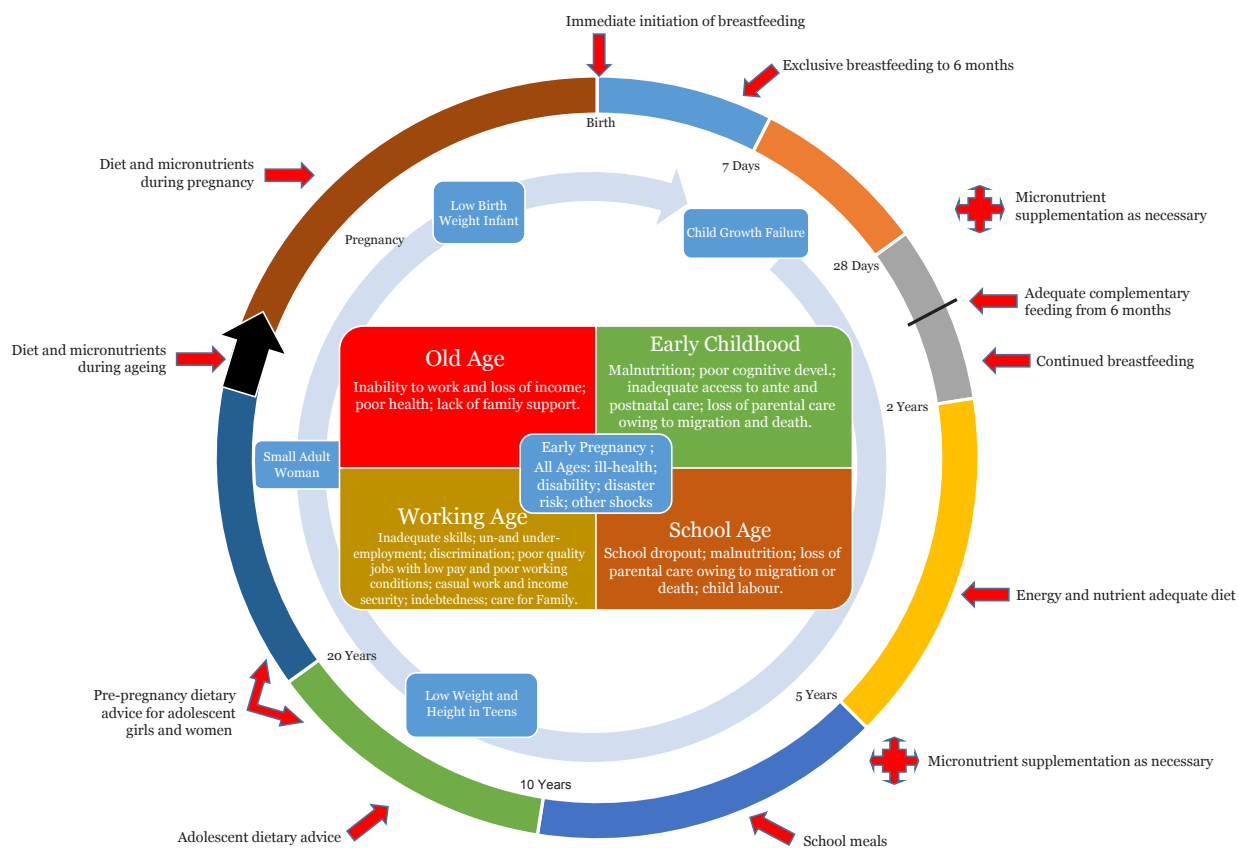
Section 3 specifically discusses these pathways under three broad questions: i) How can the impact of SP programmes for poverty alleviation on nutrition be maximized? (Sections 3. 3.1, 3.2 and 3.3); ii) How might SP programmes be better linked to nutrition? (Sections 3. 3.4, 3.5, 3.6, 3.7 and 3.8); iii) How should nutritional outcomes be measured within SP programmes? (Section 3. 3.9 ). The different policy choices that can be derived from each are also discussed.

## 2.2. The 'Life-Cycle Approach'

One common aspect to nutrition and SP interventions is that both can be explained by 'the life-cycle approach'. Research on the links between SP and nutrition (WB, 2006; Behrman et al., 2004) point to the fact that economic and nutritional vulnerabilities differ throughout the various phases of life, and that malnutrition, poverty and social exclusion have a 'hereditary' character, as they are passed from one generation to the next.

The 'life-cycle' concept (Figure 2.2) encompasses two different terms used alternatively in these two fields despite little difference in meaning. On the one hand, the term 'life-course' is used in the health sector, such as the World Health Organization (WHO), to emphasize the group of the elderly, since it is not solely a reproductive 'life-cycle' that explains changes in dietary and health patterns. The five stages of the life-course by WHO —grouped based on the different dietary needs— include: i) foetal development and maternal environment; ii) infancy and young children (pre-school and primary school); iii) adolescence; iv) adulthood, and; v) ageing and older people. Although each is distinct, the categories merge imperceptibly into one another, with different influences becoming more or less important over the course of one's life.

**Figure 2.2 The ‘life-cycle’ approach to nutrition-sensitive social protection**



*Note:* the external ring corresponds to essential nutrition-specific actions through the life-course, whereas the concentric ring depicts the intergenerational cycle of undernutrition. Central box describes risks and vulnerabilities along the life-cycle.

*Source:* Authors, adapted from WHO, 2013; WFP; and World Bank, 2012, respectively.

SP interventions, on the other hand, usually follow an integrated ‘life-cycle’ approach which addresses risks and vulnerabilities at various life phases. As understood by the International Labour Organization (ILO) (Bonilla García & Gruat, 2003), the life-cycle reflects a continuum of age-stages where the needs of an individual changes from conception to death. However, changing needs are not solely related to age. In the current global world, a new ‘life of cycles’ is replacing the previously linear path that related solely to age – birth; education; marriage; work; nurturing; and old-age cycle. An individual’s vulnerabilities change often due to economic, social and spatial changes. This leads to modifications in roles and responsibilities, requiring an individual to revisit certain cycles of their lives. Each new life-cycle represents renewed opportunities, but also challenges and risks, not only for the breadwinner(s) in a household, but also for their dependants.

In many ways, adolescent girls are at the heart of the life-cycle approach. Adolescent pregnancy

is a major concern worldwide, particularly in areas of poverty and social disadvantage, mainly due to the increased risk of adverse birth outcomes, poor foetal growth and infant and maternal health and mortality. The risk for complicated pregnancy is high in such cases, as it is the nutrient requirement of pregnant adolescents as they are still growing, and at the same time supporting the foetus. Among factors important to consider here are child protection through ensuring a supportive education environment, controlling early marriages and associated pregnancy through education and health services, and supporting livelihood initiatives beneficial to young mothers. In the ‘1,000 days window of opportunity’, maternal health and nutrition support during pregnancy and thereafter until the child is 2 years old can be facilitated through ensuring availability and access of essential public health services and food security as well as enhancing the uptake of services through conditional CT programmes. Hence, from a general SP point of view, adolescent girls are covered as long as

**Table 2.1. Social protection and nutrition-specific interventions throughout the life-cycle**

Life Stages / Programme features	First stage		Second stage		Third stage	
	Before working years (SP)	Birth & Early childhood (Nut.)	During Working years (SP)	Youth & Pregnant women (Nut.)	After Working Years (SP)	Old Age (Nut.)
CROSS-CUTTING VULNERABILITIES						
Disability, migration, covariate shocks.						
FOCUS	Social Protection	Investing in sustainable personal and social potential, chances and opportunities, including active disability when possible.	Investing in maintaining and enhancing sustainable personal and social potential, chances and opportunities, including active disability when possible.	Investing in contributing to active ageing, maintaining of independence, maintaining and enhancing participation in society and disability prevention.		
	Nutrition	Investing in tackling undernutrition's short-term consequences, by addressing stunting and other forms of undernutrition.	Investing in breaking the inter-generational cycle of malnutrition.	Investing in diverse and nutritious diets during ageing.		
TYPE OF PROGRAMMES	Social Protection	Access to essential health care services, i.e. to maternal, child, reproductive and adolescent health. Basic income security for children, i.e. child allowances. School stipends and school fees waivers. School feeding programmes. Childcare services.	Basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability. Social security and public employment and active labour market policies. Widowed and destitute women allowances. Single parent allowances.	Basic income security for older persons. Old age pensions and long-term care services.		
	Nutrition- specific	0-5 months→ Early initiation of breastfeeding and exclusive breastfeeding. Appropriate infant feeding practices for HIV-exposed infants and antivirals. Vitamin A supplementation in first eight weeks after delivery. Multi-micronutrient supplementation. Improved use of locally available foods, fortified foods, micronutrient supplementation for undernourished women.  6-23 months → Timely introduction of adequate, safe and appropriate complementary feeding. Continued breastfeeding. Appropriate infant feeding practices for HIV-exposed infants and ARV. Micronutrient supplementation, including vitamin A, multi-micronutrients; zinc treatment for diarrhoea; deworming. Community-based management of severe acute malnutrition; management of moderate acute malnutrition. Food fortification, including salt iodization. Prevention and treatment of infectious disease; hand washing with soap and improved water and sanitation practices. Improved use of locally available foods, fortified foods, micronutrient supplementation and fortification.	Improved use of locally available foods. Food fortification, including salt iodization. Micronutrient supplementation and deworming. Fortified food supplements for undernourished mothers. Antenatal care, including HIV testing.	Access to essential care services, especially for those caregivers of children.		

Source: Authors.

they remain in school, by school fee waivers or CCTs in education, when they become mothers, by CCTs in health for pregnant and lactating women (PLW), or even once they get married. In Pakistan for example, under the Benazir Income Support Programme (BISP) only ‘ever-married women’ are the recipients of the social benefits. For those adolescent girls that do not belong to any of these categories, gaps in coverage still remain as a major concern, increasing their vulnerability even more.

As shown in Table 2.1, since many SP measures aim to increase income there is a tendency for them to focus on those who are engaged in productive labour —or else, in those who are left out of it, either temporarily or permanently. But there is also a nutrition life-cycle approach that should be considered when designing and implementing social policies and interventions. An individual’s nutrient and energy needs change over their life span. During periods of accelerated growth. Among pregnant mothers, infants and young children and adolescents, the body has higher nutritional needs than normal. Since the amounts of food that a child can eat are very small, it is crucial that the food provided

to children —e.g. complementary food— is nutrient-dense. In order to achieve nutritional adequacy in children’s diets, such diets need to be diverse. In addition, meal frequency should be high, at least eight or more per day, for infants and young children.

Adequate dietary diversity should be attained not only during infancy, but in all stages of the life cycle. Besides the lack of availability or access to nutritious foods, consumption of those foods can also be effected by personal food choices, which depend on social, psychological, economic, and leisure factors. Consequently, SP programmes can ensure that policies and interventions are designed with a nutrition lens, with the aim of improving different nutrition outcome indicators, such as the dietary diversity of its beneficiaries.

The life-cycle approach is a natural starting point for both nutrition and SP programmes. Policy makers and practitioners should harness this common ground and build holistic interventions with common goals and outcomes. Both types of programmes deal with the same populations, although frequently at different stages of their life.



### 3. Programme Design: Making Social Protection Nutrition-Sensitive





In this section, the document brings tangible evidence on how to (re)design nutrition-sensitive SP programmes that incorporate nutrition outcomes and indicators. It takes stock of the latest initiatives and innovations in the Asia region and beyond, as well as the caveats and knowledge gaps that still remain. The section starts by portraying some of the attempts to make public-funded social safety nets more nutrition-sensitive. It is followed by the key principles that should guide SP programming, including nutrition outcomes, best practices, lessons learned from nutrition specific programmes, and ways to integrate these into SP schemes. An updated theory of change developed by WFP and IFPRI (WFP, 2017) is then presented, followed by two vital strategies to combat malnutrition: food-based approaches and public-private partnerships. The section ends with an overview on M&E tools for measuring the nutritional outcomes of the programmes.

### 3.1. (Re)Designing National Social Safety Nets: Examples from Poverty Reduction Programmes

The 2014 Global Nutrition Report (IFPRI, 2014) raised the question of how programmes and expenditure on underlying determinants of nutrition can become more nutrition-sensitive. Following the lead, many organizations have already put forward documents that propose guidelines to practitioners. Most documents are focused on agriculture, health and even SP, whereas there are almost none for education or water, sanitation and hygiene (WASH).

All over the world, national social safety nets (SSNs) with a focus on poverty alleviation have started to introduce a nutrition component into their programming, although not in a systematic manner. Table 3.1 provides an overview of selected examples. Despite not being a systematic compilation, what makes them central for the purposes of this document is that they can be considered a typology of innovative features and processes. Tanzania's Productive Social Safety Net (PSSN), which incorporates additional

nutrition-sensitive components, is one example. The case of Djibouti's Social Safety Net, designed with clear nutrition goals from the onset stands out too (see Box 3.2 for detailed information). Attention should also be paid to Niger's SSN, which is part of a World Bank's broader research on this subject; or Mexico's *PROGRESA*, as one of the first SSNs in mainstreaming nutrition. Likewise, Bangladesh's *Shombhob*, a pilot conditional cash transfer that was later scaled up (see Annex 2). Finally, Ethiopia's Productive Safety Net Programme (PSNP) (described in Box 3.1) is one of the biggest SSNs that has catalysed greater nutrition sensitivity.

The (re)design of these programmes provides three important topics for reflection and further analysis:

- i. **An important gap to be filled:** only one of the programmes targets children aged 2-5 years (criteria number six). Researchers stressed the importance of focusing on the first 1,000 days of life or a window of opportunity, from conception to the first two years of age, which corresponds with the period of the highest rates of return on social investments. However, researchers have also recently turned their attention to other age groups, such as school-age children and adolescent girls. Hence, nutrition-sensitive SP programmes should pay attention to additional age groups that are also vulnerable to undernutrition. Another factor to consider in other age groups is that wasting, stunting, micronutrient deficiencies and other indicators of malnutrition are usually measured in children aged 0 to 59 months, beyond the first 1,000 days of life. For example, organizations traditionally engaged in the management and prevention of wasting, such as WFP, are now exploring opportunities to link the traditional interventions to treat and prevent wasting with SP programmes in order to improve the overall impact on wasting.<sup>2</sup>

<sup>2</sup> For more information, see the REFANI consortium's experience in Fenn, 2015. REFANI examines the impact of cash and voucher-based food assistance on nutrition outcomes with the aim of creating an evidence base for high-impact and cost-effective mechanisms in the prevention of acute malnutrition in emergencies.

**Table 3.1. Main design features of nutrition-sensitive SSN**

No	Programme Design Parameters	Tanzania PSSN	Djibouti SSN	Niger SSN	Bangladesh Shombhob	Ethiopia PSNP
1	CCT	✓		✓	✓	✓
2	UCCT					
3	Public Works (PWs)	✓	✓	✓		✓
4	Promotes income/consumption.	✓	✓	✓	✓	✓
5	Promotes caring and health practices and services.		✓	✓	✓	✓
6	Targets nutritionally vulnerable population:	a) Pregnant/lactating women and children 0-2 years (within the first 1 000 days of life).	✓			✓
		b) Pregnant women and children < 5 years.			✓	
7	Accommodates women's needs (e.g. 'soft' PWs).	✓	✓			✓
8	Imposes conditionalities to caregivers attending regular nutrition activities (quarterly/monthly sessions).	✓	✓	✓	✓	✓
9	Compliance: soft conditions.			✓		
10	Promotes nutrition through education and behavioural change.		✓	✓	✓	✓
11	Promotes nutrition through growth monitoring, micronutrients and food supplements (distributed in lean season), home visits.	✓	✓		✓	
12	Produces communication materials specific to the target populations.	✓	✓	✓		
13	Focuses on quality by enforcing performance-based contracts essential when working with service providers.			✓		
14	Addresses constraints in the demand side.	✓	✓	✓	✓	✓
15	Addresses constraints in the supply side.				✓	
16	Programme was nutrition-sensitive from the onset.		✓	✓	✓	
17	Nutrition-sensitiveness was mainstreamed during implementation.	✓				✓
18	Incorporates nutrition indicators	✓	✓	✓	✓	✓
19	Has a built-in impact evaluation to show links between nutrition and SP.		✓		✓	✓

Source: Compiled by the authors.

ii. **An innovation:** it is crucial that the quality of the supply side is improved, and not only the demand (feature number 13). Even though the utilization of performance-based contracts can be an innovation and constitute a good opportunity for increased impact, they are not necessarily the only possibility for achieving this goal.<sup>3</sup> For instance, by working

on both demand and supply side measures, the ILO's Social Protection Floor (SPF) takes a holistic approach to SP. On the one hand, its activities strive to ensure the availability of goods and services in the areas of health, WASH, housing, education, SP, food security and related information. At the same time, the SPF activities secure rights and social benefits that guarantee effective access to these goods and services for all throughout the life cycle.

<sup>3</sup> The rationale behind this concept is similar to that of the performance-based budgeting model used by many multilateral institutions, like the IMF. It is associated with stronger Public Finance Management systems, an important element for sustainable social protection systems, as referred next in Section 3.2 (see also Annex 2 for more information on this subject).

### **Box 3.1. Ethiopia's Productive Safety Net Programme transition to a greater nutrition sensitiveness**

Coordinated by the Ministry of Agriculture, in 2005 the PSNP began to increase food security in vulnerable rural households and help preventing households from depleting their assets during shocks. It has since completed three phases. In its fourth phase, which began in 2015, the PSNP will transition from an independent programme to one that is integrated with nutrition, social protection, disaster risk management, and climate resilient green economy policies.

The Government of Ethiopia and other stakeholders have redesigned the programme to mainstream nutrition across its components and include nutrition-sensitive programming. Among many new provisions, nutrition-related changes include the reformulation of targeting and transfers, introduction of community-based behavioural change communication and 'co-responsibilities,' stronger links between the PSNP and existing health services, enhanced livelihood support and nutrition-sensitive public works.

The PSNP was not originally intended to address nutrition, but stakeholders recognized the potential for incorporating nutrition-sensitive approaches into ongoing activities and using the PSNP as a platform to support other nutrition initiatives. The third phase of the PSNP (2011–2015) included some optional nutrition-sensitive features, though they were not widely implemented or scaled up. With the fourth phase of the PSNP (PSNP4) that went into effect in July 2015, the government has been proactive in exploring potential linkages between the NNP and PSNP and considering ways to make the PSNP explicitly nutrition-sensitive.

*Source:* IFPRI, 2015.

### **Box 3.2. Combining workfare with a nutrition intervention within Djibouti's Social Safety Net**

To reduce high levels of malnutrition and food insecurity in the country, an integrated social protection programme has been implemented by the Government of Djibouti to encourage nutrition behaviour change and create income-generating opportunities. The 'Djibouti Crisis Response: Employment and Human Capital Social Safety Nets,' combines short-term employment with a nutrition intervention for the poor and vulnerable. The programme links the creation of employment opportunities to the improvement of nutritional practices by adding a nutrition and growth promotion component to the traditional cash-for-work program, in order to leverage the effect of the additional income on the family's nutritional status.

The programme primarily focuses on mothers, given their key role in improving household nutrition and food security. Special attention is paid to the time and workload of women with the introduction of women-friendly and community-driven artisan projects, and by giving them the option to delegate work. Along with incorporating explicit nutrition goals and objectives in the programme design and evaluation, nutrition-specific interventions, such as the availability of micronutrients, food supplements, vaccinations and care-related services, are being implemented to address the underlying and immediate causes of malnutrition. As a result, dietary diversification, iron supplementation, regular use of soap and household spending on food increased notably among participants in the first phase of the programme.

*Source:* : WB, 2013.

iii. **A glimpse of the future:** Ethiopia's experience points to a new trend; the adaptation of large SSNs to the new challenges posed by malnutrition. Although poverty rates have fallen in the last decades, malnutrition rates often remain stubbornly high or are reduced in a slower manner. For this reason, the redesign of large public social safety nets, including the introduction of nutrition sensitivity in many of its standard programmes, will be a priority for many governments in the years to come (an illustrative case study from Pakistan is explained in more detail in Annex 4).

These experiences belong to the first wave of SP schemes being adapted to tackle not only high poverty rates – traditionally, their main objective – but also mounting levels of food and nutrition insecurity in each respective country. Each of these programmes has (or should have) started with the identification of the problem through a situational analysis of malnutrition. An overview of the key guiding principles that should lead nutritionists and SP practitioners when designing nutrition-sensitive SP programmes is provided next.

### 3.2. Key Guiding Principles for Nutrition-Sensitive Social Protection Schemes

There are four key guiding principles that practitioners, from either the nutrition or the social sectors, should take into consideration when embarking in the design and operationalization of SP schemes that incorporate nutritional outcomes:

i. **Systematic assessment.** The first and most important step when designing an effective nutrition-sensitive SP programme is the proper identification of nutritional problems and their causes. Understanding the nutritional problems that affect the population, and the related causes and consequences, is aided by using methodologies such as the 'Fill the Nutrient Gap' or a 'Nutrition in the Cities' analysis. These allow for; a) the identification of

appropriate programme objectives; b) proper targeting; c) selection of effective strategies and actions to address the problems and their causes; d) identification of and design for an appropriate monitoring and evaluation system; and e) allocation of funds and resources for implementation. Unfortunately, since not all programmes incorporate a nutrition objective from the onset, this results in SP practitioners often choosing to carry out other types of feasibility studies.<sup>4</sup>

ii. **Eligibility and targeting inclusiveness.**

For the selection of the target population, SP practitioners often resort to the identification of geographic areas with the highest proportion of people living in poverty or extreme poverty. Some areas are also selected by the presence of implementing agencies and institutions of these programmes. In most of the (non-universal) programmes however, multiple layers for targeting are applied, the geographical basis being the most widely used, followed by poverty rates, and categorical targeting, in function of the age group or the civil status, as widows or unmarried women, and in some cases through the use of biological criteria –e.g. women of child bearing age and children under two years of age.<sup>5</sup> Conversely, only in very few cases is this selection made alongside considerations of malnutrition, food security inclusivity, and nutritionally vulnerable populations. The latter is particularly important for tackling stunting. Prevalence is sometimes less important than actual numbers (caseload) of

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<sup>4</sup> Cost-benefit analysis is one of the most recurrent knowledge gaps during the design process of many nutrition-sensitive interventions. Conversely, cost simulations for different programmatic options are among the most used tools when building an investment case for large-scale cash transfer programmes. The more complex the programme the more difficult to make realistic cost simulations.

<sup>5</sup> A note of caution should be introduced here. Many SP programmes use the PLW criteria instead, which might encourage women to become pregnant in order to enter into the programme. In order to avoid unintended consequences, better selection criteria are related to broader categories. Similarly, CCTs usually bear in mind these unintended demographic consequences and limit the benefits to a certain number of children.



stunted children.<sup>6</sup> Additionally, it is necessary to take action before those children become stunted, so looking at either prevalence or the number of cases will not necessarily be the most effective; rather, the targeting of households that are more likely vulnerable to malnutrition.<sup>7</sup> The profile and characteristics of those vulnerable populations can be defined by more in-depth analysis of available data, such as the Multiple Indicator Cluster Survey (MICS) or Demographic and Health Survey (DHS).

iii. **Pertinence and quality of the supplies and services provided by the programmes.** The transfer modality matters, especially when aiming for impact on nutrition. Yet, not only what is distributed needs to be considered, but also the quantity – such as the size of the transfer – and the quality of the delivery. With regard to food-based SSNs, several key aspects must be taken into consideration:

a) *The nutritional value of the food ration.*  
To have a positive effect on food security and nutritional status, the distributed rations or food baskets should be designed based on evidence on the energy and nutritional requirements of the target population. It is necessary an assessment of possible deficits regarding the three pillars of the food and nutrition security framework: food availability, access and utilization, including the conditions for food preparation as well as habits and cultural preferences. In this regard, food-based SP programmes

should incorporate extensive information and be guided by existing policies and guidelines for the planning of food distributions. Nevertheless, in most cases national programmes do not consider the nutritional value of the rations beyond the caloric value and do not ensure that these rations correspond to the real needs of the target population. Programmes usually stick to one staple, such as rice, wheat or corn, that is easy for the government to procure and distribute on a large scale. Many of these large food-based SSNs also play a price-stabilisation role in times of overproduction, which gives them an added value.

b) *The technical specificities for certain inputs and services provided, like those related to micronutrient supplements.*<sup>8</sup>  
While treatment of the different forms of malnutrition is carried out at the health system level, SP schemes can be used for preventive purposes. For example, if the population targeted by a programme is characterized by a high prevalence of certain micronutrient deficiencies, the delivery of specific micronutrient supplements – e.g. MNP – as part of a blanket supplementary feeding programme could be an effective intervention to prevent and reduce micronutrient deficiencies.<sup>9</sup> At times SP can be used to complement treatment, without necessarily targeting specific individual beneficiaries but the community; e.g. support water, sanitation and hygiene services in areas of high nutrition vulnerability to complement nutrition-specific interventions, such as

<sup>6</sup> While in many countries a big proportion of the total number of malnourished children often live in urban and peri-urban areas, the percentage of stunted and wasted children in comparison to the entire urban child population is often lower than in rural areas. Therefore, for targeting purposes, areas will have to be selected not only based on the prevalence of malnutrition, but also in the actual number of children at increased risk of becoming malnourished. If the actual number is not taken into account during the targeting process, a big proportion of children at increased risk of becoming stunted might not be reached by the nutrition interventions.

<sup>7</sup> Targeting individual beneficiaries may lead to families or communities placing some members (e.g. malnourished child) in specific nutrition vulnerability that continually attracts social protection support.

<sup>8</sup> Micronutrient supplementation is usually recommended on the basis of the prevalence of certain nutritional deficit of a population group in a situation of vulnerability to undernutrition, especially young children and women.

<sup>9</sup> In 2007, a study found that just two months' use of MNP reduced anaemia prevalence by 28 per cent among children 6 to 36 months old. For more information see: Lundeen, Elizabeth, et al., 'Daily Use of Sprinkles Micronutrient Powder for 2 Months Reduces Anemia among Children 6 to 36 Months of Age in the Kyrgyz Republic: A cluster-randomized trial', *Food & Nutrition Bulletin*, vol. 31, no. 3, September 2010, pp. 446–460.



Community-based Management of Acute Malnutrition (CMAM) services.

iv. **Institutional coordination, political and financial sustainability and degree of compliance towards national strategies:** Inter-ministerial collaboration to harmonise understanding, strategy and modality of implementation is essential to achieve the overall nutrition objective. The eradication of child undernutrition requires sustainable public policies and institutionalized SP programmes, rather than temporary measures linked to any particular government or institution. Even when the main programmes have an allocated budget, there might not be a single line ministry dedicated to mainstreaming nutrition goals. Broad political will and fiscal sustainability are fundamental to the success of the programmes in terms of nutritional impact. Legal sustainability is ensured through a strong legal framework and Public Finance Management (PFM) system. Likewise, social sustainability is necessary in the sense that populations have appropriated, participated in and constantly demanded the services provided by the programme. In addition, accountability and transparency must be also demanded by civil society. Although the grievances redressal systems embedded in some SP programmes might help to increase accountability, other public initiatives such as civil, social and participatory budgeting might be necessary to ensure accountability and transparency.

### 3.3. The Situational Analysis

An assessment of the nutritional situation of target populations should always be considered as a first step in the design process of SP programmes. Despite the fact that this is a natural step for nutritionists, social practitioners tend to overlook this type of assessment. This analysis identifies the type, severity and extent of malnutrition, and in some cases, its causes. It should answer the question of whether nutrition is a national priority; and – if not – whether it should be. Nutrition data should be sought

and extracted from national nutrition surveys or nutritional modules from other household surveys. Results from the analysis should include not just the incidence and prevalence of key nutritional indicators –e.g. stunting, wasting, underweight and overweight– but also their disaggregation by sex, age and wealth distribution. It should further include their geographical distribution to understand whether some regions are worse effected than others. The results from the assessment will help to influence decision-making for policy formulation, resource allocation and programme implementation. See Box 3.3 for an example of a differentiated analysis on urban and rural settings and across the wealth distribution.<sup>10</sup>

During this preliminary assessment, national nutrition policies are also analysed. For example, the government may have a set of nutrition targets, either formulated by the government itself or based on the World Health Assembly's targets for 2025, namely: (i) a 40 percent reduction in the number of children under 5 who are stunted; (ii) a 50 percent reduction of anaemia in women of reproductive age; (iii) a 30 percent reduction in low birth-weight; (iv) no increase in childhood overweight; (v) a 50 percent increase in the rate of exclusive breastfeeding in the first 6 months; and (vi) a reduction of childhood wasting to less than 5 percent. Likewise, the 2030 Sustainable Development Goals (SDG) agenda calls for an end to all forms of malnutrition, as part of target 2.2. As a means of fulfilling this objective, the WHO developed the Strategic Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region 2016-2025. This plan is intended to provide the basis for government actions moving forward and should be taken into account in the analysis.

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<sup>10</sup> See WFP's corporate guidelines (WFP, 2017; Pag. 13 ~Step One: Understanding) for a comprehensive view on nutrition situational assessments.

### Box 3.3. ‘Nutrition in the Cities’ study: a reanalysis of large-scale National and sub-National surveys in Pakistan

The ‘Nutrition in the Cities’ and the ‘Cost of the Diet’ (CotD) are two complementary studies conducted in Pakistan to understand the influencing environment to nutrition status. The CotD study determined the level of access and affordability of nutritious foods to households by calculating the minimum cost of a theoretical nutritious diet using locally available foods. The ‘Nutrition in the Cities’ analysis utilized existing national surveys such as the National Nutrition Survey 2011, the Multiple Indicator Cluster Survey 2011 and the Demographic and Health Survey 2014 to determine how socio-economic status, dietary practices and health behaviors influence the nutrition status of vulnerable groups of children and their mothers in urban areas.

The ‘Nutrition in the Cities’ analysis found widespread prevalence of malnutrition (wasting, stunting, and micronutrient deficiencies) in urban children with serious to alarming public health importance levels for all provinces and for all wealth index quintiles. The poor nutrition status in children was highly influenced by poor maternal health, poor infant and young child feeding practices, and a high burden of disease with chronic inflammation and infection in children.

The CotD study found that access to and affordability of nutritious foods in urban Pakistan was a widespread problem. The majority of households (64%) in urban Pakistan could not afford a nutritious diet although only 2% of households could not afford to meet their caloric needs. The findings indicate that while nearly all households are able to purchase sufficient calories, mostly in the form of grain staples such as wheat flour, they do not have access to or can afford to purchase foods rich in vitamins, minerals, complete proteins and essential fatty acids necessary for health.

The ‘Cost of the Diet’ and ‘Nutrition in the Cities’ analyses emphasize the complexity of influencing factors on the nutrition status of vulnerable groups. Direct influencing factors such as dietary intake, feeding practices, hygiene and sanitation require Behavior Change Communication (BCC) approaches; however BCC in the case of urban Pakistan is not sufficient on its own. The widespread problem of access and affordability of nutritious foods requires separate and complementary interventions to increase the supply of nutritious foods and make them affordable to those at highest risk of malnutrition. Interventions such as cash transfers or free distribution can reduce the physical and economic barriers preventing access to nutritious foods while complementary BCC can increase household demand for nutritious foods.

*Source:* MPD&R, 2016 and Blankenship, J.

Practitioners should ask whether SP is the most appropriate response for addressing the country’s nutritional concerns or not. It is important to define in advance whether a social transfer will be the most effective way to attain specific nutrition goals; and if so, what the expected nutritional impacts are prior to the selection of the transfer modality. Since CT programmes serve multiple objectives, when selecting the transfer modality it should be considered whether or not cash and in-kind support for a particular purpose

– such as protecting livelihoods or building resilience against climate change – can also prevent undernutrition and mortality. A series of crucial pre-conditions constitute the enabling environment for the nutritional impact of social transfers:

- i. **Markets:** not only must the right foods be affordable and available in the market, but they also need to be accessed regularly, particularly during lean periods and when storage alternatives are limited for perishable

foods such as milk or meat. Additionally, the local private sector must be able to produce fortified foods in sufficient quantity for an eventual increase in demand – such as an increase brought about by a vouchers scheme. The cost should also remain reasonable.

- ii. **Social and care environment:** caretakers should be able to know what to buy, how to combine foods, prepare them, and feed their children, etc. In addition, fuel, time, cooking facilities and utensils, as well as knowledge and skills to buy, prepare and feed children with age-appropriate foods, are essential.
- iii. **Gender and decision-making dynamics:** decision-making power at the household level and commitment to spend cash on more expensive nutritious foods. This is particularly important in the diets of young children and Pregnant and Lactating Women (PLW).
- iv. **Social infrastructure and delivery systems:** programmes with nutrition objectives must assess the level of infrastructure, particularly health and education facilities, and the capacity of those sectors to deliver complementary services to SP programmes.

Third, when assessing the possibility of delivering cash instead of SNF to prevent malnutrition – as is often done under the traditional nutrition-specific interventions – practitioners should consider two key elements:

- i. The ability of the transfer modality to meet the nutrient needs of the different specific target groups, particularly: i) PLW; ii) children 6-23 months (prevention of stunting and micronutrient deficiencies), iii) children 6-59 months (in case of anticipated or existing high levels of acute malnutrition); and iv) adolescent girls.
- ii. Specific market analysis should be carried out. Programmes with nutrition objectives must look beyond market function and access, to also examine: i) the availability of nutrient-dense and aged-appropriate foods to meet the nutrient needs of young children; and ii) accessibility of targeted households to foods –i.e. the cost of the diet and its affordability.

In practice, a well-designed nutrition-sensitive SP intervention must be able to address the challenges arising from the context of implementation and set up the necessary conditions for an enabling environment. In those cases where the necessary pre-conditions are missing, the programme might have to introduce specific activities to sensitize the populations on those subjects and promote learning among the programme beneficiaries before cash or food is provided. One of the most widely used methods to provide nutrition education in nutrition-specific interventions are the Behavioural Change Communication campaigns (BCC). As such, coordination with other sectors might be necessary for paving the way for a favourable environment. It is vital that all these elements are accounted for in advance under the programme's institutional arrangements.

### 3.4. Applying Best Practices in Nutrition to Social Protection

In this section, the document provides further information on the interrelations between social transfers and nutrition. It draws on best practices from nutrition-specific programmes – many of them implemented in humanitarian contexts - and proposes ways for incorporating them into SP.

Some valuable lessons about improving the impact of social transfers on nutrition emerge directly from the CCT experience, but there is also much to be learned from best practices in nutrition-specific interventions.<sup>11</sup> These practices can be incorporated as conditionalities, or considered more broadly as complementary interventions in areas covered by SSNs – under the umbrella of the 'cash Plus' type of programmes, for example – if conditionality is not deemed appropriate, necessary, or feasible.

<sup>11</sup> Nutrition-sensitive CCT programmes should be designed on the basis of sound technical justifications. According to UNICEF and WHO for example, the best frequency of periodic attendance to health units is monthly during pregnancy and for children 0 -12 months; every two months for children from 13 to 24 months; and quarterly for children 25 to 36 months old. Hence, conditionalities should be designed accordingly.

Generally, CCTs have been the most commonly used mechanism for addressing malnutrition. The successful experiences from Latin America have made them increasingly ubiquitous in other parts of the world. But then, what are the factors beyond conditionalities that can bring about a nutrition impact? Are CCTs the only alternative to incorporate nutrition-sensitive objectives into social programmes?<sup>12</sup> So far, researchers have focused on how to enhance these conditional transfer programmes. Since the vast majority of conditional programmes are CCTs, some argue (Ryckembusch et al., 2013) that the debate on conditionality has somewhat overshadowed the one on transfer modality. Based on WFP's extensive experience in this field, the document anticipates several approaches that will likely become more prevalent in the near future:

- i. Experience has shown the importance of using *preventive*, rather than *curative*, *food-based approaches* to address malnutrition. These approaches are further explored in the next sections of this document.
- ii. The combination of social transfers through both *cash and vouchers* has been successful for *nutrition* modalities; in particular, the use of vouchers/stamps for locally available nutritious foods or Fresh Food Vouchers (FFV). Evidence has shown (Pietzsch et al., 2012) that FFV may also have an impact on the micronutrient status. Increased consumption of micronutrient-rich fresh foods can address micronutrient deficiencies if poor consumption is found to be the cause—as opposed to poor absorption or utilization.
- iii. National SSNs are increasingly turning to fortified staples distributed through food-based SP programmes as an approach to

reducing food insecurity and malnutrition. As an example, the Government of Bangladesh is distributing fortified rice through the Vulnerable Group Development (VGD) programme (see Annex 4).

In order to make CTs work for nutrition, and drawing upon the lessons learned from WFP's two-sided experience in SSNs and nutrition, four strategies that can potentially increase impact for nutrition stand out:

- i. Be *system-oriented*: build systems that can specifically act as a delivery mechanism to reach the first 1,000 days of life as well as other age groups, and can potentially address the underlying causes of malnutrition in a more systematic manner.
- ii. Stimulate both the *supply and demand* sides. Even when the supply side is ensured. With nutritious foods available, the demand has to be stimulated and sustained. It is fundamental to create the necessary demand for nutritious foods by empowering households to request and look for ways to access these foods and services.
- iii. Work with the *private sector*, such as: i) smallholder farmers, in order to enhance local production; ii) vendors and retailers, to strengthen payment systems—e.g. point of sales system, or vouchers—enabling markets for nutritious food; and iii) the food industry, to stimulate production of SNF and fortified foods that are most appropriate to each context, considering food choices.
- iv. Only where none of the above alternatives are functioning, the *provision of nutritious foods* should be considered as an interim solution, particularly in areas of high food insecurity. More research is still needed to assess impact, cost, scalability and sustainability of nutrition-sensitive CT activities, and to provide information as to whether or not CT can achieve in particular contexts the same nutrition outcomes in young children as the direct provision of nutritious foods.

<sup>12</sup> There is a growing recognition across Latin America (OEA, 2016) of the need for new integral strategies to solve the problems that CCTs have been unable to address. A transition from a CCT-based model to rights-based social protection systems is perceived as necessary. Despite considerable increases from countries in the region in the programmatic offer in social protection, it has never been prioritized what exactly is expected from those programmes. For that reason, some governments argue that a review of the social protection matrix should be undertaken by weighting each nation's needs.



### 3.5. Linking the Programme Design to the Conceptual Framework of Malnutrition

The conceptual framework of malnutrition developed by UNICEF (1990) is so far the main framework of reference for improving the nutrition of children and women. Taking this framework as a reference, researchers have produced a great deal of evidence on the existing pathways leading to improved nutrition outcomes, based on the different causes that lead to malnutrition (see Figure 2.1 and A.4.2). When designing a new nutrition-sensitive SP programme, practitioners should consider the potential entry points based on the programme objectives and in accordance with the specific context of each country or group. As a rule of thumb (FAO, 2015), practitioners should always keep in mind the following aspects when aiming at:

- i. Contributing to increased and/or stabilized *household income*. As previously mentioned, while the positive correlation between CTs and household income has been well established, much less is known about the impact of transfers on household purchasing power for nutritious foods. In order to achieve those results, the appropriate amount (see Box 3.4.), frequency and method of payment delivery should be considered from a nutrition perspective. Under the public works modality, practitioners should be mindful of increasing the workload of caregivers, in particular PLW. Likewise, CTs may contribute to an increase in diversified agricultural production and diets when targeting smallholder farmers. Yet, it is necessary to keep an eye on the seasonality of the programme, intra-household allocation of resources and decision-making processes. Regular and frequent payments – monthly or bi-monthly – have the advantage of helping households to cover everyday necessities, including food, cooking fuel and sanitary products soap. An unpredictability of payments may affect not only the household's overall income but also worsen the underlying causes of malnutrition.

- ii. Contributing to *improved diets*. Programme designers should ensure that the nutritional quality of the food basket for in-kind transfers and vouchers as well as the quality of food baskets in school feeding programmes is adequate.<sup>13</sup> Nutrition-sensitive interventions might include nutrition education in the form of BCC, micronutrient supplementation where and when relevant, or any other appropriate nutrition action. When possible, local purchase should be promoted for food transfers. One important aspect that is often overlooked is the necessity to ensure that households have sufficient inputs and assets to properly store and prepare the food. Last but not least, nutritionally vulnerable individuals within households should be targeted.
- iii. Contributing to improving individuals' *health*. Programmes should both enhance access – demand side – of vulnerable groups to health care services as well as promote an integrated approach that includes the improvement of health care services – supply side.
- iv. Contributing to *improved maternal and childcare practices*. Ensure that SP interventions do not compromise maternal and childcare practices: follow the 'do-no-harm' principle. Promote the adoption and enforcement of labour regulations that protect mothers, and fathers.

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<sup>13</sup> Although this document does not consider school feeding as a nutrition intervention—usually, malnutrition indicators are not measured in school-age children—, this type of social protection programmes could also improve nutrition outcomes through the provision of fortified food to children and an adequate M&E.



### **Box 3.4. Recalculating benefit levels from a nutritious perspective: towards a metric that reflects nutrient value**

The amount of the transfer matters, both in terms of actually making a difference for beneficiaries as well as in terms of programme costs. In general, programmes in Latin America have higher transfers as a percentage of per capita expenditure than countries in South and East Asia. The type and amount of food that can be purchased when the household income is increased depends on food prices. From a nutrition perspective, the size of the transfer should not only be determined by the assessment of average household and per capita expenditures, or the poverty line and the poverty gap. Practitioners should also take into account local prices for nutritionally valuable foods as well as how much of the transfer households would have to spend on equipment for properly storing and preparing food.

The Omega tool is one of the decision-making tools used by WFP to help in the selection of the most appropriate transfer modality when designing an intervention. The tool compares the cost-efficiency and cost-effectiveness of various transfer modalities (at the output level, it is the number of beneficiaries per dollar spent. The outcome level refers to the food security and nutritional outcomes per dollar spent). It compares the nutritional value and fully associated costs of delivering an in-kind food basket, to the nutritional value and full associated costs of delivering the same number of calories through cash, vouchers, or a hybrid basket – a mix of several modalities, e.g. part in-kind and part cash.

The Omega tool can also be used to calculate the transfer value. For cash, the tool can be used to determine how much cash beneficiaries should receive in order to meet their targeted macro and micro-nutrient requirements, based on a theoretical cash expenditure basket and local prices for the food items in that theoretical basket. For example, if the programme objective is to provide a full, nutritious basket – i.e. 2,100 kcal, 52g protein, 40g fat, and 22g iron per person per day – the tool can be used to construct a theoretical cash expenditure basket which would meet these nutritional requirements, composed of locally available and commonly consumed food items. Once the local market's prices of the food items included in the cash expenditure basket are entered, the Omega tool then calculates the total amount of cash required to buy this basket on the local market; giving the cash transfer value per beneficiary per day.

The Cost of Diet analysis fits the lowest priced nutritious diet at a household level to meet, and sometimes to exceed, 100 percent of the recommended nutrition intake for protein, fat and 14 micronutrients. The exception is energy, which cannot be exceeded above 100 percent. The diet that is considered for this analysis is at the household level, with all family members included. The affordability is then measured by comparing the cost of a nutritious diet to the current household expenditure for food. This data indicates whether caloric sufficiency may or may not be met by households. A Cost of Diet analysis is most useful when chronic malnutrition and micronutrient deficiencies are identified as major nutrition concerns in the country. The tool has nonetheless important limitations. As its calculation is based on theoretical models –i.e. based on what is available in the market, rather than on what is being actually bought,, even among those households that currently spend more on food than the amount required to achieve a nutritious diet, it is not known whether nutritious foods are actually purchased.

*Source:* Ryckembusch et al., 2011 and WFP.

### 3.6. A Theory of Change for a New Generation of Programmes

In partnership with IFPRI, WFP has developed a ‘Theory of Change’ for nutrition-sensitive SP to harmonize outputs and outcomes across the different programmatic areas within the organization. Although the ToC behind the use of SP to tackle malnutrition is straightforward, not all programmatic options—e.g. general food distributions (GFD), cash and vouchers, school feeding or food and cash for assets (FFA)—address all the underlying or direct causes of undernutrition, and not all these interventions utilize all opportunities for making the programme nutrition-sensitive. Yet, national SP systems may (or may not) include a combination of these options without necessarily following the ‘corporate design’ presented here.

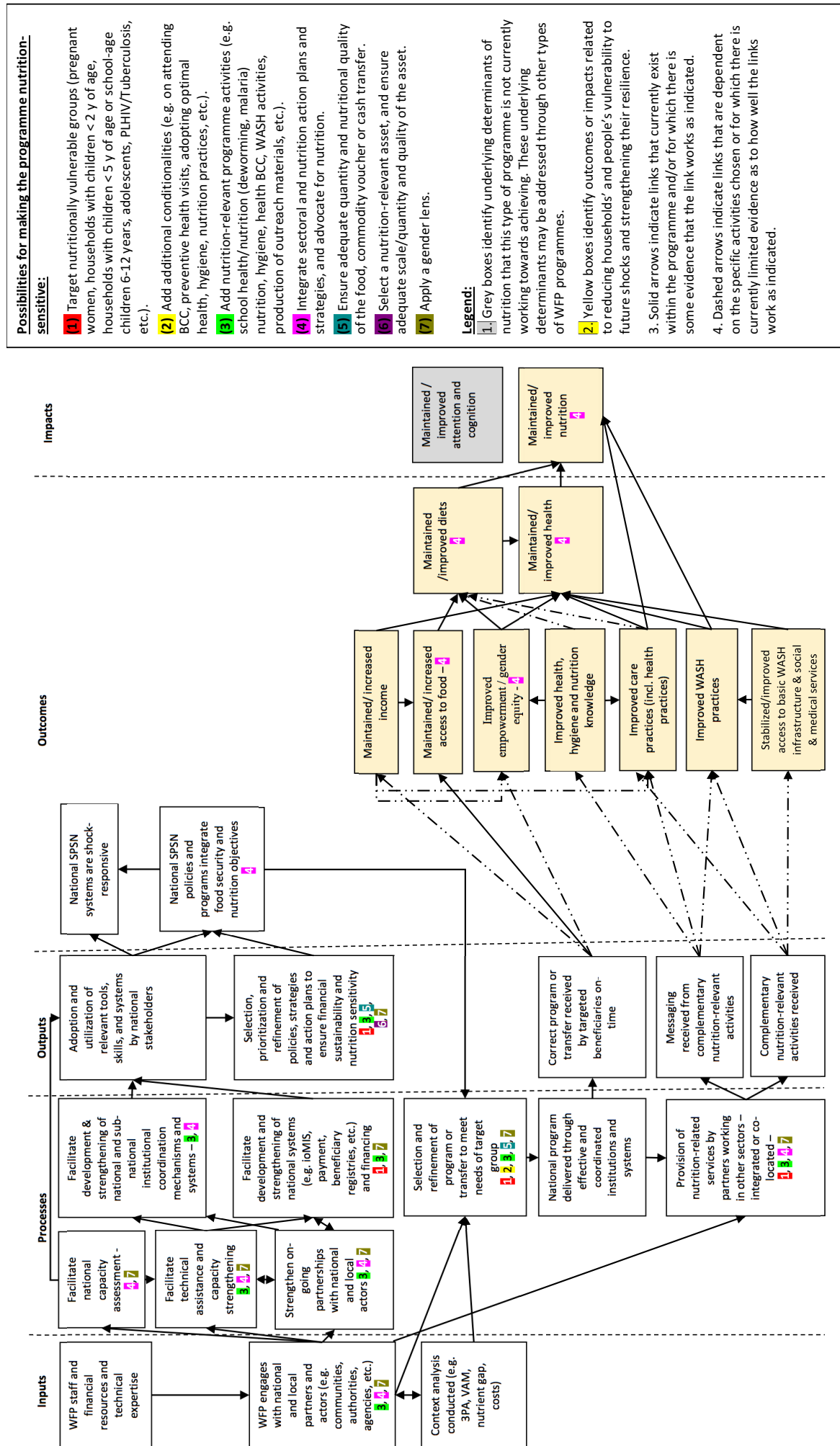
When working in SP through a nutrition lens, the ultimate goal is to ensure that food security and nutrition-sensitivity considerations are brought into the national systems through engagement with national institutions. For this reason, WFP’s ToC framework emphasizes activities regarding policy and the enabling environment that will eventually lead to that goal. Later on, specific frameworks can be developed for each one of the programmatic options. The corporate ToC presented in Figure 3.1 captures the enabling environment as a whole, with a focus on the national impact.

In practice, a favourable enabling environment is essential for increasing the chances of political buy-in from governments and stakeholders. Not only must the objectives of the programme be aligned with the national policy framework—i.e. plans and strategies— but the necessary institutional arrangements for cooperation across sectors must also be anticipated. Above all, it is important to understand the process that comes with any programme introduction, including the how – the reasons and motivations behind formulation – the why and associated advocates, and the who— whether through top-down or down-up approaches, either led by governments, cooperating partners or international advisors. For each stage of the policy dialogue, different

possibilities exist for making the programme nutrition-sensitive. Unless benefits are universal, targeting nutritionally vulnerable groups matters. The introduction of conditionalities is a possibility too, but as previously discussed, it might not be the most suitable option depending on the context. Incorporating additional activities tailored to local conditions—e.g. hygiene, BCC, WASH or production of outreach materials—might be more effective (see Box A.4.1 in Annex 4 for a detailed explanation on the BCC).

Once all those provisions have been secured, practitioners can define the operational details of the programme implementation. They are advised to follow a framework or ToC specific to the respective type of intervention—e.g. CCTs, UCTs, public works, input subsidies, insurance, etc.—to trace the right pathways to the nutrition outcomes. While weighing the different possibilities for making the programme nutrition-sensitive (Figure 3.1), practitioners should assess: i) each possibility’s feasibility for inclusion; ii) the underlying determinants of nutrition being addressed; iii) the potential for impact on those determinants; and iv) the nutrition objectives—i.e. the corresponding indicators for measuring its achievement.

Figure 3-1. Theory of Change for Nutrition-Sensitive Social Protection Programmes



Source: WFP, 2017; Olney et al., 2017.



### 3.7. Food Based Approaches to Addressing Malnutrition

Out of all the possible entry points and pathways for nutrition-sensitive SP interventions, two are highly relevant for this document:

- First, the improvement of diets, which is related to the outcome area of complementary feeding practices —e.g. minimum acceptable diet.
- Second, the improvement of care practices, related to infant, young child and maternal nutrition —e.g. infant and young children feeding practices.

In order to reduce malnutrition in both children and PLW, antenatal care and appropriate feeding habits are crucial. Importantly, the type of diet is not solely determined by physiological or nutritional needs. Other factors that influence food choice include: i) biological determinants such as hunger, appetite, and taste; ii) economic determinants such as cost, income and availability; iii) physical determinants such as access, education, skills —e.g. cooking— and time; iv) social determinants such as culture, family and gender; and v) attitudes, beliefs and knowledge about food. Since one single intervention to modify food choice behaviour will not suit all population groups, understanding the drivers of food choices of families with infants and young children should be a first step in the programme design. Among the variety of strategies for influencing food purchases and intake, SP initiatives can play an important role by introducing a nutrition lens and becoming nutrition-sensitive. First of all, these programmes should assess their effectiveness in increasing

the consumption of targeted foods that could ultimately contribute to a healthy diet in the programme's specific context.

As mentioned previously, SP should be considered a mere delivery channel for nutrition activities, rather than an objective per se. The key for bringing about the foreseen nutritional impact lies in what is being distributed, either cash, in-kind or services, with clear reference to quantity and quality, as well as in the uptake of other services and positive behavioural influence that would have longer-term impact. As shown in Box 3.5, distribution of fortified rice through food-based SSNs might be one of the most effective nutrition strategies for Asia; but it is not the only one.

Programme reviews have also shown that provision of SNF or vouchers for local equivalents through SSNs are likely to impact one of the immediate causes of malnutrition: dietary intake. Transfers using cash and vouchers for other commodities, on the other hand, tend to have a potential influence on the underlying causes of malnutrition. Conversely, expenditure patterns have shown that households may use cash to meet other household priorities —e.g. paying off debt or buying school uniforms— but might not influence the underlying causes of malnutrition. Hence, unlike food or vouchers, unconditional CTs cannot always ensure that nutrient needs are met. This argument is behind a new generation of CCTs that use cash as an incentive to accessing nutrition programmes or services, rather than as a substitute to food-based nutrition programming. Yet, their potential for a nutrition impact is still limited to the type of condition that is imposed.

### Box 3.5. Linking Rice Fortification Opportunities and Delivery Options with Nutrition Objectives

To determine the potential impact and the most appropriate delivery channel for fortified rice, it is essential to understand a population's micronutrient status, existing programmes to improve that status, and the extent to which rice fortification can contribute to micronutrient intake.

As a nutrition and population-based intervention suitable for countries where rice is the preferred staple food – as it happens to be the case throughout Asia – rice fortification must benefit those at risk of deficiencies, while remaining safe for the members of the general population that consume rice the most. Rice fortification is one component of an integrated approach to addressing micronutrient deficiencies, including micronutrient supplementation for specific target groups, promotion of dietary diversification, social protection schemes, and disease control. The potential of rice fortification to address micronutrient deficiencies varies across the life-cycle. Its potential public health impact for specific socioeconomic population groups is dependent upon the choice of delivery options: first, governments can mandate that all rice on the market be fortified. Alternatively, rice millers can voluntarily fortify rice in response to market demand. Third, distribution through social safety nets, which can occur alongside either voluntary or mandatory fortification and act as a catalyst for the latter.

Delivery option	Impact on micronutrient deficiencies by socioeconomic category			
	Low income	High income	Rural	Urban
Voluntary	Low	High	Low	High
Mandatory	High	High	High	High
Social Safety Nets	High	Low	High	High

The targeted distribution of fortified rice through SSNs is considered an intervention that has great potential to reach those most at risk of micronutrient deficiencies. However, its contribution to reducing micronutrient deficiencies among the wider population depends on the proportion of the population that is reached by the safety net. Four countries in Asia have distributed fortified rice through public SSNs with technical assistance from WFP. The most successful of these is the inclusion of fortified rice in Bangladesh's Vulnerable Group Development (VGD) programme. On a smaller scale, fortified rice was successfully introduced in Odisha state, India, through a school feeding programme. This is now being scaled up in Odisha and other Indian states. This highlights the potential of a nutrition interventions, in this case, rice fortification to be scaled up and reach a very large group of beneficiaries when associated to the right social protection programme. Indonesia and the Philippines have also experimented with fortification of their subsidized rice programmes, although neither has been successful in scaling it up.

Mandatory fortification offers the best opportunity to reach the majority of people in a cost-effective and sustainable way. However, it is only possible under certain conditions. Depending on the manufacturing and regulatory landscapes, voluntary fortification rarely achieves high population coverage, and is unlikely to achieve a public health impact for the most vulnerable. Therefore, in places where mandatory fortification is not possible, SSNs that distribute rice offer a good opportunity for reaching the most vulnerable.

Source: WFP, 2014.

### 3.8. Public-Private Partnerships for Nutrition

Given the systemic and widespread nature of child malnutrition globally, the responsibility of addressing this issue does not and cannot rest upon a single organization or sector. Since food supply and demand processes are mainly shaped by businesses, public-private partnerships play a critical role by bringing together complementary resources to deliver innovative, sustainable and systemic solutions.

National SSNs have historically resorted to public-private partnerships as a recurrent mechanism for delivering social transfers to beneficiaries. More commonly, partnerships have been built with both the public and the private banking sector, with post offices for delivering cash, and/or with nets of retailers for providing in-kind transfers.

Over the last decade, the proportion of income spent on food in many Asian countries has decreased in line with economic growth. On average, purchases of cereals have fallen, as well as consumption of fruit, vegetables and dietary fibre. However, expenditure on energy-dense and nutrient-poor processed foods that are high in sugar and fat is increasing in the majority of countries, especially in urban areas. For example, in Indonesia, most households were purchasing processed foods by 2013. Increased production and consumption of processed foods, rapid urbanization, participation of women in the workplace and a more sedentary lifestyle have led to a shift in dietary patterns and an increase in overweight, obesity and diet-related non communicable diseases. This reflects the increasing importance and influence of the private sector in food security and nutrition, from local food producers to national and multinational companies.

In this context, public-private partnerships for the improvement of nutrition are a fundamental piece of the puzzle. Partnerships with the private sector for the development and supply of SNFs or fortified foods are a good example of this. The case of ‘Wawa Mum’, a SNF that was designed

to prevent child malnutrition and is entirely produced in Pakistan stands out. Made from chickpeas, an ingredient that people throughout South Asia know and appreciate, Wawa Mum is both a potent solution to child malnutrition and a boon for Pakistan’s food processing industry. The manufacturers are currently producing enough products to respond to WFP’s demand; they are however, eager to find new markets and place their products in the local distribution channels. If done correctly, national and sub-national SP programmes are a good opportunity for these companies to expand their business. SSNs may serve a double purpose: on the one hand, whilst potential customers can be found among their beneficiaries, SP programmes could assume the distribution costs to that public. On the other hand, SSNs can boost demand for these types of products, through BCC campaigns, for example, and lead to an increase in demand at the local market level and outside the scope of the programme. As such, linking private sector and increased business opportunities with the relevant public social safety nets has the potential to reduce malnutrition at large scale in Pakistan.

Public-private partnerships for enhancing the delivery of nutrition outcomes contribute to four goals:

- i. *Nutrition learning.* Partnerships are a good catalyst for innovation, providing an integrated learning platform for nutrition and SP programmes; building a network of institutions; and enhancing South-South Cooperation.
- ii. *Product development.* Fortified food, such as fortified rice, are usually produced efficiently and effectively only by the private sector.
- iii. *Product quality.* Improve and expand supply management of SNFs — by developing product specifications, regulations and standards.
- iv. *Advocacy.* Mindful of the need to distinguish advocacy from marketing and product placement, partnerships are a good vehicle for promoting new paradigms in nutrition based on sound arguments, such as those provided by the Copenhagen Consensus (Behrman et al., 2004; Hoddinot et al., 2013) or the SUN movement.

### 3.9. Measuring Nutritional Outcomes

This section examines possible monitoring indicators for SP programmes to keep nutrition as a focus. As previously mentioned, making SP programmes more nutrition-sensitive starts by defining the nutritional objectives themselves. It then involves incorporating nutrition outcomes into the results framework. Without these outcomes, impact over nutrition cannot be measured. However, when (re)designing programmes, the identification and selection of the best indicators for measuring the impact might pose a challenge to practitioners. Illustratively, Table 3.2 offers a selection of different types of indicators classified by programme level, whereas Table 3.3 describes what (and when) nutrition indicators should be monitored in SP programmes. It is important to note that most of the nutrition indicators listed in Table 3.2. (under Impact Indicators, Outcome indicators) and Table 3.3 (under Food Consumption and Nutritious Diet, Anthropometry) should be collected, analysed and interpreted in line with international recommendations for these indicators (see WHO, 2008 and WHO, 2010 for detailed information on the definition and analysis and interpretation of those indicators, respectively).

The relevant outcomes that should be collected to monitor and evaluate the nutrition impact of social protection programmes are food consumption and anthropometric status of children 6-23 months of age, and women of reproductive age. Specific individual indicators of food consumption and anthropometric status are required to measure nutrition impact with household level data, which is currently used in SP programmes but does not provide the level of specificity required. Household level data is inadequate to capture intra-household food distribution in which one or several members of a given household eat more nutrient-rich food and/or bigger quantities than others. This can lead to inadequate intake of essential nutrients by the most vulnerable members of the household, such as young children and women of reproductive age. It is important to note

that inadequate food intake and poor dietary quality within a household can occur despite the household being food secure.

For programmes that have ‘contribution to the reduction of malnutrition’ as primary or secondary objectives, key specific indicators are required. The quality and quantity of food consumption in the vulnerable groups of young children and women of reproductive age should be measured through four indicators discussed in Table 4: Minimum Dietary Diversity (MDD), Minimum Feeding Frequency (MFF) Minimum Acceptable Diet (MAD) of children 6-23 months of age, and the Minimum Dietary Diversity for Women of Reproductive Age (MDD-W). MAD for a child between 6 and 23 months is the indicator with the strongest association to child stunting (Fanzo et al., 2014). A significant association (Ibid) has been found between MAD and the level of income – measured as GNI per capita – female-to-male adult literacy rate and rural settings. The anthropometric indicators of stunting, wasting, and underweight should be collected for children 0-59 months of age and the indicator of BMI should be collected for women of reproductive age to measure impact on nutrition status.

Implementing efforts to improve nutrition through SP and measuring their impact requires suitable indicators and tools. Indicators of nutritional status are the most common indicators for assessing the impact of interventions with a nutrition focus, including nutrition-sensitive ones. Formulating and designing targeted programmes and interventions, however, require more than just measuring nutritional status; they require a thorough understanding of what people actually eat and what personal factors underlie people’s dietary habits. Participatory methodologies that assess barriers and enablers to optimal feeding practices can be useful for gaining such an insight into peoples’ personal determinants of their dietary habits.

Formative research and focused ethnographic studies should be integrated into nutrition-sensitive programming to guide selection, design,



**Table 3.2. Nutritional indicators for M&E by programme level**

Programme Level	Description
Impact indicators	<p>They measure the effect achieved in the target population. Through them, changes in nutritional status, infant and maternal mortality, and others, can be identified.</p> <p><i>Examples: prevalence of stunting, wasting and anaemia, infant mortality rate and percentage of the population in poverty or extreme poverty situation.</i></p>
Outcome indicators	<p>They measure the products, goods and services obtained as a result of the intervention that are relevant to the achievement of effects.</p> <p><i>Examples are the 15 indicators for IYCF: i) Proportion of children born in the last 23 months who were put to the breast within one hour of birth; ii) Proportion of infants aged 0 to 5 months who are fed exclusively with breast milk; iii) Proportion of infants aged 6-8 months receiving solid, semi solid or soft foods; iv) Proportion of children 6-23 months of age who receive foods from 4 or more food groups; v) Proportion of breastfed and non-breastfed children 6-23 months of age who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more; vi) Proportion of children 6-23 months of age who receive a Minimum Acceptable Diet (MAD) (apart from breast milk); vii) Proportion of children 6-23 months of age who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home; viii) Proportion of children born in the last 24 months who were ever breastfed; ix) Proportion of children 20-23 months of age who are fed breast milk; Proportion of children 0-23 months of age who are appropriately breastfed; x) Proportion of infants 0-5 months of age who are predominantly breastfed; xi) Proportion of infants 0-5 months of age who are predominantly breastfed; xii) Median duration of breastfeeding among children less than 36 months of age; xiii) Proportion of children 0-23 months of age who are fed with a bottle; xiv) Proportion of non-breastfed children 6-23 months of age who receive at least 2 milk feedings; xv) Number of households with access to the basic food basket.</i></p>
Services and Activities indicators	<p>They are related to the services delivered by the programme. They measure the actions taken or the work done with inputs such as funds, technical assistance and other resources.</p> <p><i>Examples: changes in the coverage of services as a result of the actions of the programme; attendance to pre-natal monitoring, growth control attendance/promotion; attendance to food and nutrition training sessions. SP programs, particularly CCTs, also track inputs such as participation in health activities including public awareness campaigns and attendance in clinics and vitamin A or deworming medicine distribution. Similarly, school feeding programs track enrolment and attendance within monitoring systems, and less commonly, school performance.</i></p>
Input indicators	<p>They are related to financial, human and material resources used in the programme. They can measure the expenditures execution and the use of other resources.</p> <p><i>Examples: value of the cash transfers distributed; quantity of food distributed; number of micronutrient supplements distributed.</i></p>

Source: WFP.

**Table 3.3. What indicators should be measured and when should they be monitored in nutrition-sensitive SP?**

Category	When to Use
Food Consumption and Nutritious Diet	<p>Monitoring food consumption is data intensive, especially in rural communities where self-production and seasonal fluctuations add to the challenge of data collection. Collection of standardized indicators for diet diversity and meal frequency for the vulnerable groups of children under 2 years and women of reproductive age often serve as proxy indicators for dietary quality.</p> <p>These indicators are relatively easy to monitor and are collected for individuals in a target age group rather than for a household as a unit to allow for greater specificity. There are three indicators used to measure the adequacy of food consumption in children 6 to 23 months of age: Minimum Dietary Diversity (MDD), Minimum Feeding Frequency (MFF) and Minimum Acceptable Diet (MAD). MDD is a proxy indicator for dietary quality with adequate micronutrient density of foods and liquids other than breastmilk. MFF is a proxy indicator for adequate energy intake from non-breast milk sources. MAD is a composite indicator of MDD and MFF for breastfed and non-breastfed children to track progress on both key quality and quantity dimensions of children's diets.</p> <p>Quality of food consumption for women of reproductive age is measured through a proxy indicator for dietary quality: Minimum Dietary Diversity- Women (MDD-W). The indicator reflects micronutrient adequacy in women's diets.</p>
Anthropometry	<p>The Anthropometric indicators of stunting (height-for-age Z-score), wasting (weight-for-height Z-score, and underweight (weight-for-age Z-score) are routinely collected through community health centres and should be collected in children 0-59 months to monitor and evaluate nutrition impact as a component of social transfer programmes.</p> <p>The indicator of stunting (&lt;-2 SD height –for-age Z-score) is indicative of chronic undernutrition and is not expected to change in a short time period. Reductions in stunting prevalence are reflective long term improvements in the quantity and quality of the diet and improvements in the influencing environment around the child. The indicator of underweight (&lt;-2SD weight-for-age Z-score) is reflective of acute undernutrition and is highly influenced by short term effects such as an incidence of diarrhoea. Wasting (&lt;-2SD weight-for-height Z-score) is reflective of severe acute undernutrition as a result of failure to gain weight or weight loss due to poor feeding practices, disease or infection. Wasting in children can change rapidly and is responses to seasonal patterns and is very sensitive to changes in food availability and disease prevalence.</p> <p>Height-for-age (stunting) up to 2 years of age is considered the best predictor of human capital, considering that undernutrition is associated with lower human capital. Although evidence has shown mixed results, Aguero et al (2007) found in examining the Child Support Grant in South Africa that the duration of assistance during a child's first three years of life –their nutritionally critical 36 month window– largely determined the impact on child height-for-age. Measurement of stunting, wasting and underweight should be collected for all children enrolled in social transfer programmes.</p> <p>Anthropometric status of women of reproductive age is measured through Body Mass Index calculated from the weight and height of women. Women below 18.5 BMI are classified as underweight while women over 25.0 BMI are overweight. BMI is sensitive to food availability and disease prevalence.</p>
Food environments	<p>The foods that are available, affordable, and acceptable to the people in their households and communities are an important underlying determinant of what people eat. Food environments have a direct impact on people's food choices by setting up the universe of possibilities from which people can choose. They also have a longer-term impact by affecting people's preferences and habits. Food preferences and habits start to form in the first 1 000 days of life in a process that continues during childhood and adolescence. Although they remain malleable, preferences and habits can persist into adulthood, and then into the next generation, as infants and children are exposed to the eating behaviours of their parents and caregivers and unhealthy food environments in their homes and communities. As such, food environments are a critically important influence on the diets of individuals, households, and communities at risk of malnutrition in all its forms – undernutrition as well as overnutrition and nutrition-related non-communicable diseases.</p>

Source: WFP.

and implementation of nutrition interventions.<sup>14</sup> Likewise, qualitative research to understand barriers to participation, adoption and use of programme inputs and services should be carried out.

When incorporating nutritional outcomes into SP programmes, impact evaluations need to be adjusted accordingly to the nutritional indicators used by those programmes. The indicators identified at the programme inception level should be consistently monitored during the implementation process as well as in evaluations conducted in the course of the programme cycle.

When designing an impact evaluation for SP programmes with a nutrition lens, two elements are necessary: i) a solid understanding of the programme's theory of change, which inputs, and

outputs are sought and which processes are used to deliver them; and ii) a well-identified impact pathway on nutrition, such as linkages among the programme components for measuring the way impact is being achieved. A solid and well developed ToC, such as the one presented in Figure 3.1, is essential for that purpose.

Process evaluations are also fundamental for SP programmes in general. However, they are particularly important for nutrition-sensitive interventions, as the impact pathways on nutrition are often indirect and come determined by the complexity of the programme design. Annual process evaluations are also considered a good practice and should always be included in a programme's monitoring and evaluation framework.

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<sup>14</sup> According to Patton (1994) a formative evaluation should provide feedback on the original programme and improve its implementation, while a summative evaluation should determine if the desired outcomes are achieved and can be attributed to the revised programme. Formative evaluation encourages a process of reflective practice by providing: i) Rapid feedback, while a project is in progress; ii) Planning, allowing for revision of or recommitment to plans.







# References





- Ahmed A., Hoddinott J., Roy S., Sraboni E., Quabili W. and Margolies A. (2016) *Which kinds of Social Safety net Transfers work best for the Ultra poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative*. IFPRI and WFP.
- Alderman H. (2015) *Taking Safety Nets from Poverty Reduction to Nutrition Enhancement. A brief for the ICN2 Side Meeting - Transition from Safety Net Programs to Comprehensive Social Protection Systems: Food Security and Nutrition Perspective*. Washington, DC: International Food Policy Research Institute.
- Alderman H., Behrman J. R. and Hoddinott J. (2004) *Nutrition, Malnutrition and Economic Growth in Health and Economic Growth: Findings and Policy Implications*, Edited by López-Casasnovas, G., Rivera, B. and Currais, L. Cambridge, MA: MIT Press.
- African Union Commission, NEPAD Planning and Coordinating Agency, UN Economic Commission for Africa, and World Food Programme (2014) *The Cost of Hunger in Africa: Social and Economic Impact of Child Undernutrition in Egypt, Ethiopia, Swaziland and Uganda*. Report. Addis Ababa: UNECA.
- Bastagli F., Hagen-Zanker J., Harman L., Barca V., Sturge G., Schmidt T. and Pellerano L. (2016) *Cash transfers: what does the evidence say? A rigorous review of programme impact and of the role of design and implementation features*. London: Overseas Development Institute.
- Behrman J.R., Alderman H. and Hoddinott J. (2004) *The Challenge of Hunger and Malnutrition*. Copenhagen Consensus.
- Bonilla García A. and Gruat J.V. (2003) *Social protection. A life cycle continuum investment for social justice, poverty reduction and sustainable development*. Geneva: ILO.
- Council for Agricultural and Rural Development, UNICEF and WFP (2013) *The Economic Consequences Of Malnutrition in Cambodia. A Damage Assessment Report*. CARD.
- Committee on World Food Security (2012) *Social protection for food security. A report by the High Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security*. Rome: HLPE.
- Chambers F. (1994) *Removing confusion about formative and summative evaluation: Purpose versus time*. Evaluation and Program Planning 17(1), 9 - 12.
- De Groot R., Palermo T., Handa S., Rango L.P. and Peterman A. (2015) *Cash Transfers and Child Nutrition: What we know and what we need to know*. Innocenti Working Paper 2015-07. Florence: UNICEF, Office of Research.
- Doan D. (2014) *Does income growth improve diet diversity in China?* Minnesota: Australian Agricultural and Resource Economics Society.
- Fanzo J., Curran S., Remans R., Mara V., Sanchez Briseño J., Cisewski D., Denning G. and Fracassi P. (2014) *Simulating Potential of Nutrition-Sensitive Investments*. NY: Center on Globalization and Sustainable Development.
- Fenn B. (2015) *Research on Food Assistance for Nutritional Impact (REFANI): Literature Review*. REFANI.
- Food and Agriculture Organization (2015) *Nutrition and Social Protection*. Rome: FAO.
- \_\_\_\_ (2014) *Guidelines for assessing nutrition-related Knowledge, Attitudes and Practices. KAP Manual*. Rome: FAO.
- Hidrobo M., Hoddinott J. Peterman A., Margolies A. and Moreira V. (2014) *Cash, food, or vouchers? Evidence from a randomized experiment in northern Ecuador*. Journal of Development Economics 107: 114-156.
- Hoddinott J., Alderman H., Behrman JR., et al. (2013) *The economic rationale for investing in stunting reduction*. Maternal and Child Nutrition 9 (Suppl.2): 69–82.
- International Food Policy Research Institute (2016) *Global Nutrition Report 2016: From Promise to Impact. Ending Malnutrition by 2030*. Washington, DC: IFPRI.
- \_\_\_\_ (2015) *Global Nutrition Report 2015: Actions and Accountability to Advance Nutrition and Sustainable Development*. Washington, DC: IFPRI.
- Lancet (2016) *Trends in adult body-mass index in 200 countries from 1975 to 2014: a pooled analysis of 1698 population-based measurement studies with 19.2 million participants*. Lancet 2016; 387: 1377–96.
- Langendorf C., Roederer T., de Pee S., Brown D., Doyon S., et al. (2014) *Preventing Acute Malnutrition among Young Children in Crises: A Prospective Intervention Study in Niger*. PLoS Med 11(9): e1001714.
- Leroy J., Ruel M. and Verhofstadt E. (2009) *The impact of conditional cash transfer programmes on child nutrition: a review of evidence using a programme theory framework*. Journal of Development Effectiveness, 1:2, 103-129.

- Martínez R. and Fernández A. (2008) *The cost of hunger: Social and economic impact of child undernutrition in Central America and the Dominican Republic*. Santiago de Chile: ECLAC and WFP.
- Ministry of Planning, Development & Reform Planning Commission (2016) *Minimum Cost of the Diet (CoD) Pakistan*. Islamabad: MPD&R.
- Olney D., Gelli A. and Bliznashka L. (2017) *Making WFP's Programmes More Nutrition-Sensitive*. Rome: IFPRI and WFP.
- Organización de los Estados Americanos (2016) *Tercera Reunión de Ministros y Altas Autoridades de Desarrollo Social. Informe Final*. Asunción: OEA and CIDI.
- Patton M. Q. (1994) *Developmental evaluation*. Evaluation Practice, 15(3).
- Picanyol C. (2014) *Tracking Investment on Nutrition*. Working paper. Scaling Up Nutrition, January.
- Pietzsch S., Calo M., Jacob J. and Morel J. (2012) *Fresh food vouchers: findings of a meta-evaluation of five fresh food voucher programmes*. Humanitarian Exchange 54, pp 24-27.
- Ruel MT., Alderman H., and the Maternal and Child Nutrition Study Group (2013) *Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition*. Lancet, June.
- Ryckembusch D., Frega R., Guilherme Silva M., Gentiliny U., Sanogo I., et al. (2013) *Enhancing Nutrition: A New Tool for Ex-Ante Comparison of Commodity-based Vouchers and Food Transfers*. World Development Vol. 49, pp 58-67.
- South Asia Food and Nutrition Security Initiative (SAFANSI). Retrieved on July 2016 from: <http://www.worldbank.org/en/region/sar/brief/food-nutrition-security-initiative-safansi>
- Skoufias E., Tiwari S. and Zaman H. (2011) *Can We Rely on Cash Transfers to Protect Dietary Diversity during Food Crises? Estimates from Indonesia*. Policy Research Working Paper 5548. Washington D.C.: World Bank.
- TNP2K (2016) *Evaluating Longer-term Impact of Indonesia's CCT Program: Evidence From A Randomised Control Trial*. Jakarta: TNP2K.
- United Nations Children's Fund (2013) *Improving child nutrition: the achievable imperative for global progress*. New York: UNICEF.
- \_\_\_\_ (2009) *Tracking progress on child and maternal nutrition. A survival and development priority*. New York: UNICEF.
- \_\_\_\_ (1990) *Strategy for Improved Nutrition of Children and Women in Developing Countries: A UNICEF Policy Review*. New York: UNICEF.
- United Nations Children's Fund and Scaling Up Nutrition (2016) *Workshop on Public Finance for Nutrition in Asia. Report of a Regional Workshop, Bangkok, Thailand, April 25-27, 2016*. Bangkok: UNICEF, SUN.
- World Bank (2014) *Social Safety Nets and Gender. Learning From Impact Evaluations and World Bank Projects*. Washington D.C.: Independent Evaluation Group, WB.
- \_\_\_\_ (2013) *Improving Nutrition Through Multisectoral Approaches*. Washington D.C.: WB.
- \_\_\_\_ (2012) *Social Protection and Labor Strategy 2012-2022. Resilience, Equity and Opportunity*. Washington D.C.: WB.
- \_\_\_\_ (2011) *Program Keluarga Harapan. Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program*. Jakarta: WB.
- \_\_\_\_ (2006) *Repositioning Nutrition as Central to Development. A Strategy for Large-Scale Action*. Washington D.C.: WB.
- World Food Programme (2017) *Unlocking WFP's potential: Guidance for nutrition-sensitive programming. March 2017. Version 1.0, Interim*. Rome: WFP.
- \_\_\_\_ (2015) *Nutrition Situation Analysis*. Unpublished raw data.
- \_\_\_\_ (2014) *Scaling Up Rice Fortification in Asia*. Bangkok: WFP.
- World Health Organization (2013) *Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition*. Geneva: WHO.
- \_\_\_\_ (2010) *Nutrition Landscape Information System (NLIS) country profile indicators: interpretation guide*. Geneva: WHO.
- \_\_\_\_ (2008) *Indicators for assessing infant and young child feeding practices: conclusions of a consensus meeting held 6-8 November 2007 in Washington D.C., USA*. Geneva: WHO.



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## Additional Resources



## 1. Glossary

### Nutrition-Related

**Anthropometry:** The use of body measurements to assess and classify the nutritional status of an individual. Child's measurements should be compared against an internationally accepted standard for a well-nourished healthy population.

**Cost of the Diet:** CoD is a method used to calculate the cheapest possible cost of a locally available theoretical diet that satisfies all nutritional requirements – energy, protein, fat and micronutrients – of a household or individual.

**Dietary diversity:** Number of food groups consumed over a given reference period. Dietary diversity is an important aspect of dietary quality – understood as the nutritional adequacy of the diet.

**Hidden hunger:** Micronutrient deficiency or 'hidden hunger' occur when there is insufficient dietary intake, insufficient absorption, and/or suboptimal utilization or excessive loss of vitamins or minerals. It affects around 2 billion people, or about one third of the world's population. Vitamin and mineral deficiencies, especially for iron, iodine, zinc and vitamin A, can lead to poor physical growth and development, lowered mental capacity, reduced productivity, impaired immune function, blindness and death. The effects of micronutrient deficiencies are all preventable although the limited physical visibility of many of these nutritional deficiencies may lead to a low demand for nutritious foods and nutrition interventions.

**Malnutrition and undernutrition:** Malnutrition occurs when nutrient and energy intake does not meet, or exceeds, an individual's requirements to maintain growth, immunity and organ function. Malnutrition is a general term that covers both under-nutrition and over nutrition (overweight/obesity). Undernutrition is the inadequate and/or unbalanced intake and/or absorption of micro- or macronutrients that in turn leads to nutritional deficiency. It covers a range of disorders, including acute

malnutrition – wasting, nutritional oedema – chronic undernutrition – stunting – underweight and micronutrient deficiencies.

**Large-scale fortification programmes:** Geared toward the fortification of food consumed by the entire population: salt with iodine; wheat flour with iron and complex B vitamins; sugar with vitamin A; and rice with iron, folic acid and vitamin A.

**Micronutrient supplementation programmes:** Programmes where different micronutrient supplements with different micronutrients are provided, mostly iron, vitamin A and folic acid, in different compositions and shapes, generally to children under 5 years and pregnant and lactating women.

**Mother and child health programmes:** Programmes oriented toward ensuring health care that is focused on mothers and to children under 5 years. They generally prioritize actions for preventing and treating the most prevalent diseases in these groups – for children under 5 years there is a package incorporated that is known as Integrated Management of Childhood Illness (IMCI).

**Mother and child nutrition programmes:** Programmes that include nutritional actions aimed at mothers and children. Some of the actions include: promotion of breastfeeding, growth monitoring, nutritional education and counselling, micronutrient supplementation and distribution of fortified complementary foods.

**(Nutritional) treatment programmes:** These programmes include various actions for the treatment of children with severe or moderate wasting.

**Nutrition-sensitive Interventions:** These are interventions or programmes that address the underlying determinants of foetal and child nutrition, including food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment,



which also incorporate specific nutrition goals and actions. (Alderman, Harold 2013). Nutrition-sensitive programmes can serve as delivery platforms for nutrition-specific interventions, potentially increasing their scale, coverage and effectiveness.

**Nutrition security:** This goes beyond the traditional concept of food security – access, availability, stability and utilisation of food – and recognises that nutritional status is dependent on a wide and multi-sectoral array of factors. Individual food intake and illness are the immediate cause of malnutrition, which are in turn effected by the underlying causes of household food security, care and health practices and health and hygiene conditions. Nutrition security exists when food security is combined with a sanitary environment, adequate health services and proper care and feeding practices to ensure a healthy life for all household members.

**Nutritional status:** The physiological state of an individual that results from the relationship between nutrient requirement, nutrient intake, and utilization.

**Specialized Nutritious Foods (SNF):** This category includes fortified blended foods, Ready-to-Use Therapeutic Foods, Ready-to-Use-Supplementary Foods, lipid-based nutrient supplements and micronutrient powders. They are designed to provide a range of micronutrients, animal source protein and essential fatty acids to ensure an adequate intake of nutrients using culturally acceptable ingredients to meet the nutrient gap –e.g. the difference between what is consumed and what is required.

**Utilization rate:** An indicator used to measure the utilization of health services over the course of a single episode of illness or a single pregnancy, and to determine whether patients are receiving proper treatment as compared to standard practices. The utilization rate is equal to the number of new cases plus the number of old cases divided by the number of new cases. New cases may be defined as new episodes of

illness or new pregnancies ‘seen’ by the health facility staff for the first time. If a patient must return one or more times to undergo treatment in connection with a single episode of illness or pregnancy, these new visits fall under the category of old cases. Example: A utilization rate of 3.5 for prenatal consultations means that, on average, pregnant women undergo 3.5 prenatal consultations per pregnancy. Additional example: A utilization rate of 1.1 for consultations means that, on average, patients undergo 1.1 consultations over the course of a single episode of illness.

### **Social Protection-Related<sup>15</sup>**

**Cash transfer:** Regular non-contributory payment of money provided by government or other organizations to individuals or households, with the objective of decreasing chronic or shock-induced poverty, addressing social risks and reducing economic vulnerability.

**Childhood and adolescence attention programmes:** Includes alternative centres or homes where children in vulnerable social situations –orphans, abandoned children– are welcomed and provided with food, care, education and protection. The assisted children remain in those centres through adolescence and in some cases even up to their youth.

**Conditional transfer programmes:** Programmes that transfer cash, in kind, vouchers, food or other inputs, such as seeds and fertilizers, among others, giving families –the target population– responsibilities to be met in exchange for the transfer. Co-responsibilities relate primarily to the ‘obligation’ to send children to school and to attend health facilities. These programmes are mostly aimed at poverty reduction and human capital investment.

**Food-based social safety nets:** These represent a subset of safety net programmes, with the distinctive characteristic that they provide food to beneficiaries. This can happen

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<sup>15</sup> Sources: International Labor Organization’s glossary. WFP (2014). *WFP Safety Nets Guidelines. Module A: Safety Nets and Social Protection Basics and Concepts*. Rome: WFP.

directly (in-kind) or indirectly through food stamps, vouchers and coupons. Just like cash-based programmes, food-based programmes increase the recipients' purchasing power because the food represents an intrinsic value. But unlike cash-based programmes, food-based programmes also have other objectives, in particular improving the food and micronutrient intake of the beneficiaries (WFP, 2014).

**Public Financial Management:** PFM relates to the way governments manage public resources —both revenue and expenditure— and the immediate and medium-to-long-term impact of such resources on the economy or society. As such, PFM has to do with both how governments manage, and the results of the short-, medium-, and long-term implications of financial flows.

**Social Protection Expenditure and Performance Review (SPER):** A report providing detailed information on the performance of a national SP system as well as on the extent of coverage and exclusion from SP. In an internationally comparable way, a SPER provides information about the structure and level of total social expenditure and establishes indicators of system performance with respect to its effectiveness, efficiency and the adequacy of benefit levels.

**Scheme (social protection ~):** A distinct body of rules, supported by one or more institutional units – schemes are not themselves institutional units, as one institution may administer more than one scheme – governing the provision of SP benefits and their financing.

**Social accounting system (SAS):** Methodologically consistent compilation of the revenues and expenditures of a country's SP system. Used in social budgeting. See: European System of Integrated Protection Statistics (ESSPROS).

**Social assistance:** Social security benefits that are conditional on the level of income of recipient, i.e. are means-tested or based on similar forms of targeting —e.g. proxy means

test, geographical targeting— are generally called social assistance. They are generally a device to alleviate/reduce poverty. Benefits can be delivered in cash or in kind. Social assistance schemes are usually tax-financed and do not require a direct contribution from beneficiaries or their employers as a condition of entitlement to receive relevant benefits.

**Social protection (SP):** The term 'social protection' is used to mean protection provided by social security systems in the case of social risks and needs. SP is often interpreted as having a broader character than social security, including, in particular, informal SP provided between members of the family or members of a local community. It is also used in some contexts with a narrower meaning than social security —understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of society. Thus, in many contexts the terms 'social security' and 'social protection' are used interchangeably.

**Social safety nets:** Formal or informal non-contributory programmes designed to provide predictable support to people who are vulnerable to or living in poverty or who are facing malnutrition and other forms of deprivation. Any programme that is temporary, unpredictable, or that does not build or support government safety net systems cannot be described as a safety net (WFP, 2014).

**Social transfers:** Social transfers represent a transfer from one group in a society to another – such as from the active age groups to the old —either in cash or in kind— and access to goods and social services. The recipients qualify because they have earned entitlements through fulfilling obligations —e.g. paying contributions— and/or meeting certain social or behavioural conditions —e.g. being sick; poor; or carrying out public works. In recent years, this term has been used to describe schemes for all residents that provide benefits under the single condition of residence —universal cash transfers— or social assistance schemes that require additional behavioural conditions as prerequisites —conditional cash transfers.



**Target population:** The population that the future scheme plans to cover, including all potential members and their dependents. The target population may be defined on a geographic basis: the inhabitants of certain neighbourhoods or villages, the catchment area of certain health facilities, etc. Alternatively, it may be defined on a socio-economic or socio-occupational basis: the members of a trade union or agricultural cooperative; the customers of a microfinance institution; the employees of an enterprise, etc.

## 2. Relevant Findings from Literature

### An Operational Research Agenda for Nutrition-Sensitive Interventions

Over the past few years, national and global interest in nutrition has increased dramatically. Recurrent food shortages, rising food prices and humanitarian crises in some regions have garnered global attention. More persuasive evidence (UNICEF, 2013) has become available on the harmful consequences of micronutrient deficiencies and the positive impact of exclusive breastfeeding and adequate complementary feeding for adult life and the next generation. At the other end of the spectrum, the rising number of people who struggle with overweight and obesity in the Asia region have become more obvious (ASEAN, 2016; Lancet 2016). The improved scientific evidence on the impact of interventions has enhanced advocacy to position nutrition as a sound investment for poverty reduction and social and economic development.

In fact, the 2013 Lancet series on Maternal and Child Nutrition reports that ‘the nutrition landscape has shifted fundamentally since the first Lancet Series was published in January, 2008’, reflecting in part the emergence of movements such as Scaling Up Nutrition (SUN). However, despite improvements in the nutrition landscape, gaps remain in the evidence that is available to inform effective policy and practice, especially regarding acute malnutrition.

It has generally been acknowledged that stunting and other forms of undernutrition are also linked to health, food availability, water and sanitation,

cultural practices and social and political factors, but evidence on how improving these factors affects nutritional status is still limited. Among the multiple factors causing undernutrition, a poor diet – inadequate dietary intake – is a major contributing aspect. The role of food as a means of providing optimum nutrition and child development is undisputed. Foods not only provide energy, but are also sources of crucial nutrients that the human body requires for growth, development and health. Young children have very high nutrient needs proportionally to their body weight, including vitamins and minerals – micronutrients – protein and essential fatty acids – macronutrients – and growth factors. Meeting these high requirements is further complicated by the very small stomachs of young children, so it’s crucial that all meals and snacks are rich in nutrients and energy. Children must be fed more frequently than adults and with nutrient dense foods. Yet, complementary foods in most of the low and low-middle income countries are cereal-based and as a result have low nutrient density and a high quantity of anti-nutrients, which negatively affect absorption of available nutrients, and provide limited essential fatty acids and macro-minerals. Animal food consumption is also often limited in these contexts.

The 2013 Lancet Nutrition Series estimated that scaling up 10 proven effective nutrition-specific interventions would reduce stunting globally by 20 percent. While this would be a major improvement in the health and development of many children, it does not go far enough. It is still far from the World Health Assembly’s targets. There is still a need for nutrition-sensitive interventions and for improved understanding of how to increase the nutritional impact of the resources devoted to transfers. However, experts (Alderman, 2015) have noted the important operational knowledge gaps still remaining on how to effectively implement nutrition-sensitive safety nets and other SP interventions.

### Poverty: Income and Diets

Researchers (Bouis and Haddad, 1990) have demonstrated the existence of a low calorie-income elasticity: as income doubles, calorie

intake increases by only 10 percent. Conversely, many CT programmes assume that preferred expenditures on nutritious foods can be achieved simply by an increase in income, such as through an unconditional CT alone. There is much less research on the nutritious diet-income elasticity: the effect of income and prices over diets, efficiency in food consumption patterns or how a change in the transfer size – i.e. in the generosity of the programme – would affect the suitability of the dietary intake.<sup>16</sup>

As a rule of thumb (Alderman, 2004) rates of stunting, defined as low height for age, decline at approximately half the rate that income increases. Thus, a 10 percent increase of income might achieve a 6 percent decrease in stunting rates. Similarly, anaemia in women declines at roughly 25 percent of the rate of income growth. This gives a first approximation of the effect of the income transfer alone –that is, not including any behavioural change activity or other add-ons. The increase in food expenditure is always larger than the increase in the amount of food, as measured by calories. It is estimated that the quantity of food increases at half the rate that expenditure increases. This implies that an affordable transfer programme might increase calories by 3-4 percent, although this data does not shed light on the quality of the food purchased.

The challenge in measuring these associations comes from the hitch of mixing disciplines such as economics and nutrition. One of the first factors economists examine when analysing food consumption behaviour is household income, which determines the budget that is available for expenditures and imposes constraints on consumer behaviour. When available, they rely on national food consumption surveys or on household surveys. In low-income countries however, these surveys are not always a reliable source of data. Nutritionists on the other hand, use the same sources in a different way complementing them with other tools, like those

shown in Box 3.3 (see Section 3.3). Nutrition data always refers to a specific category of the population, such as women in reproductive age or children from 6 to 23 months, and as such household data cannot inform on these specific groups.

A study done by Skoufias et al. (2011) is a good example of the interrelation between these two disciplines. Researchers used data from two cross-sectional household surveys in Indonesia carried out before and soon after the 1997/98 economic crisis to estimate the income elasticity of micronutrients and assess how they change during economic crises. The justification behind the study was the argument that those changes may affect the effectiveness of cash transfer and nutritional supplementation programmes.<sup>17</sup> Another series of studies (CARD et al., 2013; Martínez and Fernández, 2008; African Union Commission et al., 2014) analysed the economic consequences of hunger and malnutrition and ‘the cost of inaction’ in order to provide projections on the economic burden of malnutrition and facilitate policy discussion in different regions, from Latin America to Africa and Asia. As one of these studies (CARD et al., 2013) acknowledged, converting indicators of malnutrition to economic activity and attaching a monetary value to that economic activity ‘travels a long and winding road’. Monetizing the consequences of malnutrition is dependent on a relatively thin evidence base, often used way below its full potential. This is particularly true in the case of overweight and obesity, which very frequently are left out from these exercises. The analysis is usually done for one particular form of malnutrition, not malnutrition as such, which would be quite difficult to do as it is not known exactly how much overlap there

<sup>16</sup> Doan (2014, p. 7:8) provides an extensive list of empirical studies that look at income effect on diet variety, mostly in high-income countries.

<sup>17</sup> The research found that income elasticity of some key micro-nutrients, such as iron, calcium, and vitamin B1, is significantly higher in the crisis year compared with a normal year; and the income elasticity for certain micro-nutrients—vitamin C in this case—remains close to zero. These results suggest that CTs programmes may be even more effective during crises to protect the consumption of many essential micro-nutrients compared with non-crisis periods but in order to ensure that all micro-nutrients are consumed, specific nutritional supplementation programmes are also likely to be required.

is between the different forms of malnutrition. Ultimately, all the available evidence gathered on ‘the economics of malnutrition’ leads to a clear conclusion: poverty – i.e. income – is neither the only driver of malnutrition nor the most relevant in every country. In many cases, researchers and practitioners will have to dig much deeper in the additional underlying causes and adapt their responses accordingly.

### **Food and Nutrition Security**

The Rome declaration on World Food Security from 1996 defined food security as a situation where ‘all people at all times have physical and economic access to sufficient, safe and nutritious foods to meet their dietary needs and food preferences for an active healthy life’ (World Food Summit, 1996).

From a nutrition perspective, these three dimensions of food security – access, availability and utilization – are fundamental to understanding the reasons for any nutrient gap: i) availability of high quality nutritious foods; ii) economic access to an adequate diet at the household level; and iii) adequate individual intake, especially for vulnerable groups. The third dimension, food utilization, is particularly important and refers to the quantity of food people eat, what and how they eat: at the household level. Utilization covers food preparation, intra-household food distribution, as well as adequate diversity of the diet and proper feeding and care practices. At the individual level, utilization refers to how efficiently individuals absorb nutrients they consume, which is effected by their health status.

Food security and malnutrition are not always interlinked: the latter occurs even in areas that are considered food secure. Examples from Tanzania or Pakistan indicate that high levels of undernutrition and a low penetration of diversified diets are found even among the food secure. Thus, improving household food security does not necessarily positively impact individual nutritional status – mainly due to other factors such as intra-household distribution patterns that mediate household inputs and individual consumption.

Statistics, however, underestimate the true extent of food insecurity, which includes hidden hunger: micronutrient deficiencies that, beyond calories, limit the potential for active and healthy lives. In South Asia, national food security has largely been achieved, but nutrition security below the national level down to the household level has not (SAFANSI 2016). In less secure households where income and dietary energy supply are low, malnutrition resulting from inadequate caloric intake will be exacerbated by poor dietary diversity. In both cases, increasing consumption of nutrient-rich foods is key to improved nutrition outcomes.

In an agricultural context like those found in low-income countries, nutrition security refers to the ‘quality’ aspect of food production, consumption and utilization by all individuals in a household. While food security may increase the total quantity of energy available for consumption, only nutrition security can guarantee the quality and diversity of food necessary for protecting and promoting good nutritional status and health.

Social transfers programmes have been able to address much more easily the quantitative and economic aspects of food security by increasing the consumption of food than the qualitative and social ones, such as through the adequate intake of food. This is mainly due to an important aspect effecting undernutrition beyond food security, an individual’s health status, which depends in turn on the broader social and care environment and access to health care and hygiene conditions. The latter constitute the underlying causes of malnutrition.

### **Dietary Diversity**

It is widely accepted that CTs increase dietary diversity but it is important to analyse the type of food that is increasingly purchased, as well as the exceptions to the rule. While enhanced dietary diversity is essential to improved nutritional status, diversity alone will not be enough to address the nutrient gap for small children during the critical window of opportunity.



A transfer modality study carried out by WFP and the Food Policy Research Institute (IFPRI) in Bangladesh (Ahmed et al., 2016) concluded that while all the transfer modalities analysed – cash, food, cash and food, and cash or food plus a nutrition behaviour change component – improved expenditures on both food and non-food consumption, only by combining transfers with nutrition BCC trainings consistently caused considerably larger improvements than transfers alone. Adding BCC to transfers induces significantly greater expenditures on food, resulting in both higher caloric intake and purchase of more expensive calories, with the latter corresponding to a reallocation of the diet from staples to more non staples, including animal source foods such as dairy and meat, eggs and fish. Since the provision of BCC does not change the amount of transfer resources available to households, the implication is that it changes how households use the same amount of transfer resources. In particular, findings suggest that households are encouraged through the BCC to allocate their transfer resources toward a considerably more diverse diet, relying on fewer staples and more nutritious non staples. Lessons learned from WFP’s experience with nutrition-specific programmes indicate that a combination of CTs and SNF is the transfer modality that is most likely to have a positive influence on the nutritional status of children as it may help to limit sharing or the sale of the food distributed.

### **Caring Practices and Environment**

Gender relations play a key role in a social and care environment as they impact household decision-making power and ultimately resource allocation. Indeed, transfers targeted at women may have a greater likelihood of leading to improved nutrition outcomes. But women’s time allocation is also one of the greatest determinants of the care environment. Therefore, transfers that positively impact women’s time may also positively impact the social care environment and ultimately the nutrition status. This is particularly important when designing SP schemes such as public works and CCTs.

Additionally, SP programmes should consider that women and children are more vulnerable to nutritional deficiencies; special efforts are therefore needed to address the biological and social inequities that affect them (UNICEF, 2013). Women’s low education levels, unequal social status and limited decision-making power can negatively influence the nutrition status of their children, as well as their own. Improving access to education and creating opportunities for both girls and boys, and their families, will confer many benefits in terms of nutritional status and child development.

### **What Evidence Does Not Tell**

Research has successfully addressed the first factor of the equation: the ‘what’. The answer to what can be done to improve nutrition is now twofold: not only nutrition-specific interventions but also nutrition-sensitive. The pathways are quite clear and the target populations too. Yet, the ‘how’ still remains unknown. How to scale up nutrition-sensitive interventions (for reaching universal coverage) remains one of the main challenges. Large poverty-alleviation SSNs in low and low-middle-income countries usually targeted the poorest rather than being universal schemes. The challenge from a social policy point of view is not so much how to scale them up but how to convince governments about the benefits of universal schemes. In many cases, it is not so much a problem of financial constraints, not enough fiscal space or lack of revenue, but a question of ideology and social theory.<sup>18</sup>

Despite renovated efforts for making SP, and social assistance in particular, more nutrition-sensitive, one of the main obstacles so far has been the lack of evidence on the effects of CTs upon the nutritional status of children. An extensive literature review carried out

<sup>18</sup> Not only the State is involved in the provision of Welfare, but also the Market, the Family and the so-called Third Sector —Civil Society— are. The ideological debate around social policy is defined by the views of the different perspectives, both political and academic: from the Neoliberals and Conservatives to the Marxists, Social Democrats, Feminists and Ecologists. Each one stressing the role of one or several of the institutions conforming the social structure in providing Welfare to society.

by UNICEF (de Groot et al., 2015) showed that the direct impact of CT programmes on children's nutritional status is mixed. In most cases, the pathways of impact are not analysed and it is therefore unclear why some CT programmes have a significant impact on nutritional outcomes, while others do not. Yet, the concept of resources for care in relation to CT programmes is generally understudied. Generally, most programmes have no focus on either maternal nutrition or the minimum nutritious diet necessary to achieve good levels of nutrition. Conversely, there is strong evidence that cash transfer programmes have a positive effect on the necessary resources for achieving food security – food access – and accessing health and care services.

As previously mentioned, food security is usually measured through its food expenditure proxy. In a recently published report from ODI, synthesizing evidence from 165 studies, in 30 countries, from 56 cash transfer programmes covering low and middle income countries worldwide (Bastagli et al., 2016), the findings did not include information on their impacts upon overall food consumption –in addition to dietary diversity. While the study did not specifically look at food consumption, it did look at impacts on food expenditures as part of the monetary poverty analysis. There are important trade-offs when using this narrow approach for measuring food and nutrition security. All the analytical richness of using multi-dimensional approaches for measuring poverty is lost as poverty –i.e. income and expenditure– is not the only driver of malnutrition but only one of them.

In contrast, when using a wider array of indicators a clearer picture of malnutrition can be obtained. An evaluation of a SP programme in Niger carried out by WFP, MSF and Epicentre (Langendorf et al., 2014) did look at both food and nutrition security. Findings suggest that support to vulnerable households via cash or food transfers should also include nutritious foods for vulnerable groups –from 6 to 23 months of age. Likewise, evidence from Ecuador (Hidrobo et al., 2014) showed that vouchers led to significantly

larger increases in dietary diversity. While food was the least cost-effective modality, vouchers were usually the most cost-effective.

Some reasons why targeted household transfers appear to have only a modest impact on nutrition point to the fact that the objectives of SP programmes vary widely, from reducing poverty and vulnerability to building human capital, empowering women and girls, improving livelihoods, and responding to economic and other shocks. As a result, the form and function of SP programmes can be quite distinct, according to the particular objective. However, nutrition is rarely among their main objectives; neither have they targeted the right population. Furthermore, most of the programmes that have been studied extensively have not been in regions of high stunting rates and often their nutritional impact has been assessed outside the critical 1,000 days, which diminishes their value.

Despite the increasing number of pilots of multi-sectoral nutrition-sensitive interventions, governments continue to struggle with scalability. Findings from two nutrition-sensitive SP programmes combining social transfers – in-kind and cash – with BCC in Bangladesh – i.e. World Bank's Income Support Programme for the Poorest (ISPP) and WFP's Transfer Modality Research Initiative – put the cost between US\$ 500 and US\$ 700 per child (for the intervention's span), respectively. In order to operate these types of programmes on a larger scale, it will be necessary to gather more systematic evidence on the relative effectiveness of alternative modalities for combining CT with BCC campaigns.

Experts (Alderman, 2015) have also pointed out existing limitations in the research around the transfer modalities, i.e. food versus cash modalities as well as new add-ons, like BCC. Research often takes place in unique contexts – e.g. post-emergency of tsunamis or cyclones – or involves differences beyond modality type, which complicates the interpretation. The difference in value of the food basket compared to the cash basket – usually the former is higher than the latter – makes it difficult to attribute the

difference in consumption habits solely to the type of transfer received rather than the value. Yet, differences between the food and cash groups go beyond modality differences – e.g. lack of randomized controlled trials, difference in value of the transfer, conditionalities or access to and availability of markets, and insufficient understanding of the pathways – which makes it difficult to generalize and extrapolate across countries. Both forms of transfers increase household food security but their relative roles for improving diet diversity – a key factor in nutritional impact – depends on contexts including structure of local markets and seasonality of purchases. Finally, some evidence is based on a too short a period for full cumulative results.

As noted by a recent strategic review of food security and nutrition in Bangladesh commissioned by WFP, the relevant lesson from the Transfer Modality Research Initiative is that in order to best learn from different approaches ‘it is not enough to measure the outcome indicators of our efforts; it is also necessary to identify pathways that enable the outcomes’. This is especially important for new schemes as the ones analysed in the present document: for each scheme one should be able to answer the question of what exactly leads to the reduction of stunting, and what does not.

At the macro level, the Global Nutrition Report (IFPRI, 2015) observed that efforts to track the extent to which national policies and

programmes are sensitive to nutritional concerns are still in their relative infancy and there are no agreed-upon metrics or data sources. The relatively new tracking of governments’ and donors’ nutrition-sensitive budget allocations and disbursements begins to fill this gap (UNICEF et al., 2016). Likewise, stronger and more transparent PFM systems are necessary for an effective tracking of investment across the nutrition-sensitive sectors. The Public Finance for Children (PF4C) methodology developed by UNICEF can be considered a good practice in this field and a good model for assessing the new wave of nutrition-sensitive SP programmes. Additional tools and methodologies tailored to the specific needs of this new wave of SP programmes will be instrumental in building a strong case alongside governments.

### 3. Poverty, Food Insecurity and Malnutrition in Asia

The level of child and maternal undernutrition remains stubbornly high throughout the world. More than 90 percent of the world’s stunted children live in Asia and Africa. Eighty percent of the developing world’s stunted children live in only 24 countries (UNICEF, 2009; the 2008 Lancet Series on Child and Maternal Undernutrition). Six out of the ten countries (Table A.3.1) that contribute most to the global burden of stunting among children are in Asia: India, China, Pakistan, Indonesia, Bangladesh and the Philippines.

**Table A.3.1. 18 Top ten countries with the largest numbers of children stunted**

Ranking	Country	Stunting Prevalence (%)	% of developing world total (195.1 million)
1	India	48	31.2%
2	China	15	6.5%
3	Nigeria	41	5.2%
4	Pakistan	42	5.1%
5	Indonesia	37	3.9%
6	Bangladesh	43	3.7%
7	Ethiopia	51	3.5%
8	DR Congo	46	2.8%
9	Philippines	34	1.9%
10	Tanzania	44	1.7%

Source: UNICEF, 2009.



The bulk of the world's undernutrition problem is mainly localized in Asian and African countries. The situation in the Asian countries is highly worrying as they still remain far above the World Health Organisation's thresholds considered as serious – above 40 percent of stunting – and critical – 30-39 percent.

Since 1990, stunting prevalence in the developing world has declined from 40 percent to 29 percent, a relative reduction of 28 percent. Progress has been particularly notable in Asia, where prevalence dropped from 44 percent around 1990 to 30 percent around 2008 (UNICEF, 2009). Cases like Bangladesh's significant reduction on stunting demonstrate that improvements can be achieved.

Overall, Asia accounts for about 60 percent of the global stunting burden. As seen in Table A.3.1, more than one third of the developing world's children who are stunted live in India.<sup>19</sup> With 44 percent of the children under-five stunted – almost 11.5 million cases – Pakistan exceeds by far the World Health Organization (WHO) critical threshold for stunting of 20 percent. With 41 percent of the children under-five stunted – almost 7 million cases – Bangladesh is considered to be in the critical zone of high-burden countries. Similarly, and despite the difficulties for its proper measuring, the burden of wasting, both moderate and severe, is particularly critical – 15 per cent or more – in countries with large populations like India (20 percent), Bangladesh and Pakistan (around 16 and 15 percent, respectively in 2015), and serious – 10 to 14 per cent – like in Indonesia with 12 per cent in 2015 (WFP, 2015).

The current nutrition profile of the South-East Asia region is characterized by stunting rates that are declining slowly alongside rapidly rising rates of overweight and obesity, often within the same communities, and even in the same households. This double burden is depriving people of reaching their potential, and is fuelling

rising rates of non-communicable diseases. Across the region, an estimated 60 million children aged 0-5-years are stunted, while 8.8 million are overweight. Underweight affects 24 to 47 percent of adolescent girls, while between 2 and 24 percent are overweight. Among adult women, the prevalence of overweight or obesity ranges between 18-30 percent.

Despite the region's economic growth, it has not seen a quick reduction in hunger and malnutrition.<sup>20</sup> The economic costs of malnutrition are substantial and bring about a cascade of individual and social costs. Estimations in the 2016 Global Nutrition Report (IFPRI, 2016) pointed out that annual GDP losses from low weight, poor child growth, and micronutrient deficiencies average 11 percent in Asia and Africa; greater than the loss experienced during the 2008–2010 financial crisis. In contrast, the cost-benefit ratio of nutrition programmes is highly positive. Every US\$ 1 invested in reducing stunting in children in the first 1,000 days after conception through nutrition programmes is estimated to generate US\$ 18 in economic returns in Bangladesh and US\$ 48 in Indonesia (Hoddinott et al., 2013). Governments in Asia have tackled food insecurity by introducing different measures: from food price stabilization to poverty alleviation and SP programmes. The latter has been high on the agenda of policy makers in developing Asia and the Pacific since the economic and financial crisis almost a decade ago.

By definition, SP programmes should be pro-poor and geared in first place toward the most vulnerable population groups. Countries should commit themselves to making resources available 'to the maximum extent possible' in order to fulfil the right to health care, education, and other human basic needs. Since the fulfilment of rights is better achieved if the maximum available resources are made available to finance social sectors, broader societal engagement with

<sup>19</sup> Although India does not have the highest prevalence of stunted children, due to its large population it has the greatest number of stunted children.

<sup>20</sup> Indonesia has the largest GDP of the Association of Southeast Asian Nations (ASEAN), whereas Pakistan has the second largest in the South Asian Association for Regional Cooperation (SAARC). World Development Indicators, World Bank: <http://data.worldbank.org/indicator>

**Table A.3.2. GDP of ASEAN countries, 2014-15**

Ranking	Country	Current US\$ (billions)	% Annual Growth
1	Indonesia	890.5	4.8
2	Thailand	404.3	2.8
3	Malaysia	338.1	5.0
4	Singapore	306.3	2.0
5	Philippines	284.8	5.8
6	Vietnam	186.2	6.7
7	Myanmar	64.3	7.0
8	Brunei	17.1	-0.5
9	Cambodia	16.8	7.0
10	Lao	11.7	7.0

Source: World Bank.

**Table A.3.3 GDP of SAARC countries, 2014-15**

Ranking	Country	Current US\$ (billions)	% Annual Growth
1	India	2,042.4	7.6
2	Pakistan	243.4	5.5
3	Bangladesh	172.9	6.6
4	Sri Lanka	80.0	4.8
5	Afghanistan	20.1	1.5
6	Nepal	19.8	3.4
7	Maldives	3.1	1.5
8	Bhutan	2.0	3.3

Source: World Bank.

issues relating to Public Financial Management (PFM) must take place in the public debate. Not only does economic growth play an important role in shaping national social policies but also all the fiscal instruments through which governments can create the necessary fiscal space for their implementation while maintaining fiscal sustainability: i) domestic revenue mobilisation; ii) Official Development Aid, through aid and debt relief; iii) deficit financing, through domestic and external borrowing; and iv) increasing the efficiency of expenditures.

Many Asian countries have been able to take advantage of their demographic dividend, high population density and dynamic economies to raise their revenues. In recent decades, many have undertaken various reforms of their national PFM systems in order to improve the effectiveness and efficiency of resource mobilization. Many others however, are still struggling with their PFM systems particularly

in the countries that are highly decentralised. Furthermore, when tracking down public investment in nutrition, governments – and stakeholders involved in Public Expenditure Reviews and PFM – have traditionally looked into nutrition-specific interventions across sectors. However, tracking nutrition-sensitive policies is something relatively new. Since The 2013 Lancet Nutrition Series, more attention has been paid to the policies, strategies and plans that address the underlying factors contributing to malnutrition – including hunger, poverty, gender inequality, and poor access to safe water and health services. New evidence and guidelines for tracking investments in nutrition at country and sub-national levels (Picanyol, 2014) already include the financial analysis of SP programmes and budgets. In order to make the analysis functional, nutrition-sensitive strategies and plans must be developed in parallel and programmes (re) designed to make them nutrition-sensitive from the onset.

**Table A.3.4. Relevant poverty, health, social & labour indicators in Asia, 2014**

Country	Adolescent fertility rate (births *1 000 women ages 15-19)	Pregnant women receiving prenatal care (% , 2008-15 period) <sup>a</sup>	Women who were first married by age 18 (% of women ages 20-24, 2009-14 period)	Labour force participation rate, female (% of female population ages 15+)	Population below national poverty line (% National)
Bangladesh	83	64	52.3	58	31.5
Afghanistan	77	48	40.4	16	35.8
Nepal	73	68	36.6	80	25.2
Lao	65	54	35.4	76	23.2
Philippines	61	95	15	51	25.2
Cambodia	51	95	18.5	79	17.7
Indonesia	50	95	13.6	51	11.3
Thailand	45	98	22.1	64	10.5
Pakistan	39	73	21	25	29.5
Vietnam	38	96	10.6	73	13.5
India	26	75	-	27	21.9
Bhutan	23	98	25.8	67	12
Brunei	21	99	-	52	-
Myanmar	17	83	-	75	-
Sri Lanka	15	-	-	35	6.7
Malaysia	13	98	-	45	0.6
Maldives	7	99	3.9	57	-
China	7	96	-	64	-
Singapore	4	-	-	59	-

Source: World Bank.

<sup>a</sup> These are the percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy. An optimized indicator for antenatal care is however, four or more visits rather than one.

As we have seen previously, many of the underlying causes of malnutrition effect women and adolescent girls in a much higher degree. Women's economic and social living conditions mark the future of their children. As shown in Table 8, high adolescent fertility rates are related – but not only – to high rates of early marriage and low female participation in the labour force. A vicious circle of poverty, lack of empowerment, poor availability of health services and low demand for them result in higher and generationally reproduced malnutrition rates.<sup>21</sup>

<sup>21</sup> The spectacular progress in female education that Bangladesh has achieved in the last two decades, along with general economic progress, has failed to make any serious dent into the culture of early marriage and teenage pregnancy. In the same period, the proportion of 15-19 years-old women who had already started child-bearing has fallen only marginally from 33 per cent in 1993-94 to 30.8 per cent in 2014.

This is the argument behind many SP systems that have been targeting women through their SSNs. However, the impact of those interventions over malnutrition is unclear. Despite significant evidence on the positive impact of cash transfer programmes upon household consumption and food security, impact assessments have been unable to robustly demonstrate their role in tackling malnutrition. A new wave of social safety nets in the region is forthcoming with the aim of contributing to this end as a complement to traditional nutrition-specific interventions.



## 4. Case Studies

This section draws from WFP experience in nutrition-sensitive SP in the Asia region. The two selected case studies presented here illustrate the workflow followed during the (re)design of existing SP interventions for making them more nutrition-sensitive. They exemplify the ToC presented previously and the necessary inputs and processes for an enabling environment and fruitful policy dialogue.

### Pakistan: From Situational Analysis to Operationalization

Efforts to address malnutrition in Pakistan have been focused mainly on nutrition-specific interventions, both in terms of delivery and policy support. Due to the characteristics of its current national SP system, it is unclear what the most appropriate SP pathways are to address malnutrition. Pakistan's SP system is basically formed by two federal SSNs under a common umbrella institution: i) the Benazir Income Support Programme's (BISP) unconditional CT programme; and ii) the *Waseela-e-Taleem* (WeT), BISP's CCT to education. The social transfers provided by these two federal programmes are in the form of cash. The lack of links to preventive food based approaches for addressing malnutrition has been pointed out as the main cause of the limited impact of Pakistan's SSNs over nutrition. Additionally, constraints with the supply side of nutritious food – related to both availability and access – have impacted negatively upon complementary feeding practices, particularly for those children from 6 -36 months of age.

Mindful that increasing the transfer value alone won't be enough to attain the national nutrition objectives, representatives from the BISP are interested in fully boosting the potential of its CT programmes.<sup>22</sup> On the other hand, despite having introduced new sub-national programmes, it is

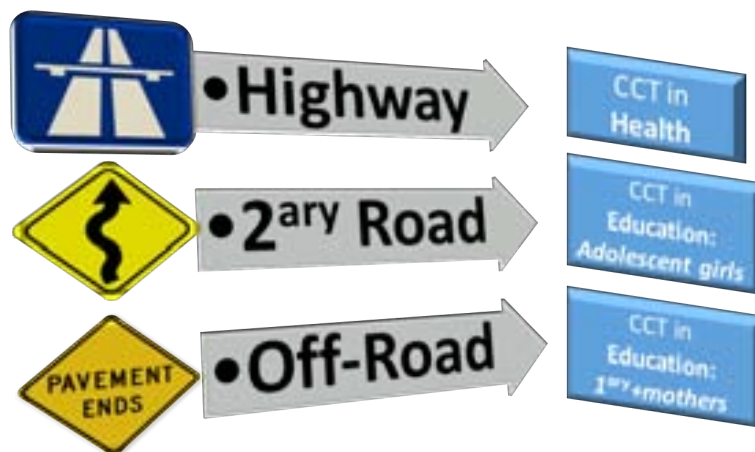
still unclear to the government, both federal and provincial, how to operationalize the linkages with other important sectors like education, agriculture or the private sector, particularly with those companies manufacturing SNF like Wawa Mum.

Findings from the Cost of the Diet analysis point out the non-affordability of a nutritious diet as one of the main problems in Pakistan. The potential of CTs – either through direct cash or vouchers – for reducing malnutrition is directly linked to accessibility to the right nutritious foods. However, food availability is another important aspect of the puzzle that has been left unaddressed at both the federal and the provincial levels. While this puts CTs at the centre of the solution for its value in increasing purchasing power, additional responses are also deemed necessary to address availability; in particular, responses from the supply side. During the situational analysis stage, WFP identified three existing SP programmes that could be included in operational research in order to formulate lessons for the future expansion of the programmes. The approach shown in Figure A.4.1, represents the most suitable CT interventions in Pakistan offering an entry point for nutrition: i) a CCT in health with provincial coverage in Punjab Province; ii) a provincial CCT in education targeting adolescent girls in Punjab Province; and iii) a CCT in education with national coverage – the *Waseela-e-Taleem* – targeting children in primary school, whose mothers are organized in beneficiary committees (the BBCs). While the first two are part of a sub-national SP system, the latter is part of the largest national safety net, the BISP.

Out of the three options, only the provincial CCT in health already incorporates a specific objective on nutrition. Several challenges arise in relation to the nutrition pathways that the Pakistani system could choose to address the underlying causes of malnutrition (see Figure A.4.2): from the most straightforward cause-effect pathways – categorized as a 'highway' – to the less explored pathways – categorized as 'off-road' – through the more indirect causal chain, categorized as a 'secondary road'.

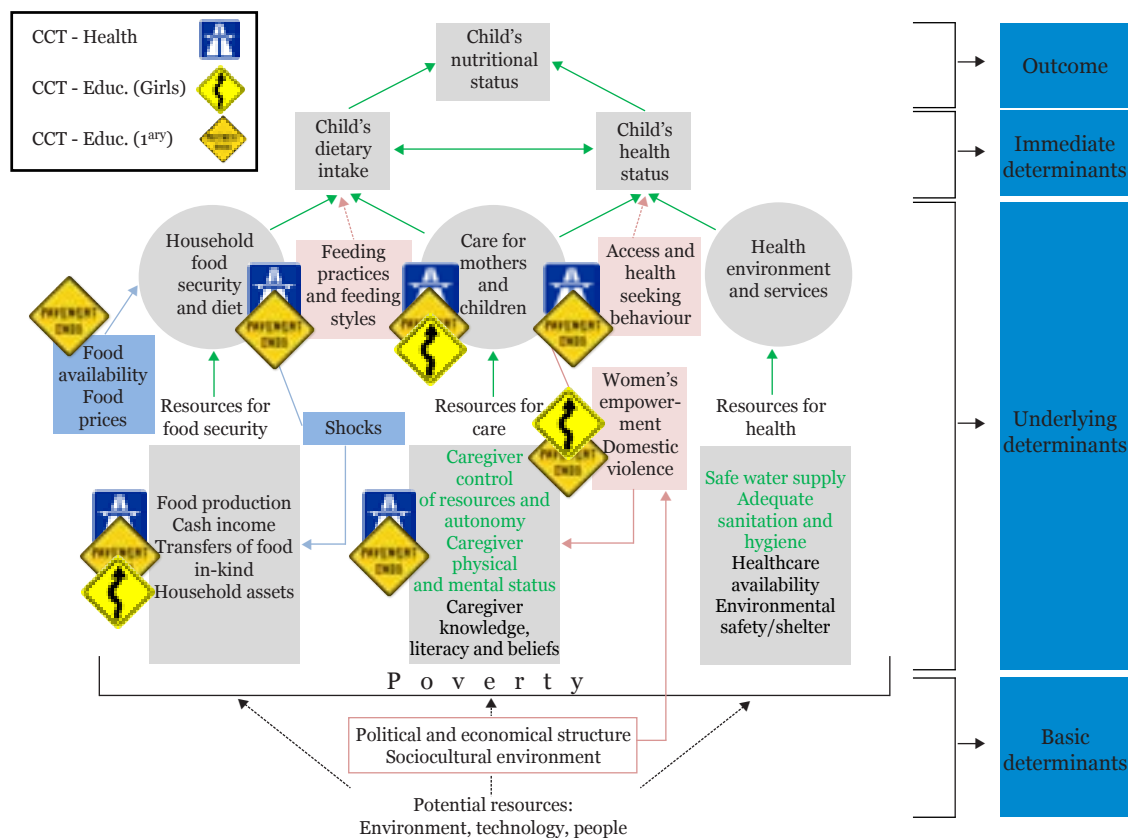
<sup>22</sup> BISP is at the early stages of designing an improved nutrition programme for BISP beneficiary families targeting pregnant and lactating women and children under 5, initially in one or two districts as a pilot project, under a hypothetical 'Health Plus programme'; a CCT on health. So far, only a concept note has been prepared for discussion.

**Figure A.4.1. Approach for nutrition-sensitive social protection in Pakistan**



Source: Authors.

**Figure A.4.2. Impact Pathways through social protection for Pakistan**



Source: Adapted from de Groot et al., 2015.

Based on this typology, a nutrition-sensitive strategy could for example build on a sub-national CCT based on health for introducing vouchers for nutritious foods for the right populations. Besides increasing retention rates among adolescent girls through a cash transfer, a CCT in education would also be a good opportunity for empowering girls, and raising their awareness about the importance of balanced and nutritious diets for a healthy

life.<sup>23</sup> This strategy would also test the viability of using BISP's Beneficiary Committees (BBC) as the entry point for accessing communities and

<sup>23</sup> As per the National Nutrition Survey, majority of rural mothers had opinion that women lack the freedom to access medical care for themselves and their children unless the household decision maker allows them to do so. Also a greater part of participants of group discussion across country stated that pregnancy was not considered as a special event and no extra dietary consideration was given to it.

increasing the uptake of health and nutrition services within their respective communities.<sup>24</sup> Likewise, availability of nutritious foods would be addressed through links to other sectors like agriculture (e.g. promotion of kitchen gardening)<sup>25</sup> and the private sector. Additional features to these two programmes – such as the provision of nutritious products through vouchers to selected BBCs and adolescent girls in schools – could create a ripple effect on the demand side.

In summary, a strategy for a nutrition-sensitive SP programme in Pakistan could be twofold:

- i. Capacity enhancement within the Waseela-e-Taleem, focusing on its female Beneficiary Committee Members (BBCs);
- ii. Strengthening the availability, access and utilization of nutritious food products through innovative approaches with the public and private sector by:
  - a. Supplying SNF to children from age 6 to 23 months with Wawa Mum, a locally produced super nutritious, ready-to-use product.
  - b. Setting a nutritional supplementation programme – e.g. a food voucher scheme – for the adolescent girls with BISP beneficiary families to contribute to the reduction of micronutrient deficiencies among future would-be mothers. Under this program fortified wheat – five nutrients – could be also made available through vouchers to be cashed only at certified and registered suppliers.

<sup>24</sup> WeT relies on the BISP's Beneficiaries Committees for social mobilization and empowerment of its female beneficiaries. The potential of these groups though, has not been fully developed yet. Their degree of maturity varies from one district to another due to the gap in time since the first groups were formed in 2012 –in 5 districts– and the latest in 2015 –in 16 districts.

<sup>25</sup> Kitchen gardening is an activity to gain fresh vegetables, fruits and herbs the household's meals. The Government of Pakistan promotes this approach to easily cultivate seasonal vegetables for the household's kitchen by teaching families to preparing their lawn effectively. For more information see: <http://www.parc.gov.pk/index.php/en/kitchen-home>

## **Bangladesh: Mainstreaming Fortified Rice and BCC into Social Protection Programmes**

In Bangladesh, WFP carried out a thorough strategic review of the national nutrition and food security policy context. The findings have informed the organization's strategy on SP for the coming years. The ToC developed considered the World Health Assembly's targets for 2025 and aligned WFP vision accordingly. Drawing from this contextual analysis, WFP agreed that the best way forward was to build upon its success on rice fortification and the lessons learnt from combining CT with BCC – Box A.4.1. – as two of the successful stories.

With rice as the primary staple food, providing 70 percent of daily caloric intake for most Bangladeshis, and the high prevalence of micronutrient deficiencies in the country, rice fortification has the potential to further improve micronutrient health in Bangladesh.

In 2011 an initiative was launched for the first time to make fortified rice available through Bangladesh's SP systems. A collaborative effort between the Government and WFP, the initiative built upon existing public and private partnerships and earlier efforts by the Global Alliance for Improved Nutrition (GAIN), DSM (private sector), and non-governmental organizations like PATH and BRAC. The Vulnerable Group Development (VGD) programme, a state-funded and food-based SSN, was identified as an appropriate channel to reach with fortified populations most at risk of micronutrient deficiencies. The VGD reaches 22.6 million beneficiaries providing 26 kg of rice or 30 kg of wheat – equivalent to BDT 900 or US\$ 12 – for a two-year period after their enrolment.

After the first trials, in 2013 the Government in partnership with WFP formally launched the 'Scaling Up of Rice Fortification in Bangladesh' programme. The project aims to reach 500,000 beneficiaries with fortified rice through the public SSNs, including VGD and the hot school meals programme, and to establish a



#### **Box A.4.1. Lessons learned & best practices on BCC**

From 2012 to 2014 WFP in partnership with IFPRI carried out the Transfer Modality Research Initiative (TMRI) with the aim of providing evidence on the comparative impact of different social transfers on household income, household food security and child nutrition. Five alternative transfer modalities were given to the study participants –women pertaining to the lowest socio-economic groups– in the northern and southern regions of Bangladesh: (i) Cash only; (ii) Food only; (iii) A cash and food combination; (iv) Cash conditional on attending nutrition BCC training; (v) Food conditional on attending nutrition BCC training.

The nutrition BCC involved a holistic approach to the promotion of positive nutrition behaviours in the household, and was targeted at (i) participating women –primary target–, (ii) their family members and (iii) influential community members –secondary target– through well-defined strategies. The strategies applied an appropriate mix of inter-personal, group and interactive methods delivered by locally hired community nutrition workers (CNWs).

Factors that have made the model of BCC successful in achieving behaviour change include the use of frontline workers from the community (CNWs), empowering women and creating inclusive environments, where key actors in the community and households can come together to provide support to women. BCC has to be adaptable to meet the changing requirements of the target audience. Messages used for the BCC need to be sensitive to the local context and culture, and formulated to be easy to understand and implement for the target audience. Training and messages need to be repeated frequently to remind participants. Much of the success of the BCC model used for the TMRI can be attributed to the low CNW to participant ratio – either 1:10 or 1:20–, which allowed CNWs to build strong relationships with participants, and really get participants to trust them. One thing to be still determined, as the follow up with CNWs still continues, is whether messages and behaviours adopted through the BCC are sustainable and adhered to in the long run by the participating communities and households.

Factors critical to success include: Appropriate coverage at the field level; A well-defined monitoring system with a feedback loop; An initial intensive investment in capacity development; Simple messaging to key target and influential audience; Framing nutrition messages as accessible, familiar and desirable; Strong relationships between front line workers and the target audience; Enhanced empowerment of women and positive gender norms; Necessary inputs through the integration with complementary interventions; Appropriate exit strategies to sustain behaviour change beyond the life of a programme.

*Source: WFP.*

sustainable commercial market for fortified rice in Bangladesh by 2017.

By increasing distribution through SP schemes and advancing commercial demand for fortified rice, the project aims to reach economy of scale. Currently, WFP is supporting the government in setting up sustainable domestic production of fortified kernels and installing blending equipment in rice mills and at large rice warehouses. Although a few of these suppliers

are already providing fortified rice to the SSNs, the aim is to keep increasing the supply capacity of the private sector alongside the demand from the SP public sector.

The experience has shown how introducing sustainable production of fortified rice requires a multi-stakeholder – comprising a variety of ministries, the private sector, donors and technical partners – and multi-dimensional approach – technical, political and business aspects.



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