Learning from six government-led and UNICEF supported cash plus programmes in Eastern and Southern Africa

Synthesis of learning from the integration of social protection and nutrition
Acknowledgements
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Background

Poor nutrition and child poverty remain serious problems in Eastern and Southern Africa (ESA) where an estimated 28% of children are stunted, 4.6% wasted and 1% severely wasted. Poverty drives child undernutrition by restricting household access to food and services, and undermining caregivers’ ability to engage in optimal care and feeding practices. This leads to poor child diets and care and ultimately, poor nutrition. Poverty is rife in ESA where an estimated two out of every three children experience multi-dimensional poverty and access to social protection is low. Malnutrition drives poverty as children who are undernourished have lower educational outcomes and lower economic productivity as adults. Across Africa, only 12.6% of children are covered by at least one social protection benefit.

Social protection interventions such as cash transfers can help to prevent child undernutrition. A cash injection into the most nutritionally vulnerable households can help to improve access to foods and services and facilitate uptake of optimal care and feeding practices. Evidence suggests that this is most likely to improve child nutrition when additional (‘plus’) elements are delivered alongside the cash transfer, such as Social and Behaviour Change (SBC) and systematic links to health and nutrition services. UNICEF’s Global Nutrition Strategy 2020-2030 positions the social protection system as key to improving nutrition outcomes.

National cash transfer programmes are rapidly expanding in ESA as part of broader social protection systems. Over the last few years, UNICEF has supported governments to implement cash plus programmes to address child poverty and undernutrition. Many of these have been trialled as pilot programmes, some of which are now being scaled up alongside national cash transfer programmes.

In 2022, UNICEF documented six case studies of cash plus programmes in the ESA region. Through this process, we aimed to describe the design and implementation of each programme, broader policy and system linkages between social protection and nutrition, and evidence of impact on child nutrition and wellbeing. We also identified and documented lessons learned and opportunities for further linkages within each country. This paper provides a synthesis of results and lessons learned across these examples to help inform social policy and nutrition programmers and decision-makers in ESA and beyond.

The cash plus programmes studied

Cash plus programmes supported by UNICEF were documented in Burundi, Ethiopia, Kenya, Mozambique, Rwanda and Tanzania. All six programmes delivered regular cash transfers to vulnerable populations with one or more of the following ‘plus’ elements:

1. Social and Behaviour Change (SBC) to improve nutrition practices;  
2. Referrals to essential services, sometimes using a system of integrated case management; and  
3. Livelihoods support and/or cash top ups to increase household income and access to nutritious foods.

In some countries, design changes were also made to the wider national cash transfer programme and broader linkages sought between social protection and nutrition policies and systems. A description of each country programme and available results is provided at the end of this document.

1 Joint Malnutrition Estimates, 2021  
2 Multidimensional poverty includes monetary and non-monetary dimensions, which includes deprivations of rights and access to essential health, HIV/AIDS, nutrition, education, WASH and child protection services.  
Lessons learned

Of those programmes that were monitored and evaluated across a range of indicators, evidence shows that cash transfers delivered alongside ‘plus’ interventions can address multiple child vulnerabilities, including the underlying determinants of child undernutrition. Specifically, they can improve child diets, uptake of multiple and essential services and improve child care and feeding practices.

Across the six examples, the following lessons have been learned about how to maximise results for children at each stage of programming:

Evidence, learning and knowledge management

Cash plus programmes are more likely to have positive impact on child nutrition and wellbeing when their design is based on evidence of the context-specific drivers of child poverty and malnutrition. This is most effective when social protection and nutrition colleagues work together to develop a shared understanding of the evidence.

Use of an adaptive management approach can increase programme impact over time. This means using results of monitoring and evaluation and learning to inform programme adjustments, the next programme iteration and scale up. Opportunities for programme improvements are maximized when colleagues from social protection, nutrition and other relevant sectors work together to interpret and apply the evidence.

Policy, governance and financing

Linked social protection and nutrition strategies, policies and plans are an important enabler of integrated responses. Social protection can be embedded within national nutrition strategies, policies and plans, and social protection strategies, policies and plans can include nutrition objectives and linkages. Aligning cash plus programmes with social policy, nutrition and wider national plans and strategies can help to secure political will, sustained commitment from both sectors and public finance contributions.

Strong partnerships between agencies including UNICEF, World Bank and World Food Programme will maximize the comparative advantages of each agency to support the government to deliver nutrition responsive social protection at scale.

Social protection and nutrition colleagues can jointly advocate for finance to support nutrition responsive social protection programmes. This includes public finance contributions and bi-lateral contributions where gaps in public funds exist. Cash plus approaches can also be positioned within country plans for global initiatives (such as ‘No Time to Waste’ and the ‘Global Action Plan’ on child wasting) to access global funds.

Locating the governance of cash plus programmes within multi-sectoral coordination structures for both nutrition and social protection at national, sub-national and local levels enables the engagement of multiple sectors, linkages between multiple systems at each level, and decentralized decision-making.

Programme design

Cash transfer programmes are more likely to have nutrition impact when they include specific nutrition objectives and an evidence-based theory of change for improved nutrition that maps out expected change along the food, services and practices pathways.

Adding ‘plus’ elements to cash transfer programmes to address barriers to optimal nutrition along the foods, services and practices pathways can support greater nutrition impact. This is best achieved when social protection, nutrition and other relevant sectors work together to plan and design programmes based on a shared understanding of the evidence.
Cash transfers can maximize nutrition impact when targeted to the most nutritionally vulnerable stages of life, especially during the first 1,000 days (pregnancy until the child’s second birthday).

Cash transfers will be more impactful when transfers are of adequate value and maintain their value through regular adjustment for inflation. The longer the programme duration and wider the coverage, the greater the nutrition impact is likely to be.

Delivering social and behaviour change (SBC) alongside cash transfers can ‘nudge’ vulnerable populations towards optimal child feeding and care practices. For maximum nutrition impact, SBC should be designed to address context-specific barriers to the uptake of optimal practices and must be accompanied by access to quality nutrition services and diverse foods.

SBC can be delivered by trained community volunteers using volunteer cadres within the social welfare and/or health system. SBC can be delivered on cash payment days at payment sites but will be more effective when delivered as part of wider community strategies.

A system to refer cash transfer participants to multiple services can increase access to and uptake of multiple services to support child nutrition and wellbeing. This will be most effective when clear referral pathways exist between sector workforces and information systems are integrated or shared. Integrated case management services provide an effective means to manage referrals - this can be delivered by the formal social welfare workforce, or by trained community volunteers.

Delivering savings, food security, livelihoods, and job creation support to cash transfer participants can improve household earning potential to support sustained improvements in child nutrition and wellbeing. Food security and livelihoods interventions can be tailored to support the availability of nutrient-dense foods for children, for example by providing seeds and small livestock. This will help families to put SBC messages around healthy diets into practice.

Public works and other jobs programmes can be designed and adapted to support child nutrition. For example, by temporarily excusing pregnant women and caregivers of young children, selecting public works assets that support local food production, providing quality childcare, and training women to provide nutrition SBC as their public service contribution.

Programme implementation

Cash transfers will achieve maximum impact (including nutrition impact) when payments are predictable, delivered regularly and on time.

Adequate multi-sector workforce capacity is required to support implementation of cash plus approaches. Existing frontline and community-based health, nutrition and social assistance staff may need to be strengthened. Where existing staff are overburdened, new cadres of community volunteers can be mobilised with a view to incorporating them into formal structures. This requires sustained investments in training, supervision and reporting.

Cash transfers and all plus elements must be delivered in tandem. This requires joint planning, co-location of services, linkages between systems, regular communication between staff workforces and, where possible, shared information systems. Locating programmes within multi-sectoral coordination structures at local governance level can support this.

A minimum set of health system and community based promotive, preventive and curative nutrition services for mothers and children must be consistently available and accessible to the population receiving cash transfers. These services must be of consistent quality and predictability so that caregivers will attend regularly.

Nutritious foods must be available and affordable to populations receiving cash transfers to ensure that cash translates into improved diets for children. Simultaneous food systems transformation efforts will likely be required to support this. For example, support
for household production of nutrient dense food and small animal keeping, support for larger scale agricultural production of nutrient dense crops and animals, and food policy and regulation changes. Provision of specialized nutrition supplements may be necessary in severely food insecure and fragile contexts.

**Monitoring, advocacy evaluation and learning**

Cash plus programmes must be robustly monitored and evaluated to provide quality evidence to support iterative learning. This should include an analysis of costs to support advocacy for scale up.

A monitoring framework based on an evidence-based theory of change will support the comprehensive monitoring and evaluation of cash plus programmes. Indicators to measure long-term change on nutrition outcomes (such as stunting) can be incorporated if the programme is of long enough duration. Indicators to measure shorter-term change (such as dietary diversity, uptake of services and changes in practices) are more likely to show results and should be prioritised for informing programme adjustments.

**Shock response**

Large scale, national social protection systems with appropriate coverage will build overall population resilience to shocks. While systems are being built, cash transfers programmes can be designed to scale up in response to shocks to prevent nutrition deterioration. Scale up can be vertical (higher cash transfer value) and/ or horizontal (reach more households), triggered by early warning systems (for example the Integrated Phase Classification (IPC)), and tailored to the scale and level of emergency.

Many of the lessons learned here apply to Humanitarian Cash Transfer (HCT) programmes delivered by national social protection systems, or in parallel where national systems are weak. Additional considerations are for HCTs to coordinate with food assistance, particularly where quality foods are unavailable on local markets and populations are at high risk of wasting. On the nutrition side, alternative delivery platforms may be needed to ensure that HCT participants can access quality nutrition services. For example, use of outreach/mobile teams, find and treat campaigns and NGO partnerships. Strong coordination between humanitarian partners is essential.

**Conclusions**

For all contexts where poverty and malnutrition co-exist, to have any chance of meeting the Sustainable Development Goals (SDGs), social protection and nutrition teams, partners and sectors must work in collaboration. This makes sense because poverty is a driver of malnutrition and malnutrition is one of multiple manifestations of poverty and a driver of economic deprivation. Together, national social protection and nutrition systems can deliver a comprehensive, coordinated package of support to poor and nutritionally vulnerable populations to address multiple, context-specific drivers of both poverty and child nutrition. This has the potential to prevent malnutrition before it occurs, averting its negative consequences and allowing children to reach their full potential into adulthood.

The six ESA case studies summarised here demonstrate the strong potential of cash plus programmes to contribute to this process. The examples showcase different ways that cash plus programmes can be designed and delivered, based on context-specific needs, systems and capacities. For these six countries and any others implementing cash plus programmes, the lessons learned here can be used to inform the design of future programme iterations, national scale up, and deeper system linkages to maximise results. This learning can also be used to inspire and inform other countries to embark on nutrition responsive social protection programmes catalysed by joint working.
Merankabandi Programme, Burundi

Pilot 2018-2022
Scale up 2022-2026

Programme size
Pilot – 56,090 households in 4 provinces.
Scale up – 250,000 households in 18 provinces.

Target group
Extremely poor and vulnerable households with children under 12 years of age.

Cash component
Bi-monthly electronic cash transfers of USD24.

‘Plus’ components
SBC + ECD + livelihoods support
Complementary (‘plus’) activities: nutrition social and behaviour change (SBC) and cooking and home garden demonstrations delivered by community volunteers. Participants also join community ‘solidarity’ groups to facilitate group savings and investments in productive livelihoods, Early Childhood Development (ECD) SBC, financial literacy training and support for job creation.

Results
Monitoring results from pilot showed positive impact on several determinants of child nutrition including access to health care, exclusive breastfeeding, access to food for children, WASH indicators, and women’s empowerment. Survey data showed lower rate of child stunting in participating versus non-participating households.

Productive Safety Net Programme (PSNP) V, Ethiopia

Integrated Basic Social Services with Social Cash Transfer (IN-SCT) pilot delivered within PSNP IV 2016-2018

Integrated Safety Net Pilot (ISNP) programme delivered within PSNP V 2019 – ongoing

Programme size
PSNP V – 8 million households
IN-SCT and ISNP – 4 woredas

Target group
PSNP V is targeted to extremely poor rural households.
IN-SCT and ISNP targeted to ‘direct support’ households with pregnant and lactating women and children under five years.

Cash component
PSNP households receive food transfers of 3kg of cereals for each day worked or cash equivalent where markets are functioning. Households unable to work receive transfers without public works (‘direct support’). Pregnant women and caregivers of children under 12 months receive temporary ‘direct support’ in exchange for uptake of health services.

‘Plus’ components
Integrated case management
IN-SCT and ISNP target households receive integrated case management services. In ISNP, case management has been enhanced by delivery through a new workforce of community service workers who link clients to multiple services including SBC, nutrition and health services and livelihoods support.
Design changes also made to the PSNP V to improve nutrition including: selection of nutrition-sensitive assets for public works, embedded case management and referrals to health and nutrition services, enhanced SBC, cash without public works for pregnant women, mobilization of female community nutrition champions, childcare at public works sites and capacity to scale up support in response to shocks.

Results
Evaluation of IN-SCT pilot revealed that clients were successfully linked to additional services by social workers, but there was little impact on child nutrition outcomes. ISNP not yet evaluated.
Nutrition Improvements through Cash and Health Education (NICHE), Kenya

Phase one pilot 2016-2018
Phase two pilot 2019-2026

Programme size
Phase one – 3,800 households in 2 counties
Phase two – 12,000+ households in 5 counties

Target group
Phase one - participants of the Government’s Cash Transfer for Orphans and Vulnerable Children (CT-OVC).
Phase two - participants of any government cash transfer with a child under two years and/or pregnant woman.

Cash component
Bi-monthly cash top-ups in addition to government cash transfer 500 KSH per child and/or pregnant woman up to two household members (max 1,000 KSH per household).

‘Plus’ components
SBC
Counselling by Community Health Workers (CHWs) on nutrition following set modules. Positive parenting counselling is also given by social welfare volunteers to support Early Childhood Development (ECD) in high-risk households.

Results
A Randomised Control Trial (RCT) of phase one showed minimal positive changes in stunting reduction (as expected due to short project duration), but positive impact on young child diets (minimum acceptable diet), early initiation of breastfeeding, exclusive breastfeeding and WASH indicators.

Child Grant 0-2 programme, Mozambique

Pilot 2018-2020
Scale up 2022-2026

Programme size
Pilot – 15,000 households in one province.
Scale up – 250,000 households in nine provinces.

Target group
Caregivers of children aged 0-6 months until the child’s second birthday identified by health workers as being from poor and vulnerable households.

Cash component
Bi-monthly flat transfer of 540 MZN (around 9 USD) per child per month.

‘Plus’ components
SBC + case management
The care component involved nutrition SBC delivered by social assistance volunteers, trained by health workers to deliver simple messages to participants on payment days. Social assistance volunteers also provided case management services, psychosocial support and early childhood development (ECD) messages to households identified as being extremely vulnerable.

Results
Impact evaluation showed no impact on nutrition outcomes but positive impact on various determinants of child nutrition including child diets (meal frequency, diet diversity, consumption of animal source foods and vitamin A rich foods), household poverty, household food insecurity, caregiver wellbeing.
Modelling Nutrition-Sensitive Social Protection Interventions (MNSSPI), Rwanda

Pilot programme 2019-2021
Scale up ongoing

Programme size
720 households in 4 provinces.

Target group
Participants of the Expanded Public Works (ePW) programme of the national Vision 2020 Umurenge Programme (VUP) in the socioeconomic band with children under five years.

Cash component
ePW participants receive 15,000 FRW per month in exchange for light public works.

‘Plus’ components
SBC + case management + livelihoods support

Complementary services included integrated case management and referral (IMCR) delivered by volunteer para-social workers, nutrition-sensitive interventions (farmer field school training, kitchen garden support, and small livestock provision), nutrition services delivered by community health workers (CHW) including SBC, growth monitoring and micronutrient supplementation, increased financial access through membership of village savings and loans associations (VSLA) and financial literacy training, and community SBC on key topics.

Results
No evaluation undertaken and no monitoring of outcome indicators.

Stawisha Maisha pilot programme, Tanzania

Pilot programme 2018-2019
Scale up and integration into Productive Social Safety Net (PSSN) II ongoing.

Programme size
10,837 household members in two districts.

Target group
Caregivers of young children in households participating in the PSSN II - the government’s national social assistance programme.

Cash component
PSSN II households receive bi-monthly transfers to value of USD 5.3 and 24.1 per day depending on eligibility criteria.

‘Plus’ components
SBC

Additional SBC sessions to PSSN II households on payment days to enhance infant and young child feeding practices. Peer-led sessions were delivered to caregivers and other household members in groups. Based on learnings from the pilot, the programme is now being scaled up through delivery of community SBC infant and young child feeding (IYCF) sessions supported with radio programmes.

Design changes also made to the PSSN II to improve nutrition impact including: systematic linking of participants to health and nutrition services including SBC, inclusion of health service utilisation conditions, and the exclusion of pregnant women from public works until their child’s second birthday.

Results
An impact evaluation was not undertaken, but results of an endline review showed that the approach was well accepted by participants, activities were successfully integrated into the social protection workforce, and IYCF knowledge of participants increased.