



World Food
Programme

SAVING
LIVES
CHANGING
LIVES



Fill the Nutrient Gap Rwanda

30th October 2018, Kigali



Acknowledgements

Collaborators



NECDP
NISR
Social Cluster Ministries
RSB
Food Nutrition and WASH
Technical Working Group

Donors



Ending all forms of malnutrition...

What does it take?

Nutrition
specific

Life cycle

THE LANCET

The Lancet's Series on Maternal and Child Undernutrition
Executive Summary



The problem of maternal and child undernutrition in developing countries. More than 35 million mothers and children under five die unnecessarily each year due to the underlying cause of undernutrition, and millions more are permanently disabled by the physical and mental effects of a poor dietary intake in the earliest months of life. By the time children reach their second birthday, if undernourished, they could suffer irreversible physical and cognitive damage, impacting their future health, economic well-being, and welfare. The consequences of insufficient nourishment continue into adulthood and are passed on to the next generation as undernourished girls and women have children of their own.

Undernutrition includes a wide array of effects including intrauterine growth restriction (IUGR) resulting in low birthweight; underweight, a reflection of low weight-for-age; stunting, a chronic restriction of growth in height indicated by a low height-for-age; wasting, an acute weight loss indicated by a low weight-for-height; and less visible micronutrient deficiencies. Undernutrition is caused by a poor dietary intake that may not provide sufficient nutrients, and/or by common infectious diseases, such as diarrhoea. These conditions are most

significant in the first two years of life, highlighting the importance of nutrition in pregnancy and the window of opportunity for preventing undernutrition from conception through 24 months of age.

Today, using recent estimates and latest data and standards, it is estimated that 13 million children are born annually with IUGR; 112 million are underweight and 128 million children under 5 years suffer from stunting, the vast majority in south-central Asia and sub-Saharan Africa (figure 1). Of these, 160 million (90%) live in just 36 countries, representing almost half (46%) of the 348 million children in those countries. An estimated 55 million children are wasted, of whom 19 million children are affected by severe acute malnutrition (SAM), defined as a weight-for-height measurement 3 standard deviations below the median.

Although in recent years the global public health and nutrition community has focused primarily on obesity and specific micronutrient interventions, maternal and child undernutrition continues to place a heavy burden on low- and middle-income countries. Because undernutrition is an intergenerational problem, countries with high rates of maternal and child undernutrition face an uncertain future in which the health of their

Nutrition
sensitive

Multiple
sectors



What is the **right “mix”** for a **specific context**?

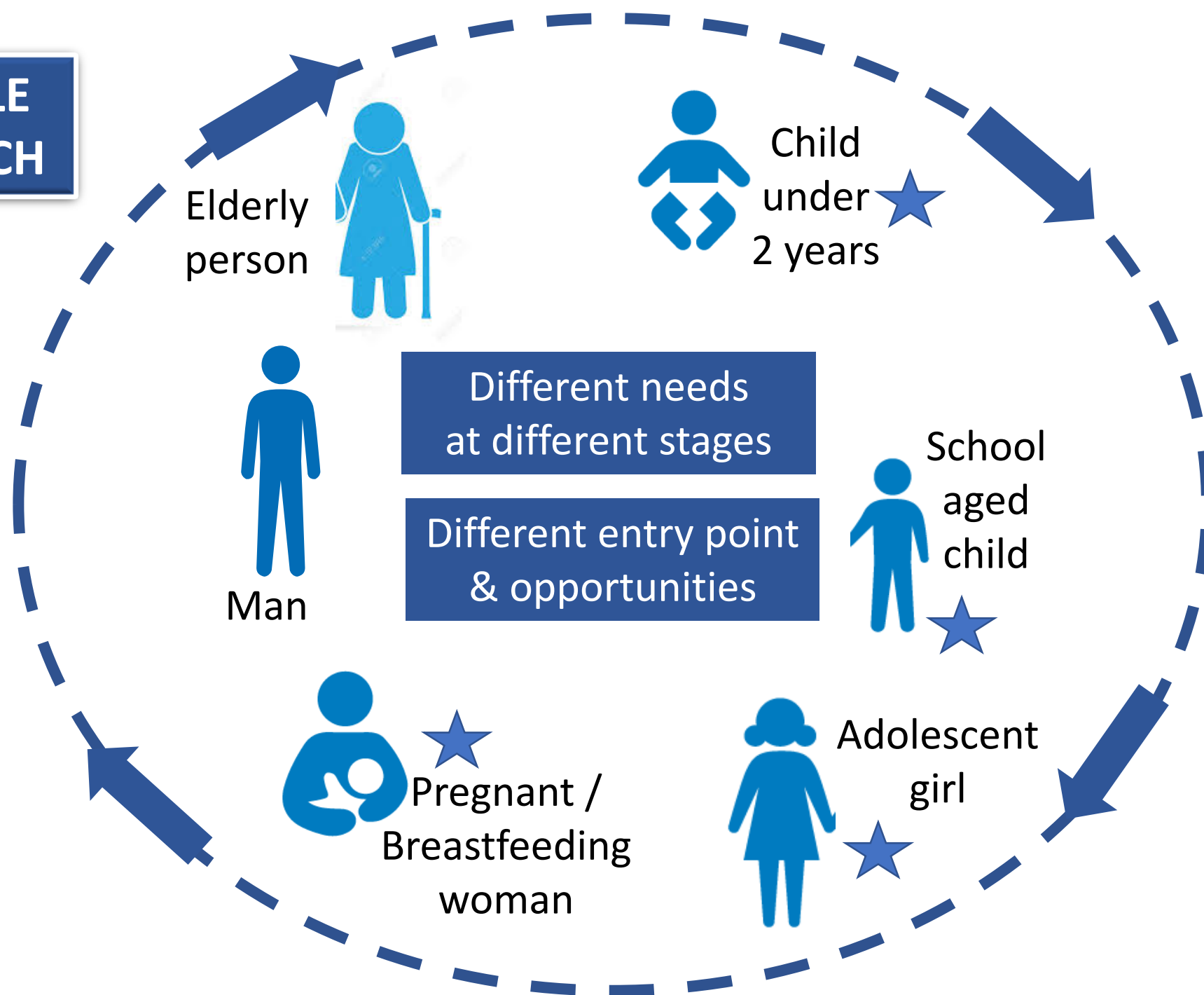
Recognising the need for shared understanding of issues, context and solutions

Fill the Nutrient Gap
aims to identify
the barriers to
adequate nutrient intake:

Specific target groups
in a specific context

Multi-stakeholder
input and involvement

LIFECYCLE APPROACH



Analytical Process

Secondary data

Sourced data / grey literature /
peer reviewed articles / reports

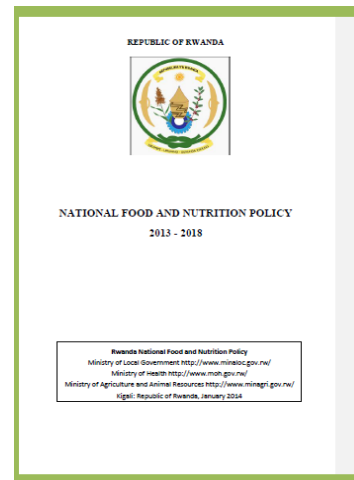
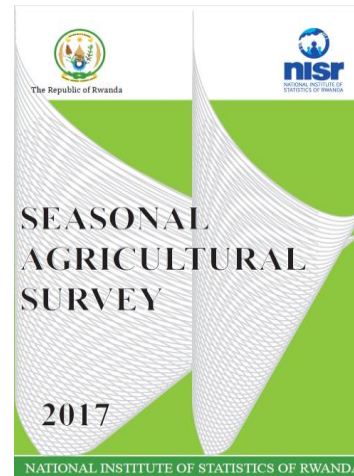
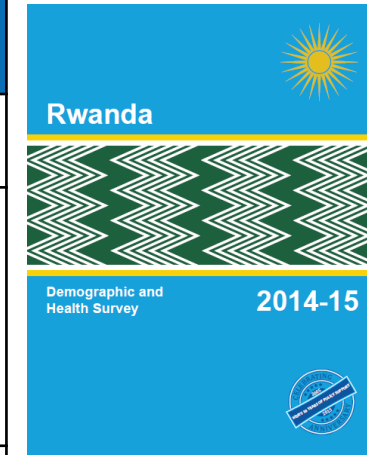


Malnutrition characteristics,
enabling policy environment,
food availability, access, local
practices

110+ sources identified and
reviewed

Secondary data: 110 sources were reviewed

Data category	Key data sources
Nutrition situation	DHS (1994 – 2015), CFSVA (2015, 2018).
Policy and programmes	National Food and Nutrition Policy (2013-2018); Rwanda Vision 2020; PSTA II (2009); Rwanda Country Strategic Review for Food and Nutrition Security (2017); EPDRS 2013-2018; National Strategy for Climate Change and Low Carbon Development (2011)
Access and availability of nutritious foods	CFSVA (2015, 2018), FAO (2015), Seasonal Agricultural Survey (2014, 2018), Rwanda nutrition, markets and gender analysis (2015)
Nutrient intake	DHS (1994 – 2015), Global Dietary Database (2010)
Local practices	Assessment of the Nutrition and Food Security Situation in Rusizi District, Rwanda (2011); Understanding Consumer Demand for Nutritious Food in Nyanza District, Rwanda (2016); Adolescent girls' capabilities in Rwanda (2017)
Optimisation and Cost of the Diet	Seasonal Agricultural Survey (2014); EICV (2013-2014)



Analysis Process

Secondary data

Sourced data / grey literature /
peer reviewed articles / reports



Malnutrition characteristics,
enabling policy environment,
food availability, access, local
practices

110+ sources identified and
reviewed



Cost of the Diet

CPI data for 83 commodities collected
from **30 markets**



5 provincial
assessment zones

Urban/Rural

Estimate Cost of staple adjusted
nutritious diet
for a household of 5 people

The Cost of the Diet tool AIMS to:

To estimate at the **lowest cost**, the **quantity** and combination of **local foods** that are needed to provide a **typical family** with their **average needs for energy** and their recommended intakes of **protein, fat, vitamins and minerals**.



The Staple-Adjusted Nutritious Diet

WHAT IT IS...

- Based on what is available in markets.
- Based on lowest cost
- Adjusted to reflect basic local preferences.

WHAT IT IS NOT...

- Not necessarily what people are actually eating.
- Not designed to provide recommendations of what people should eat.

Analysis Process

Secondary data

Sourced data / grey literature /
peer reviewed articles / reports

Malnutrition characteristics,
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Cost of the Diet

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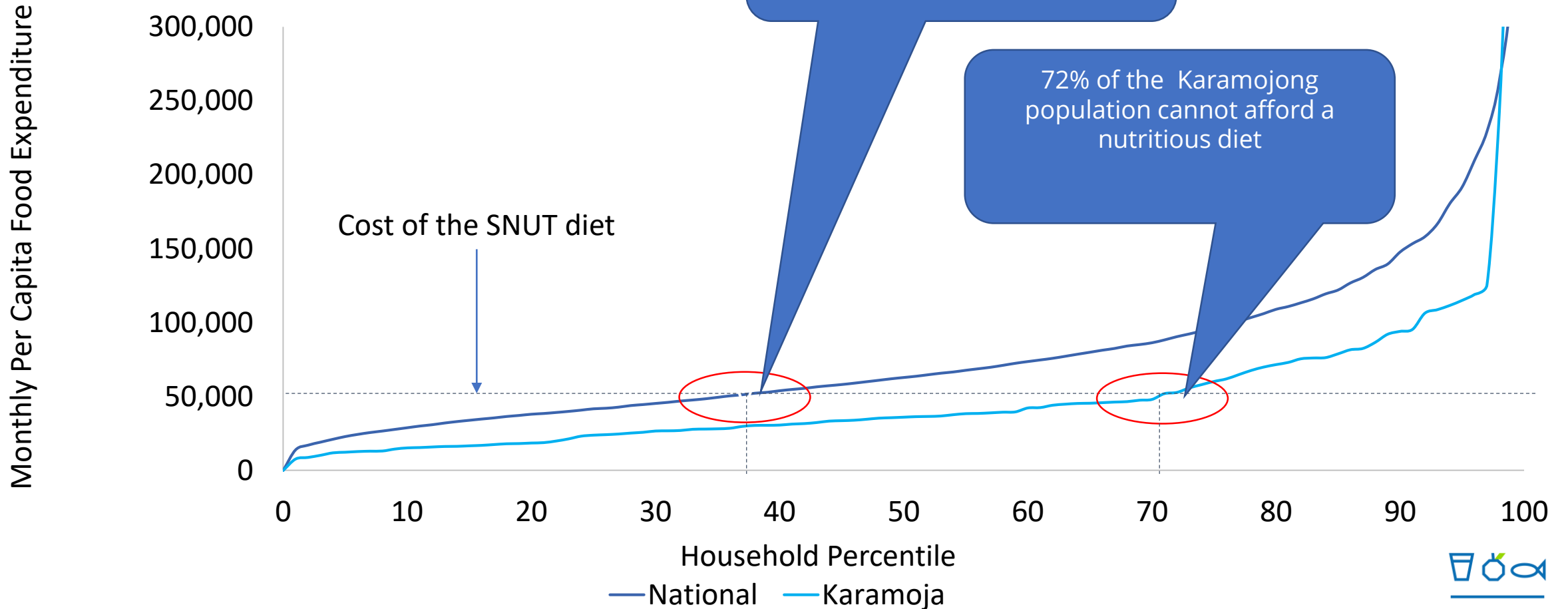
Estimate Cost of staple adjusted
nutritious diet
for a household of 5 people

Non-Affordability of the nutritious diet
using expenditure data (EICV 2013-2014)

How to address economic access issues

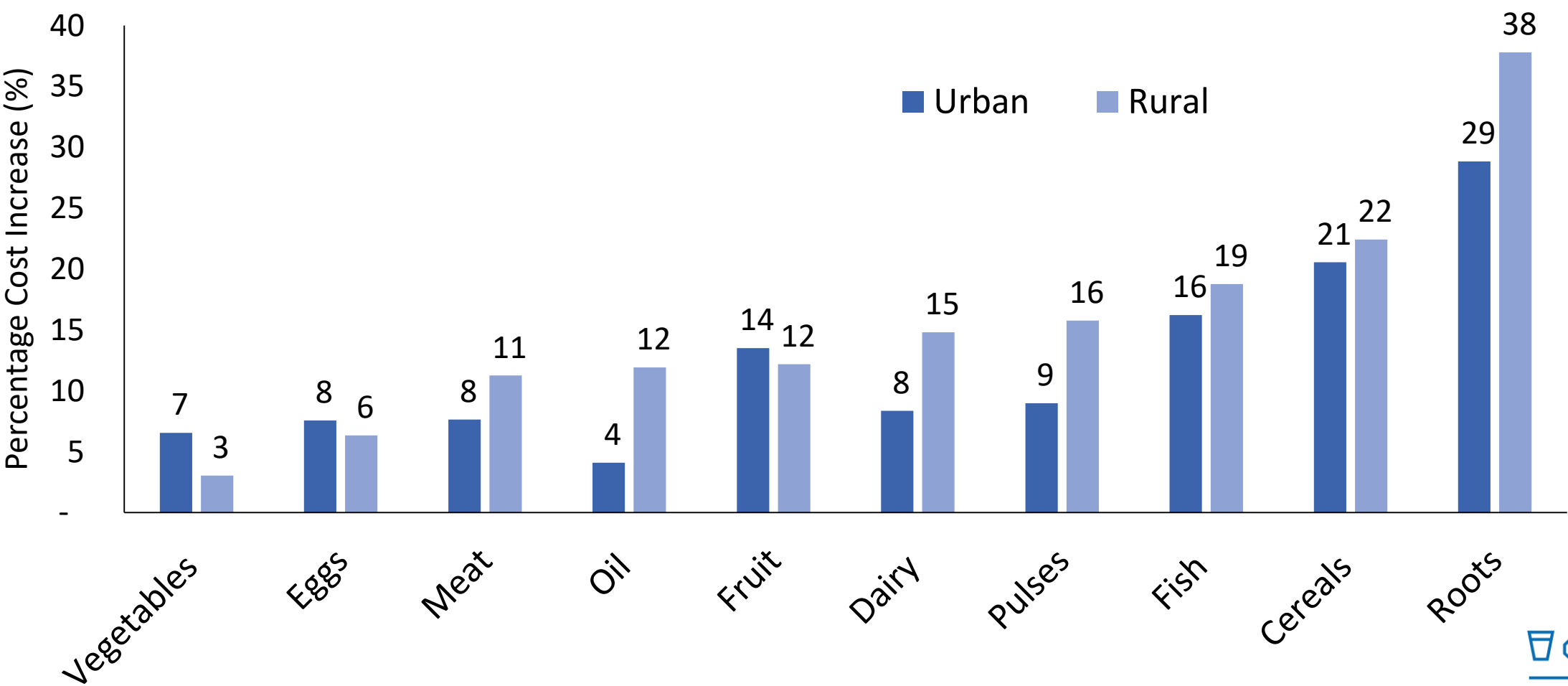
Intervention modelling

Non-Affordability Calculation



Food prices increased by 3-38% and increased most in rural areas

Limitation: Used 2014 price data to align with available 2014 expenditure data



Strategies modelled to improve the affordability of a nutritious diet...

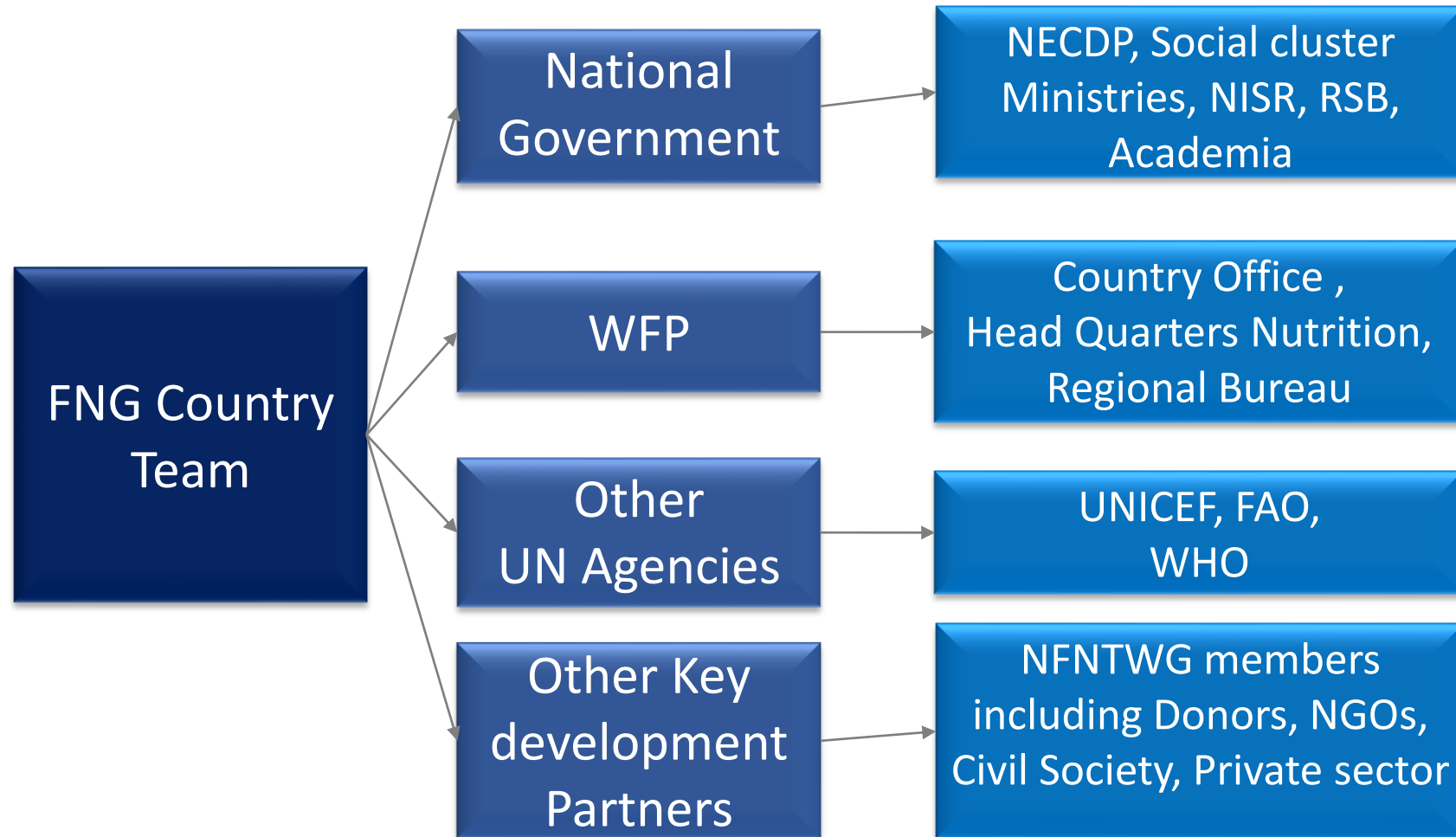
Household and individual level:

1. Improving the availability and access of existing **local nutritious foods**

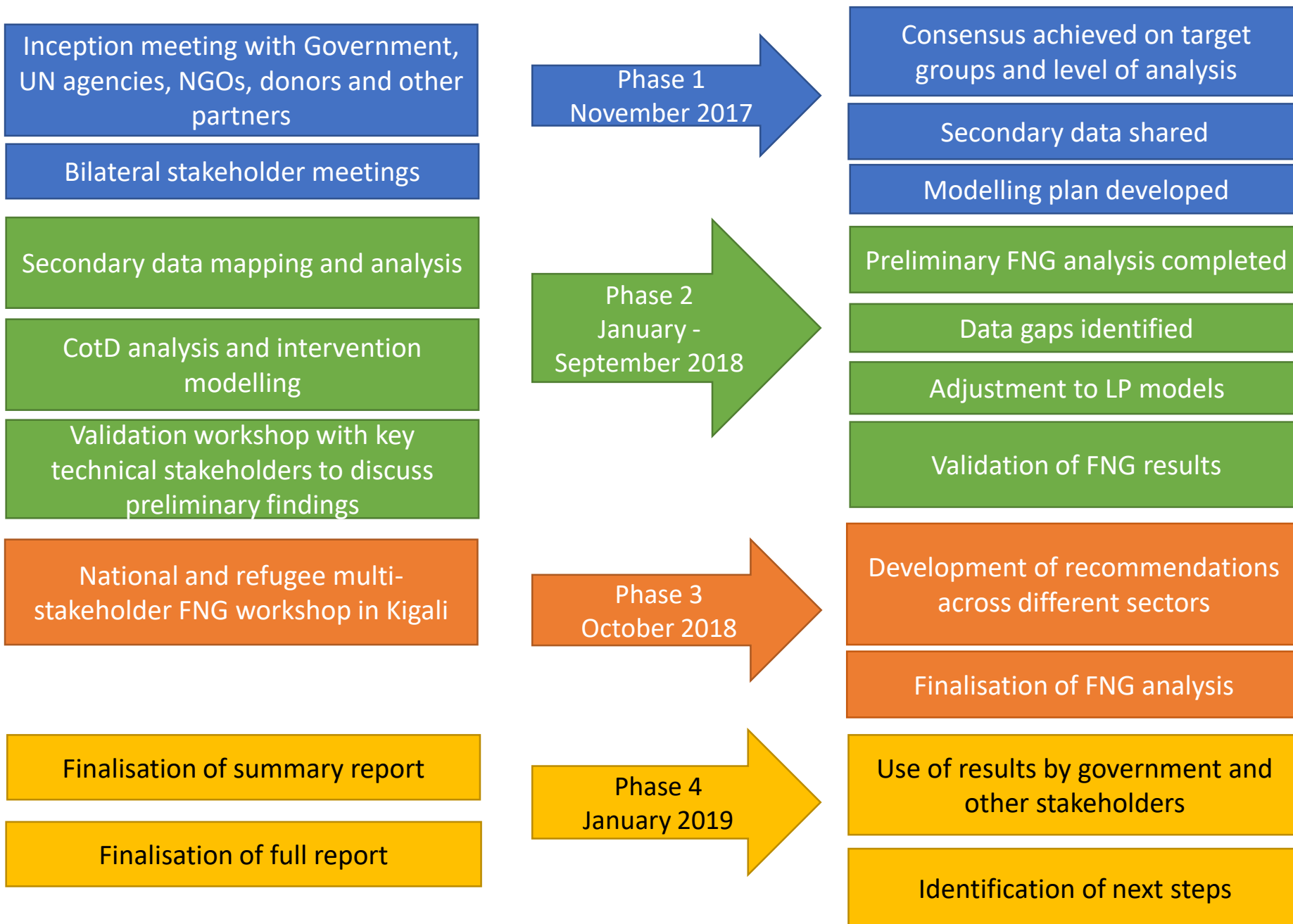
N.B

2.
 1. The modelling is not a cost benefit analysis exercise.
 2. Reductions in the cost of the nutritious diet for the household or individuals do not take into consideration input and implementation costs.
- 3.
- 4.
- 5.
6. Combinations of targeted interventions as **household packages**.

The process engaged multiple stakeholders, from several sectors



Timeline and Process





Key Findings





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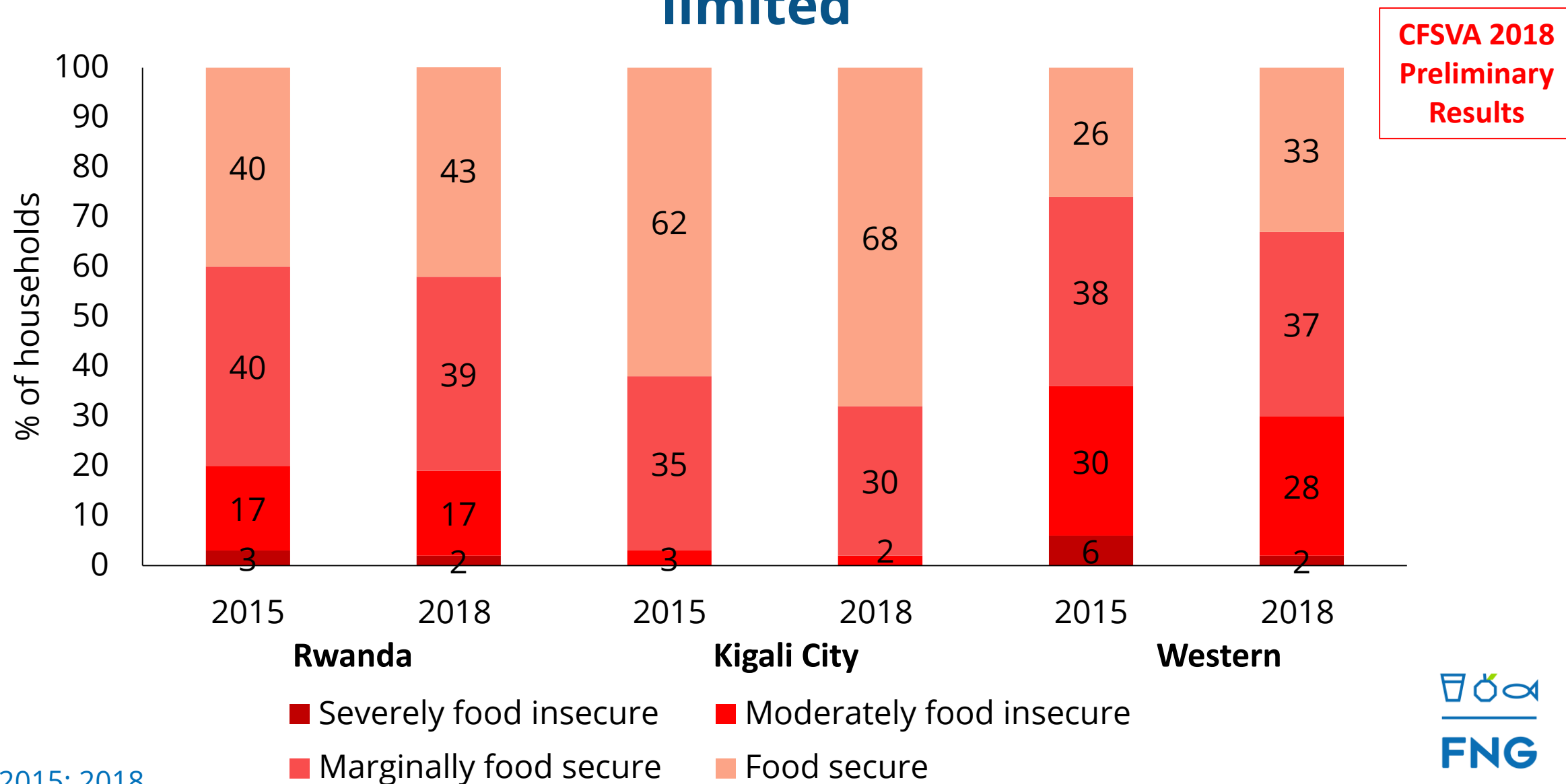
KEY MESSAGE 1

Significant improvements have been made
BUT **malnutrition** remains
the **top disease risk factor**.

The **majority** of households are **food secure**,
BUT diets are **dominated** by
staple foods.

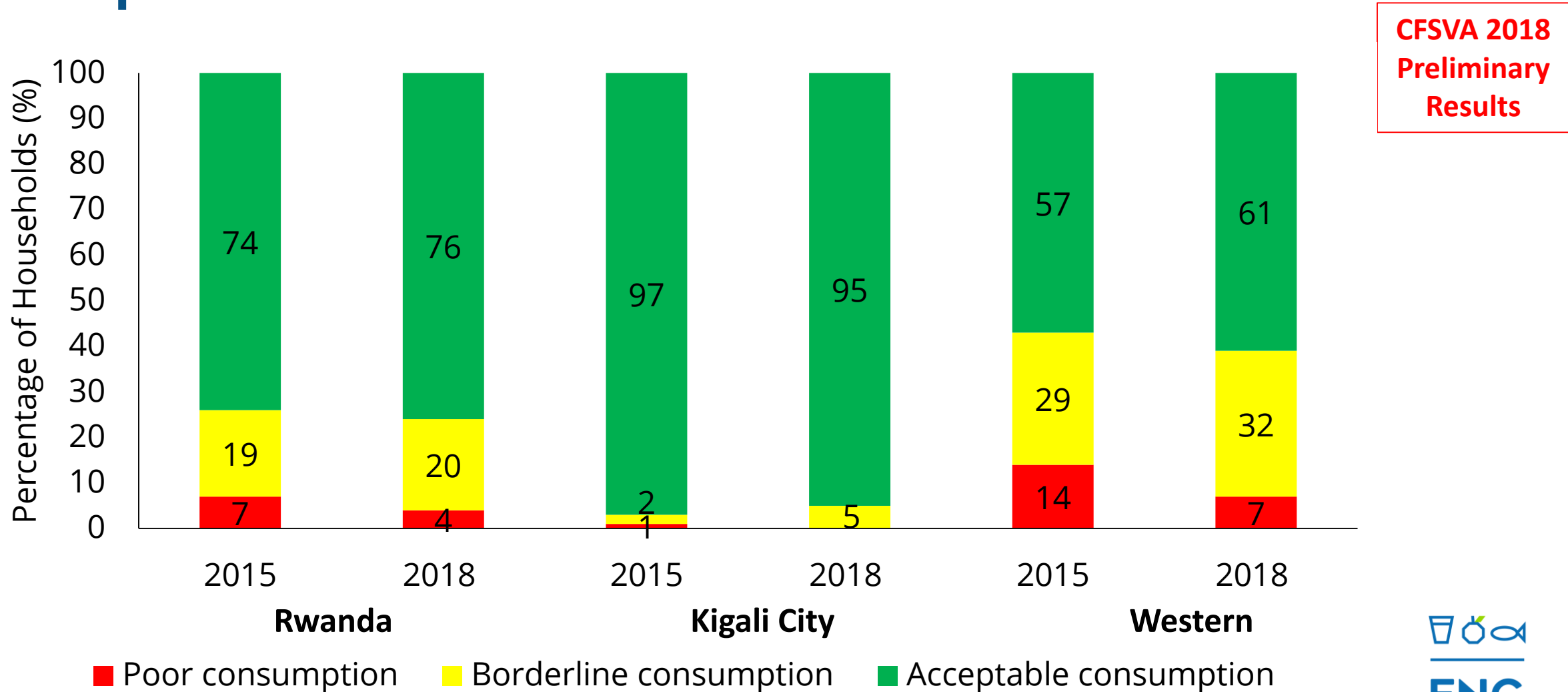
To achieve **nutrition security**, diets must
diversify to include **animal source foods**.

Majority of households are fairly food secure BUT improvements in food security (2015-2018) have been limited

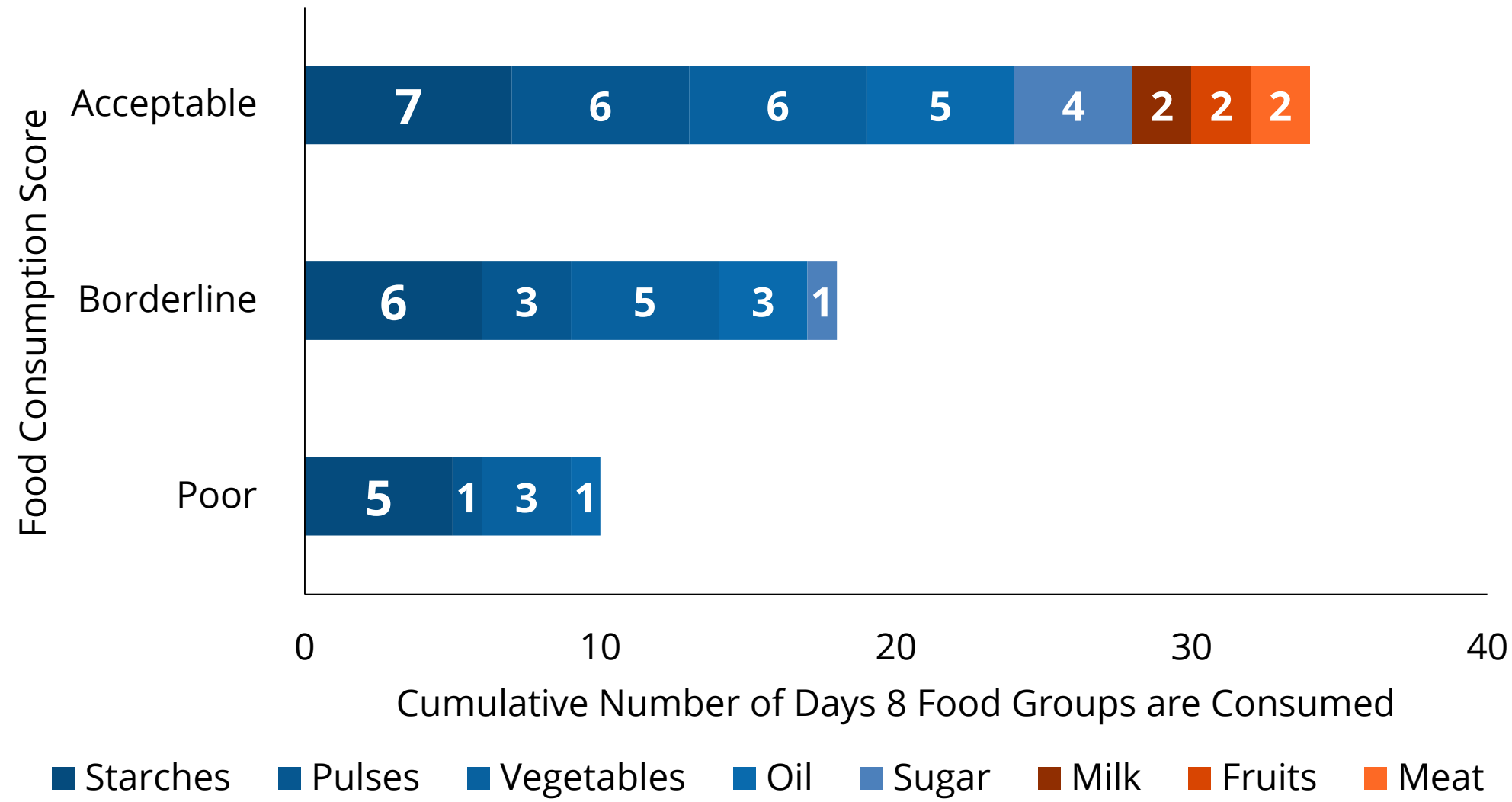


3/4 of households have an acceptable Food Consumption Score.

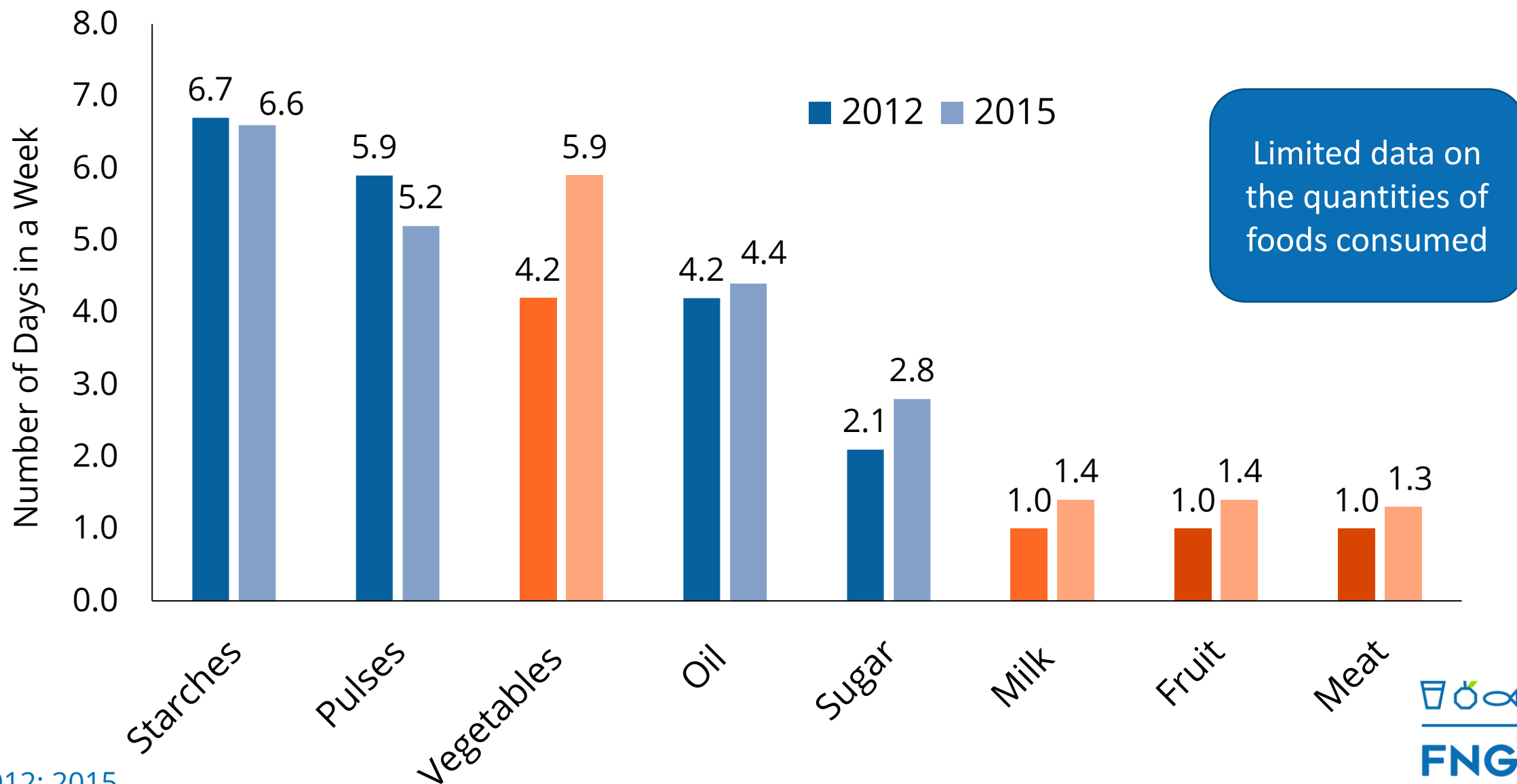
Improvements have been made in the North and West



Despite an acceptable Food Consumption Score... Households only consume animal source foods and fruit twice a week...



...and the consumption pattern hasn't changed substantially from 2012





FNG

KEY MESSAGE 2

Despite progress
stunting and **anaemia** in children
remain a **public health problem**.
Varies geographically | Impacted by socioeconomic
factors.

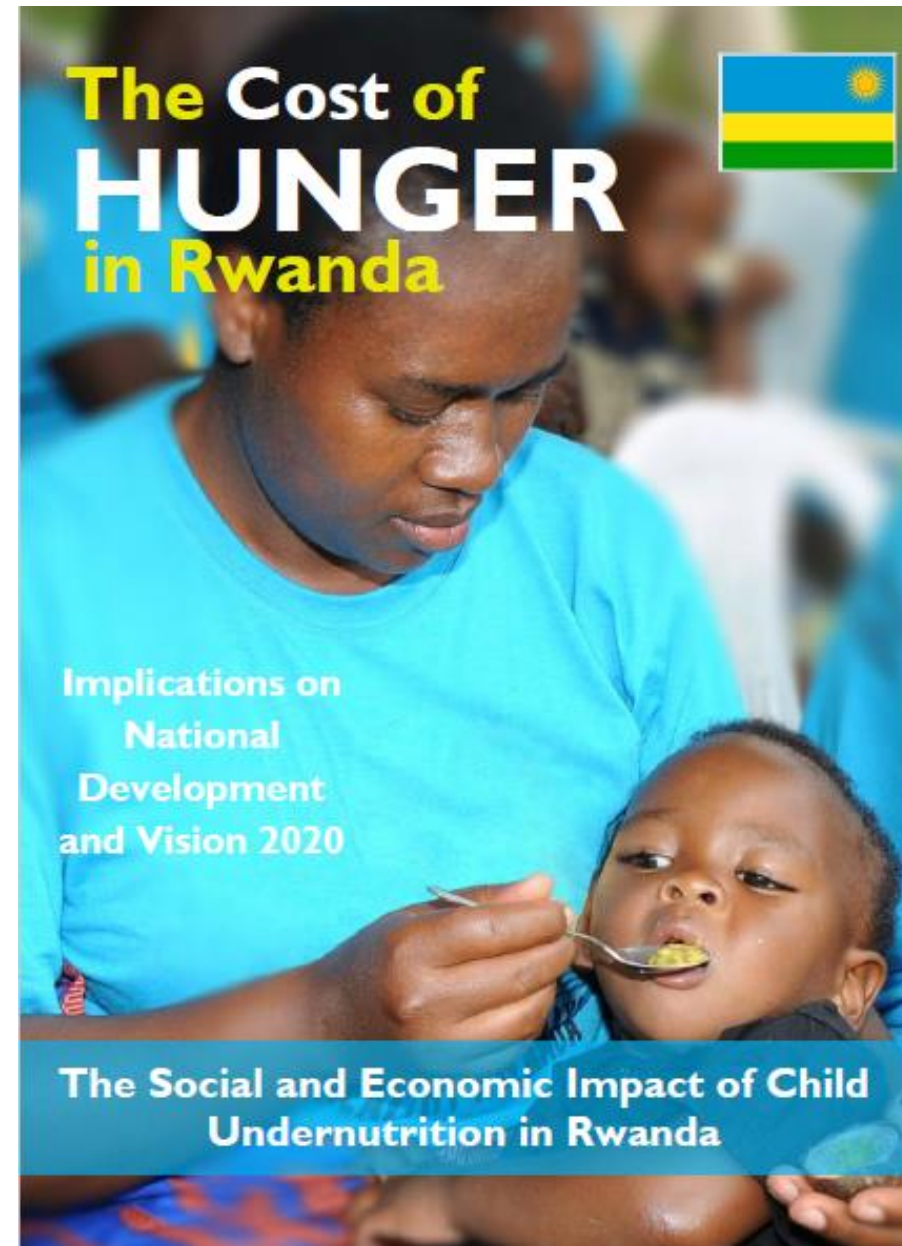
More information on **micronutrient deficiencies**
necessary **fully understand** the **nutrition situation**.

WASH has **improved substantially**
BUT rural areas **still at risk of disease**.

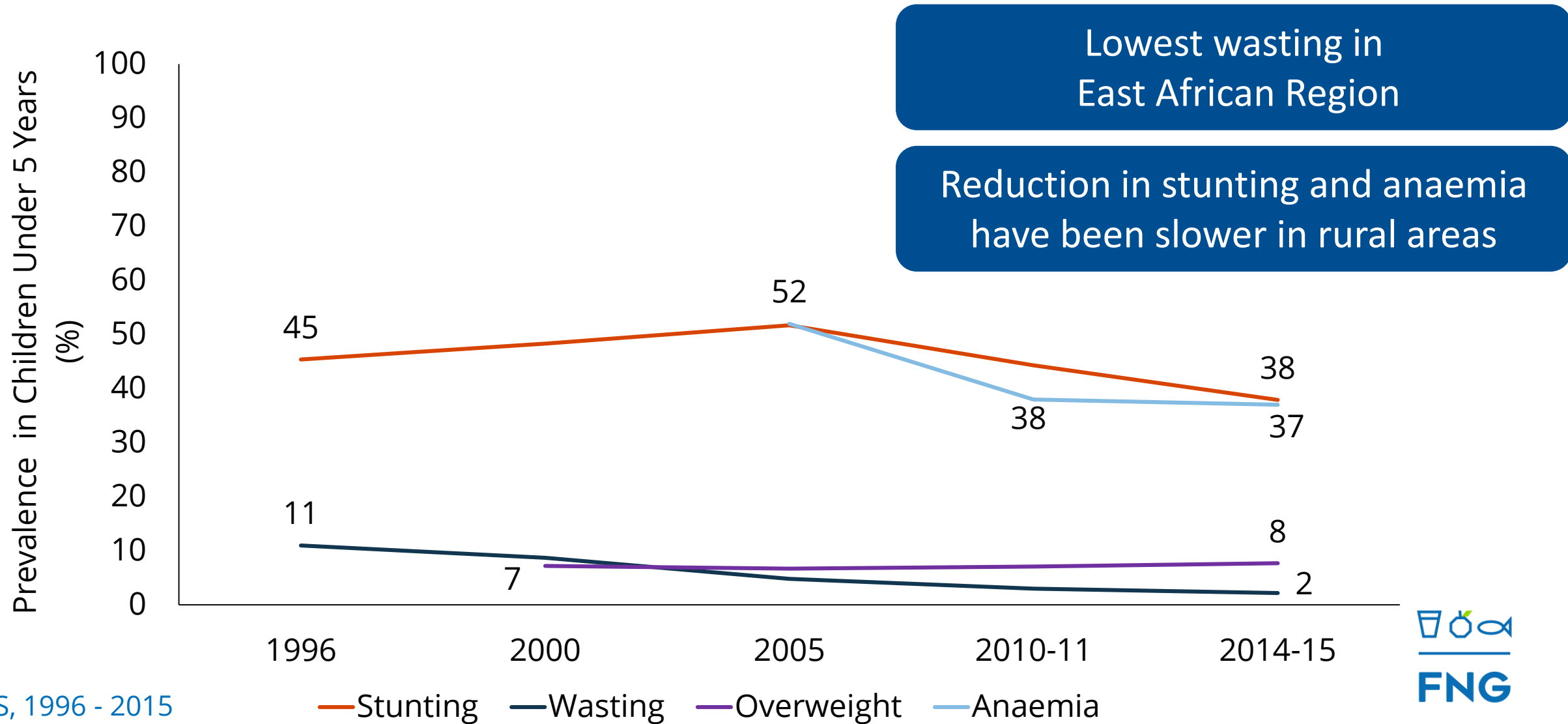
**2012
Child undernutrition**

=

**Loss of 504 Billion RWF
(11.5% GDP)**

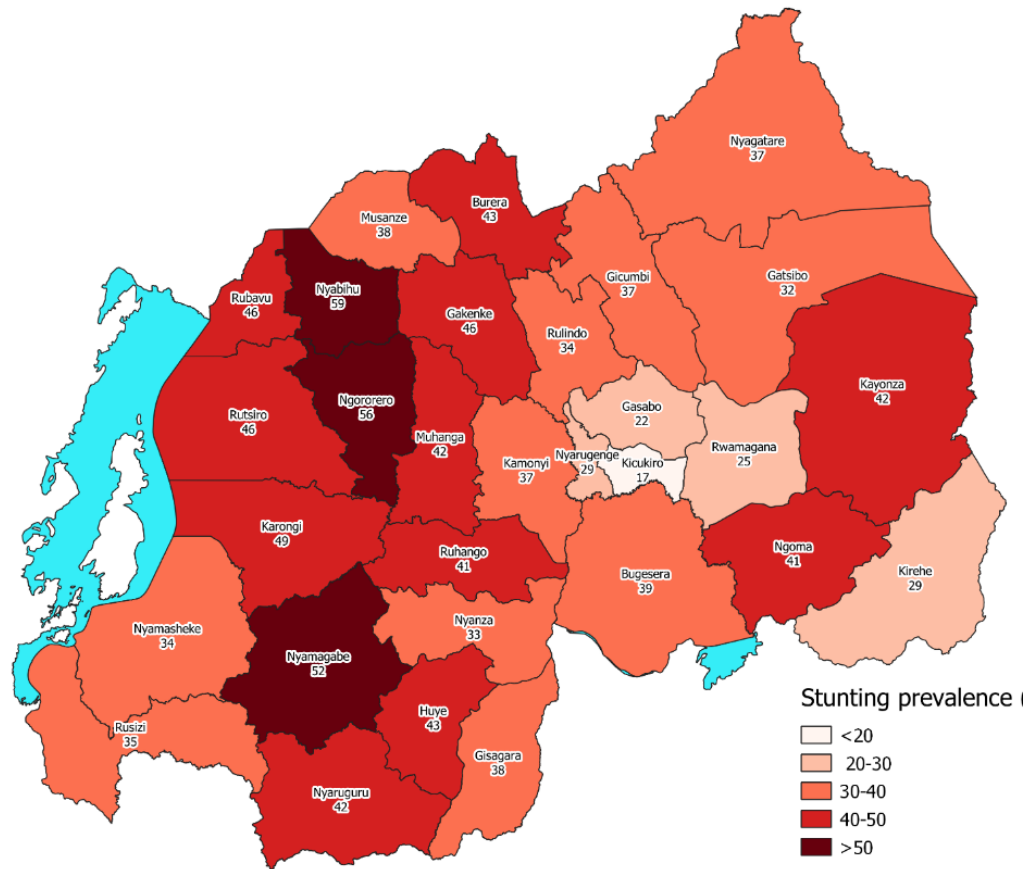


Major stunting reduction over the past 10 years BUT prevalence remains very high (38%). Anaemia also remains high.

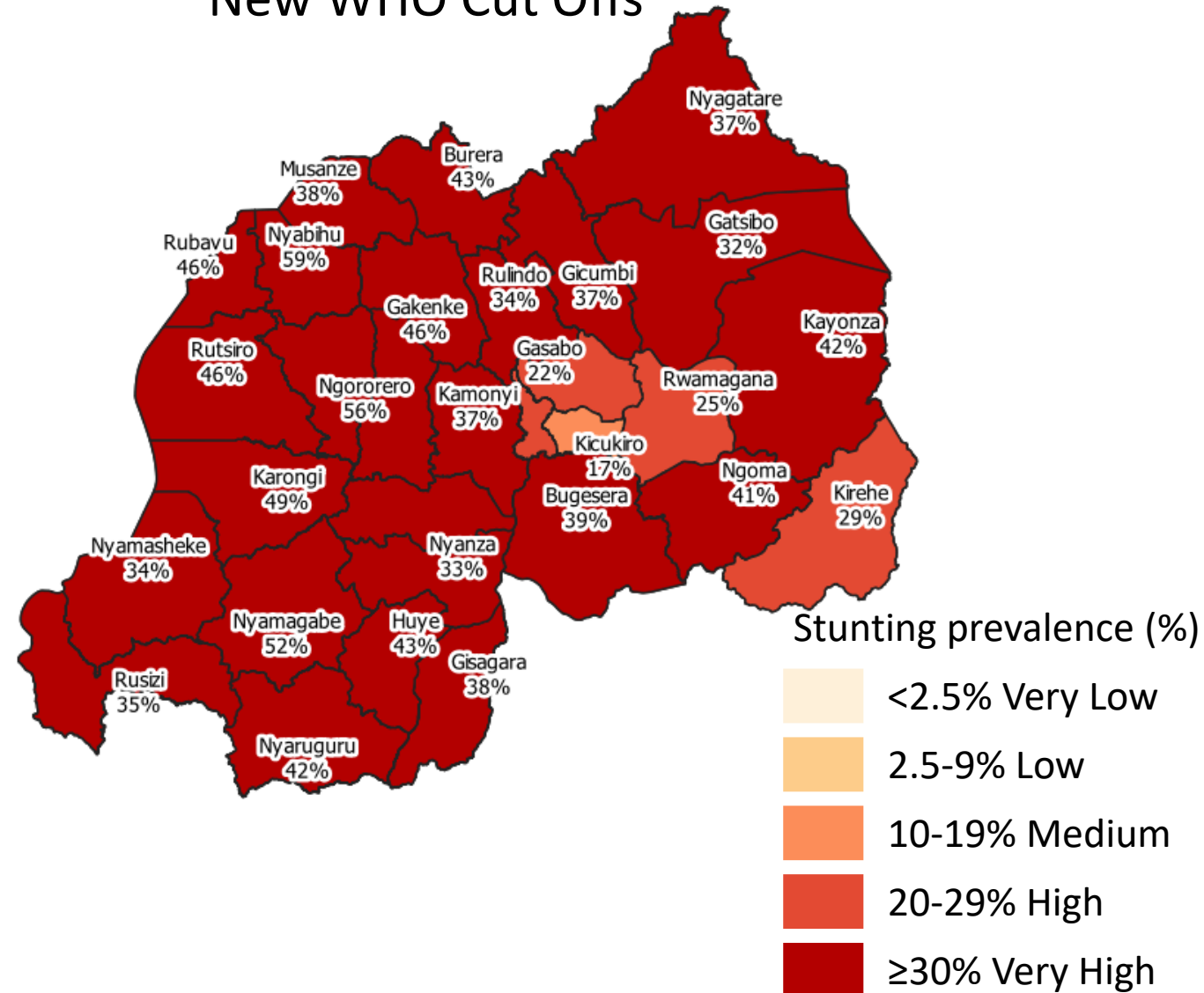


New WHO cut-offs indicate that stunting remains critical with high levels in almost all districts

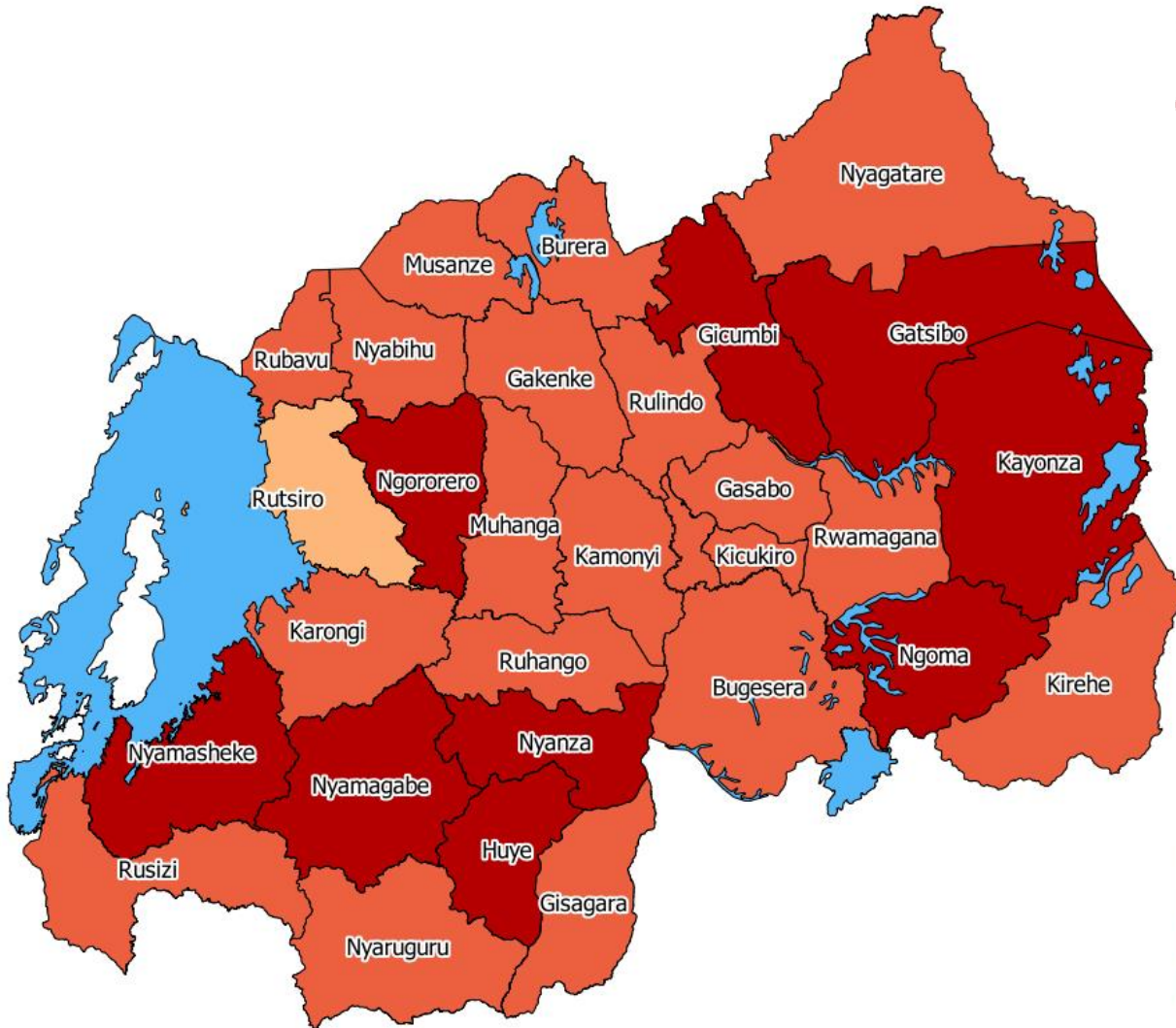
Old WHO Cut Offs



New WHO Cut Offs



Anaemia in children under 5 years of age: A moderate - severe public health problem



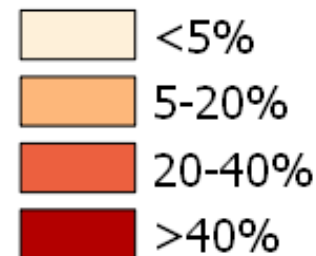
DHS, 2015



Anaemia prevalence: 37%

Likely due to low intake of iron and other micronutrient deficiencies.

Anaemia in U5



Supplements:

86% receive vitamin A.

70% consumed vitamin A rich plant foods.

20% consumed iron rich foods.



Deworming

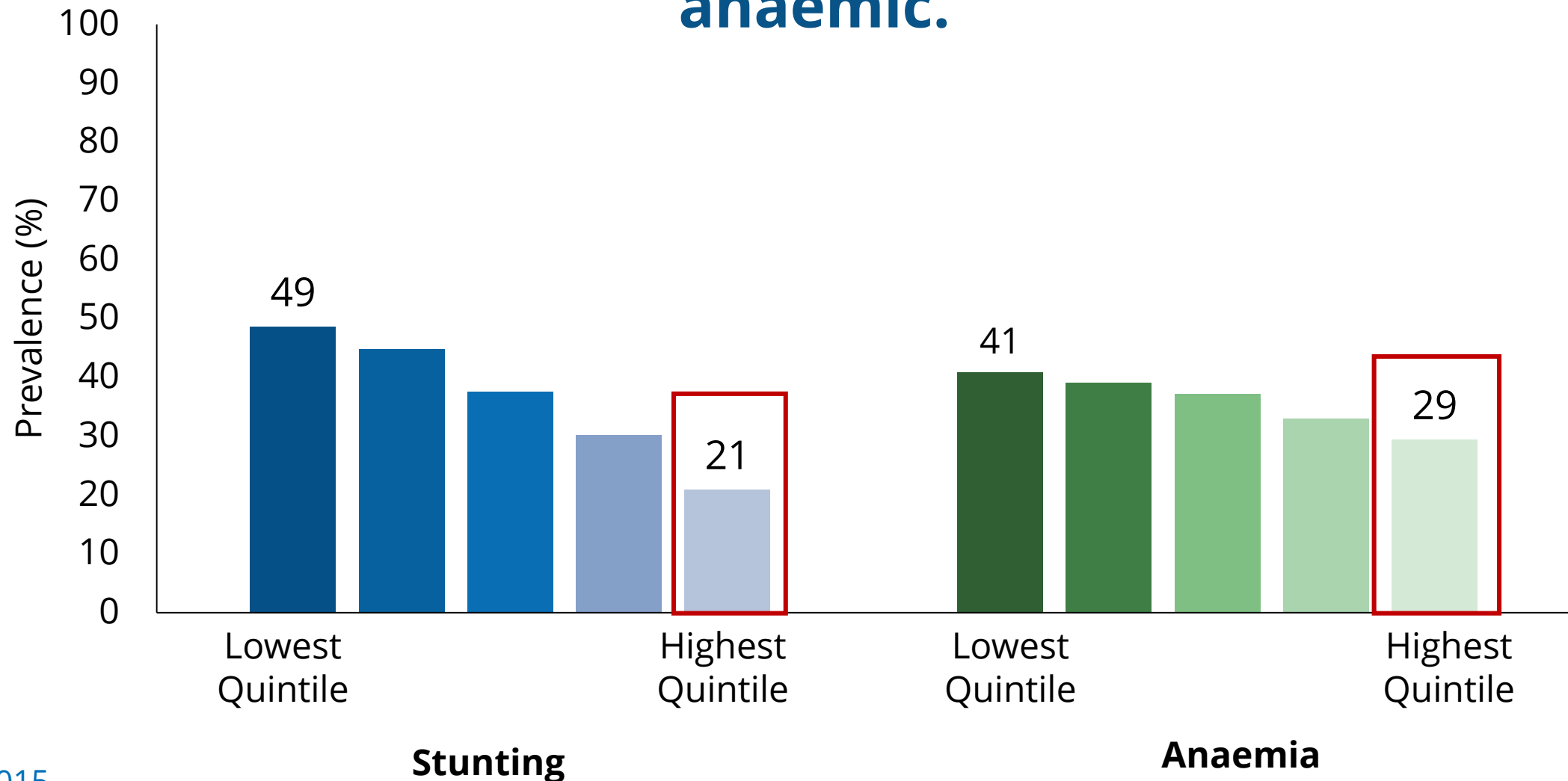
80% received tablets.



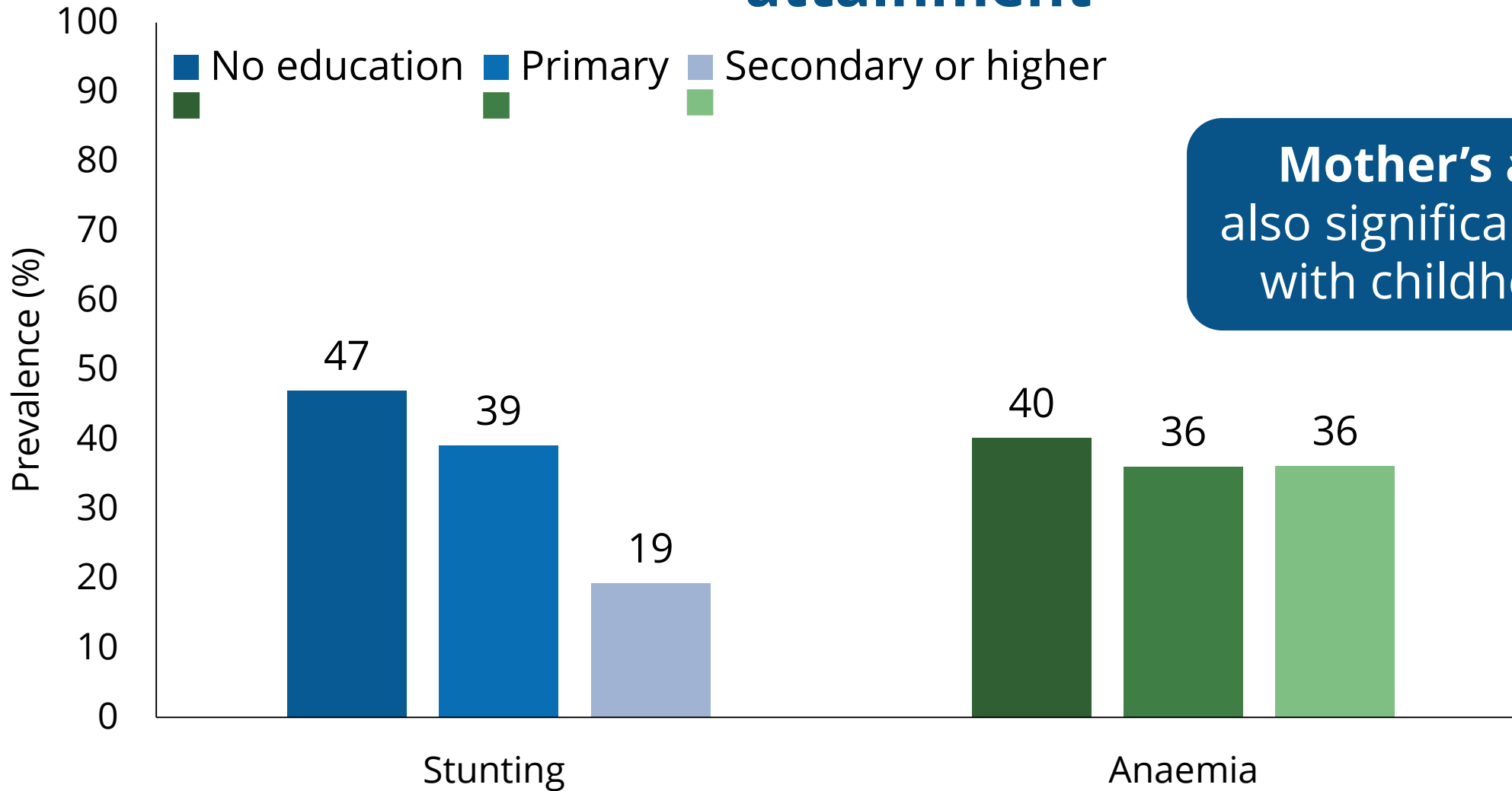
Malaria-related

anaemia: 2%.

**Children in the wealthiest households
at lower risk of stunting and anaemia.
BUT almost 1/3 of these children are still stunted and
anaemic.**



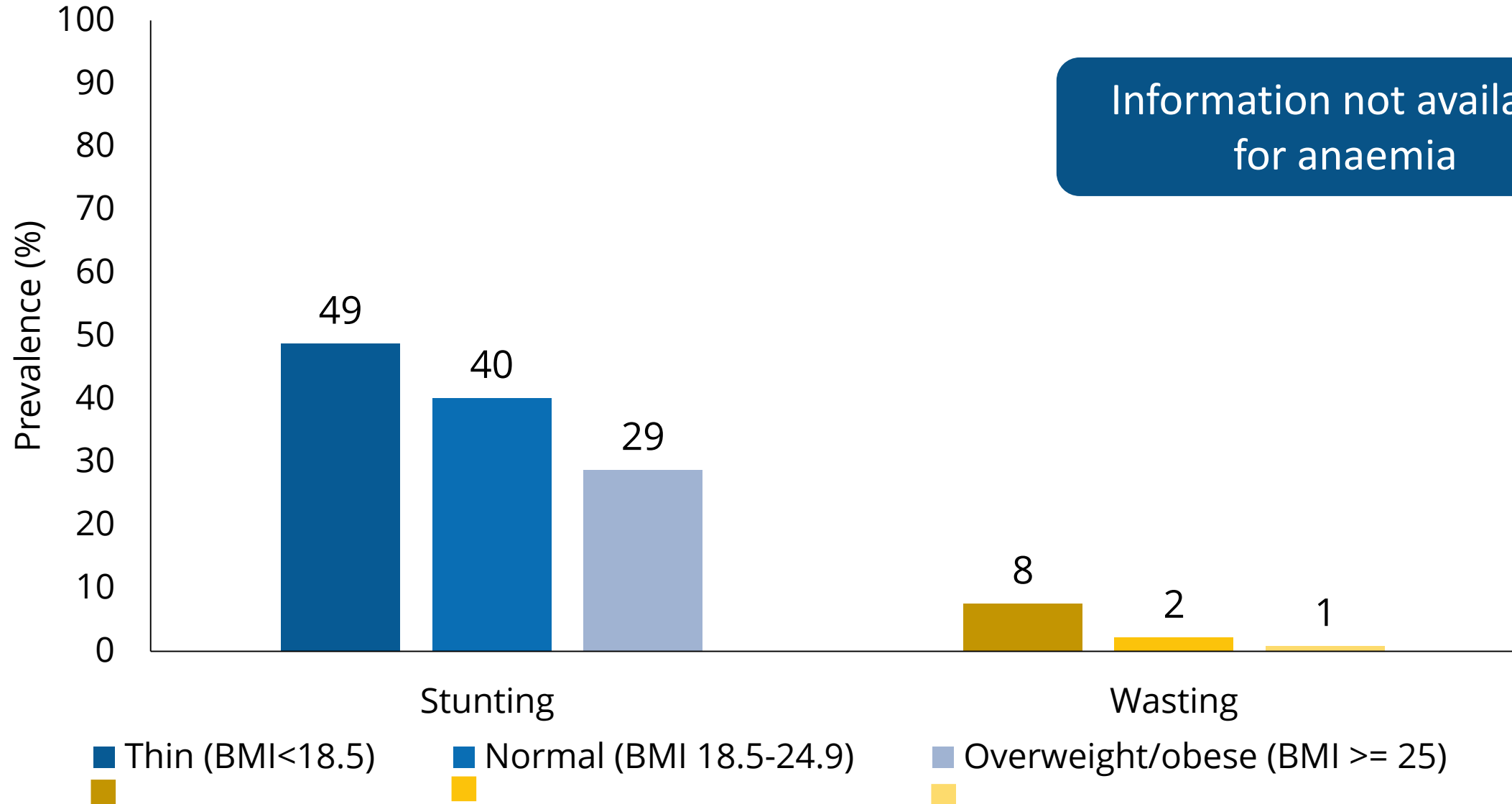
Stunting is associated with the mother's educational attainment



Mother's age at birth
also significantly associated
with childhood anaemia

Stunting and Wasting are associated with mother's nutritional status

Information not available for anaemia



Significant improvements in WASH in the last 15 years BUT rural areas require more attention

Water and sanitation for health (WASH)
is an underlying cause of diseases.
Together with food intake it causes malnutrition.



Access to
improved
source of
drinking
water

69 % Rural
91% Urban



Dedicated
place for
handwashing
10% Rural
20% Urban



Time to obtain
drinking water
> 30 min
55% Rural
20% Urban



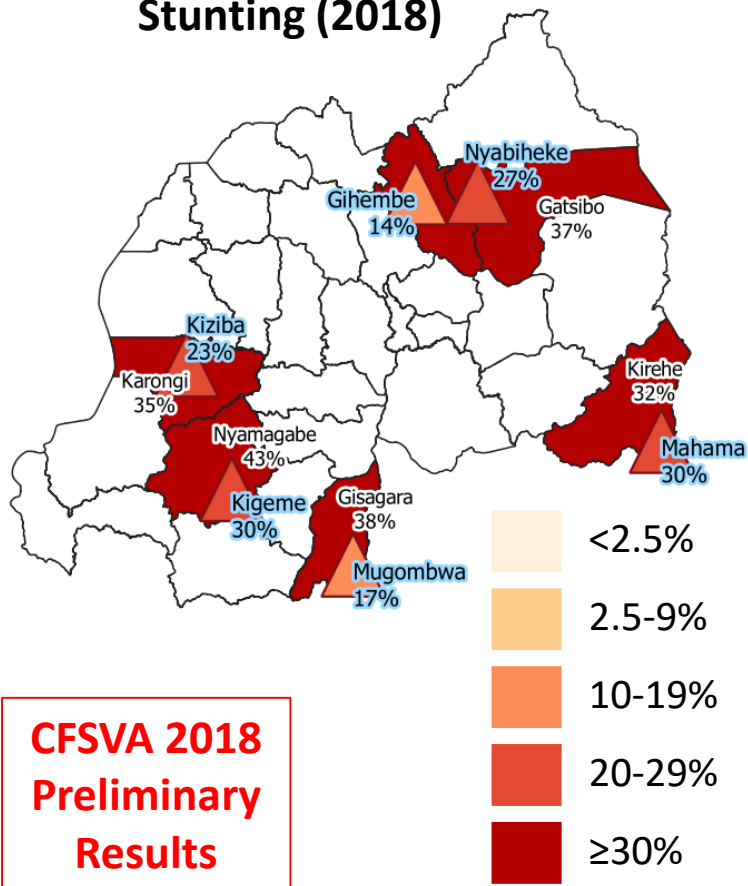
Access to sanitation
infrastructure
Improved:
69% Rural
87% Urban

Note: Cleanliness of living environment also depends on access to
sanitation and hygiene of other community members.

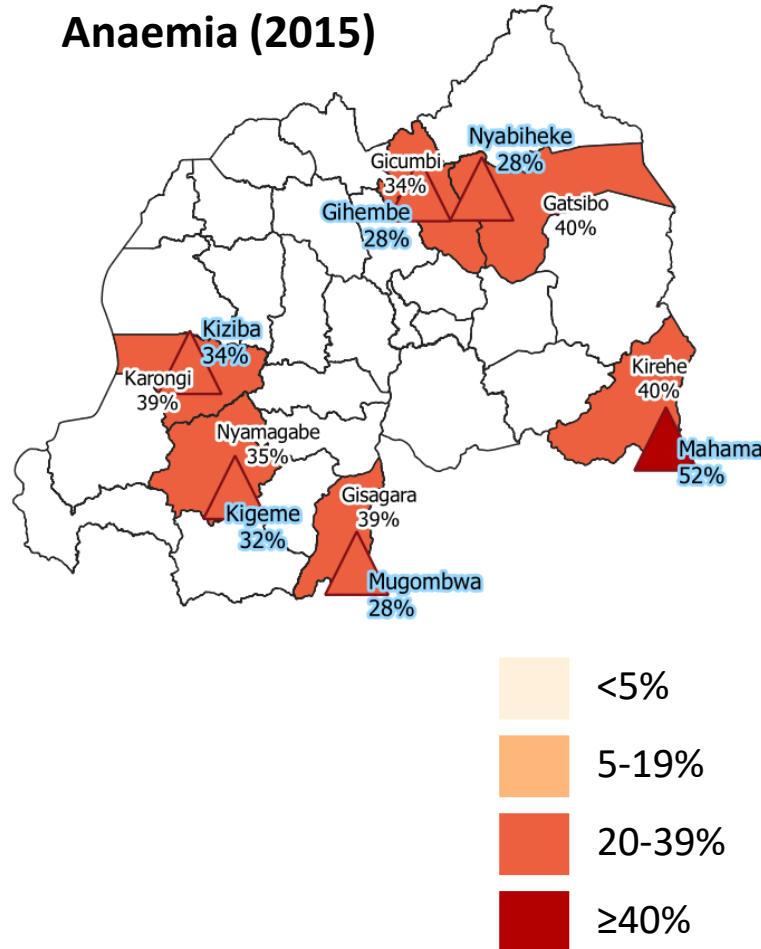
Stunting is generally lower in refugee camps compared to the host communities.

The rates of anaemia and global acute malnutrition are similar.

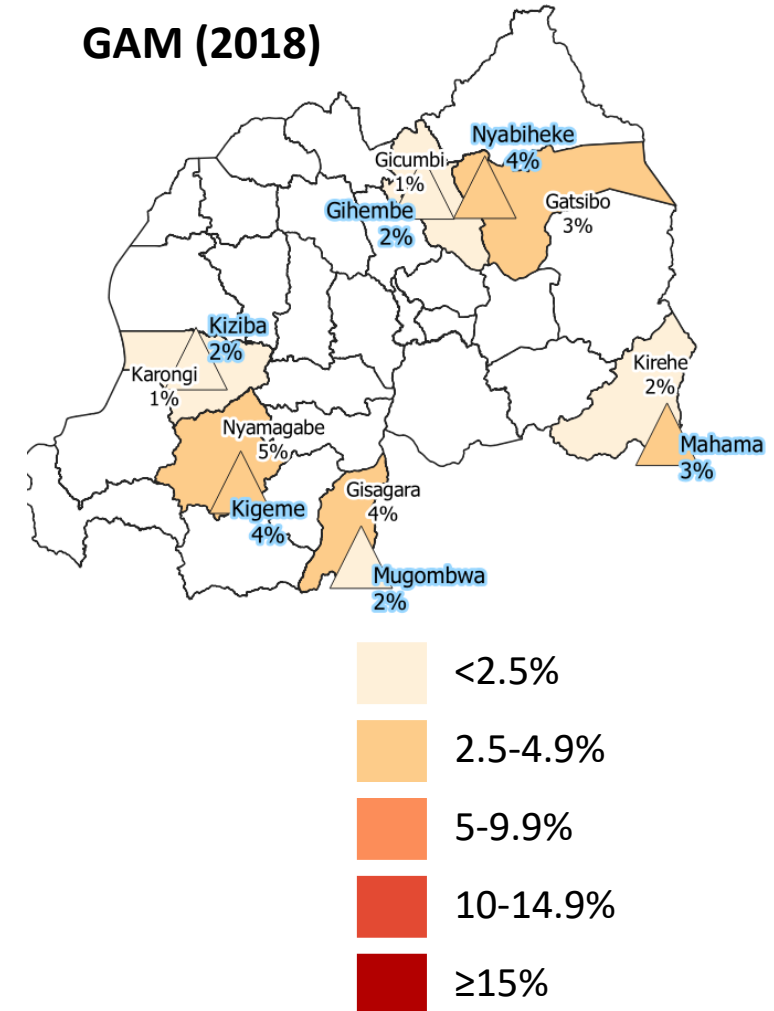
Stunting (2018)



Anaemia (2015)



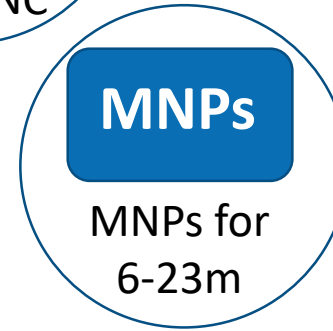
GAM (2018)



Lower stunting in refugee camps can be attributed to:

A controlled setting allowing for:

- Higher coverage of nutrition specific and sensitive interventions
- Implementing partners with higher staffing levels
- Increased complementarity across sectors



Questions

1. What might be the causes for high stunting and anaemia persisting in the highest wealth quintiles?
2. What could we learn from the work that's being done in the refugee camps to reduce stunting in the Rwandan population?



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KEY MESSAGE 3

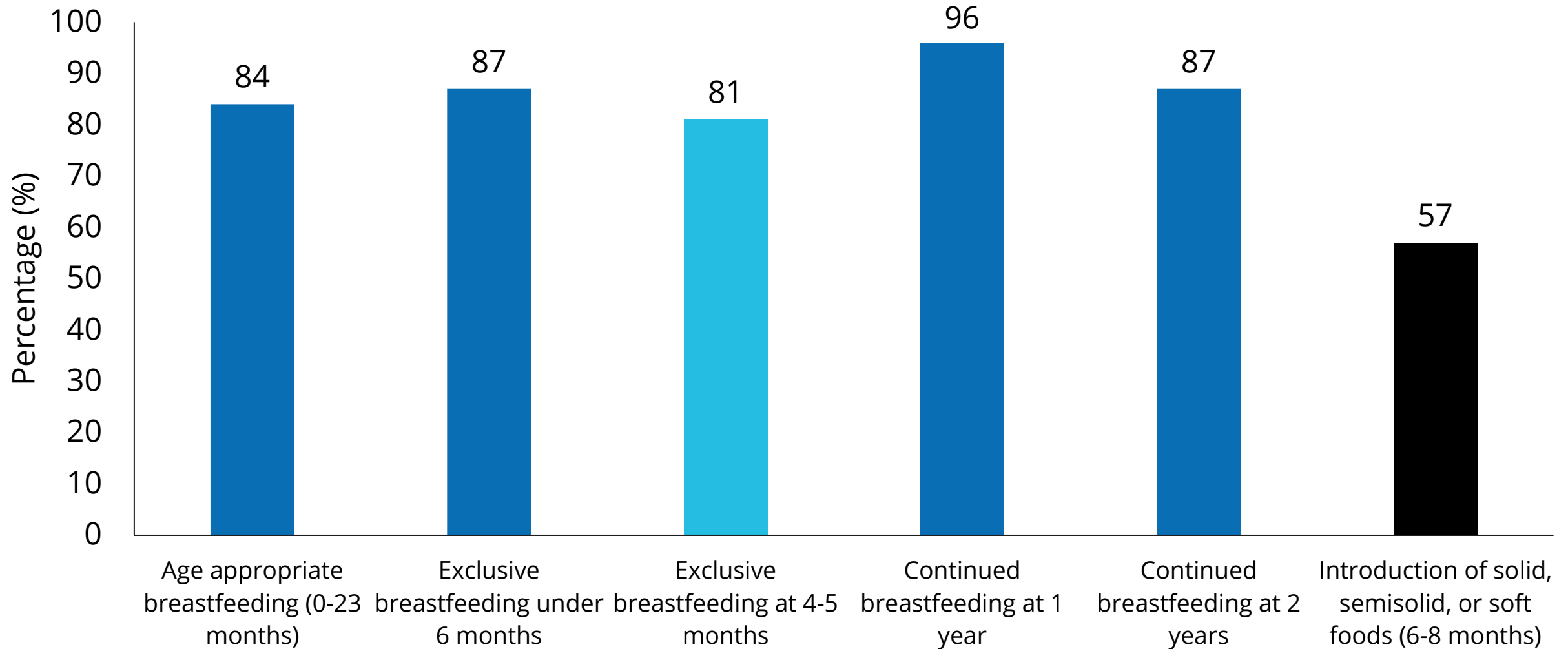
CELEBRATE the **best breastfeeding practices** in the world.

ADDRESS suboptimal **complementary feeding** which prevents an adequate nutrient intake.

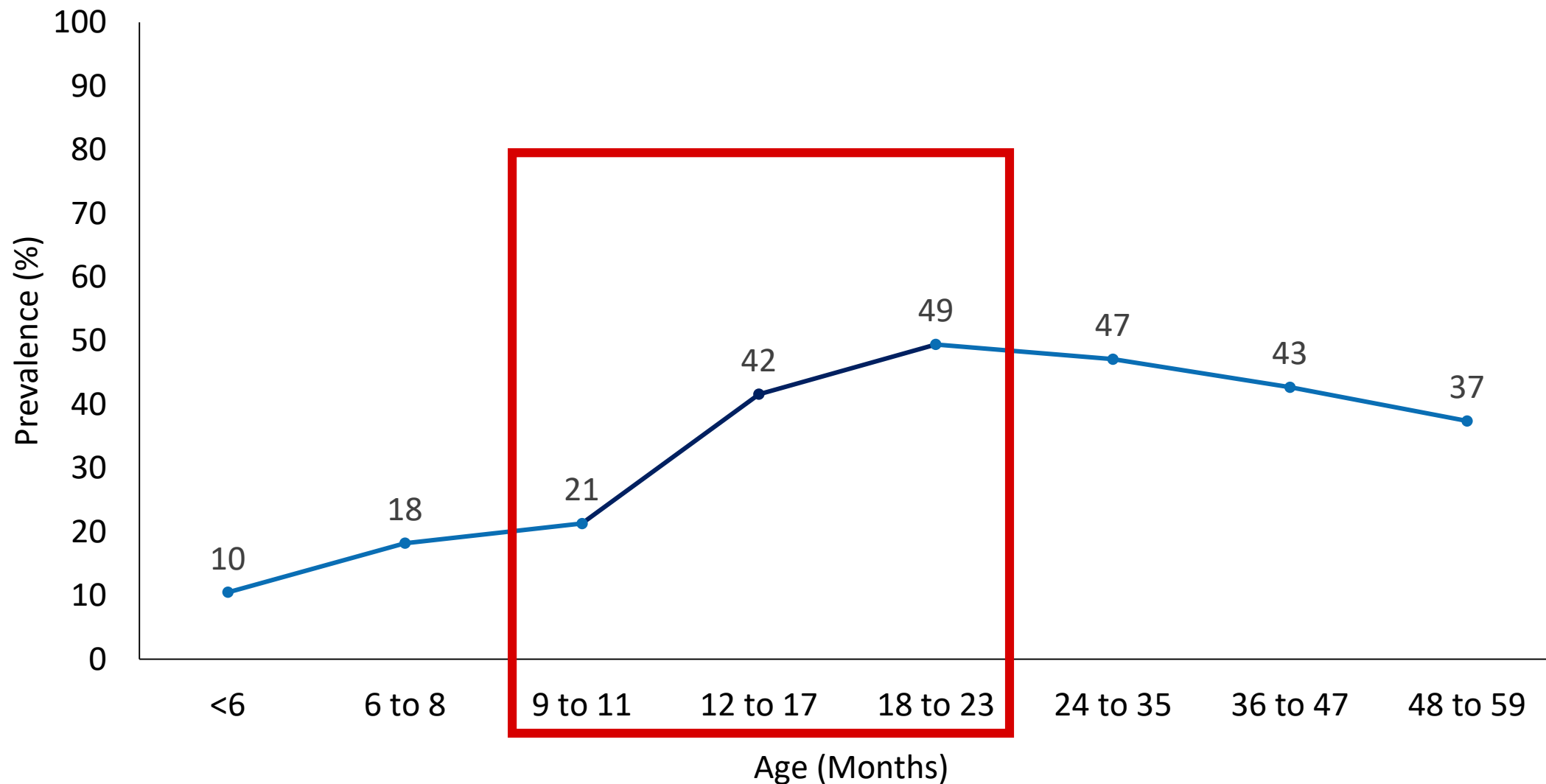
Key barriers:

- Food availability
- Affordability of nutritious foods
- Food habits, culture and beliefs
 - Time constraints

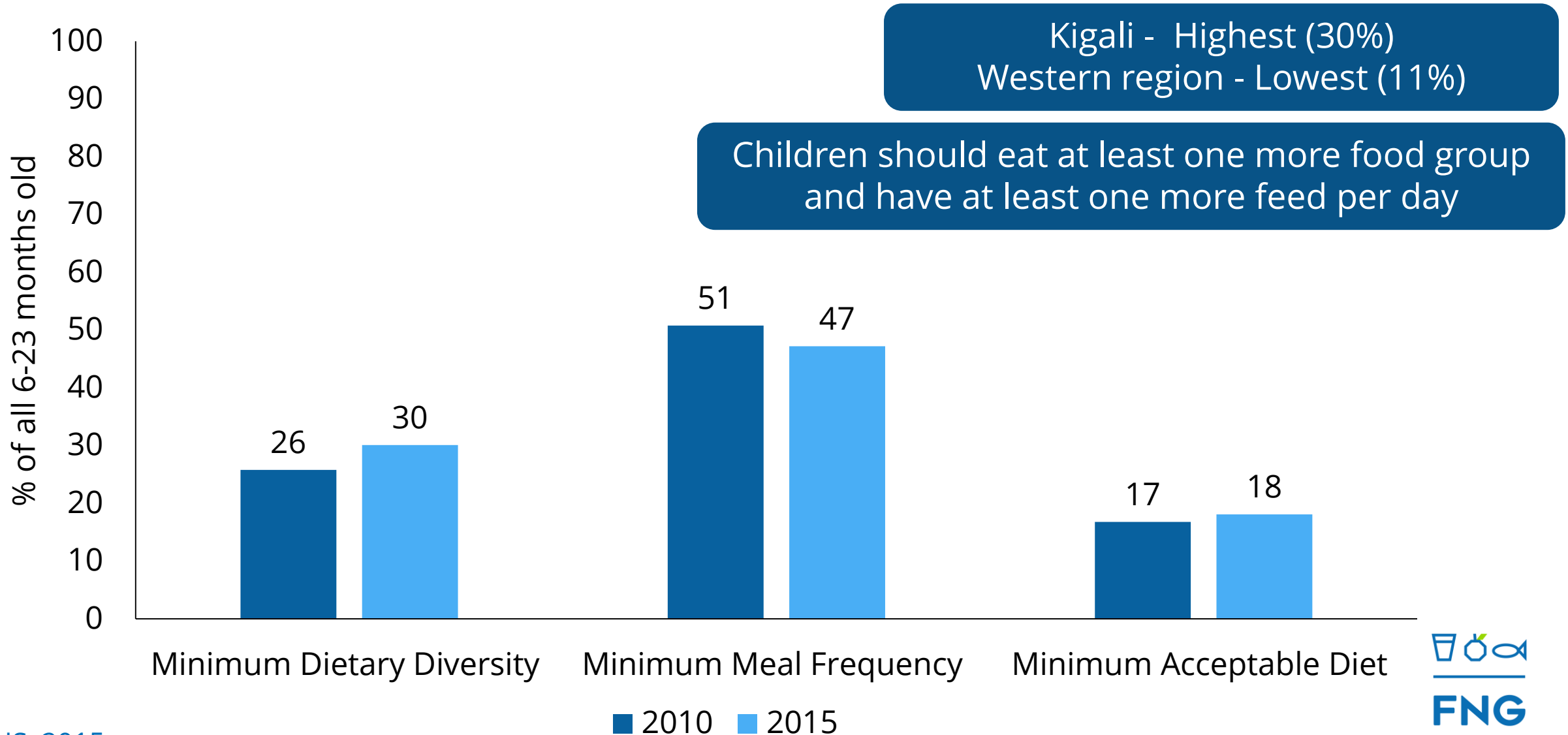
Exclusive breastfeeding for 6 months is widely practiced. Only half of children are introduced to complementary foods at the recommended age.



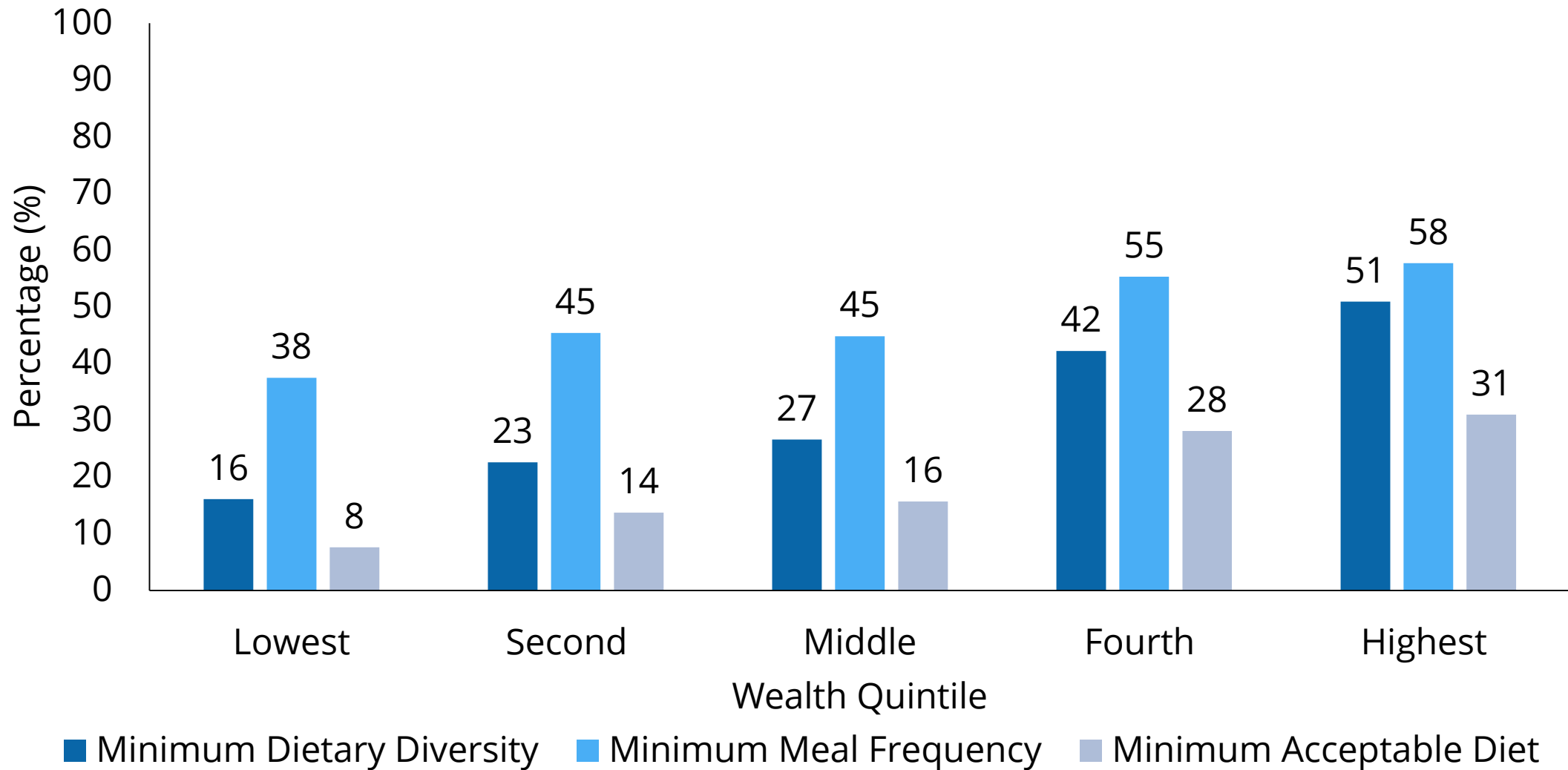
National level stunting trends suggest an inadequate nutrient intake during the complementary feeding period



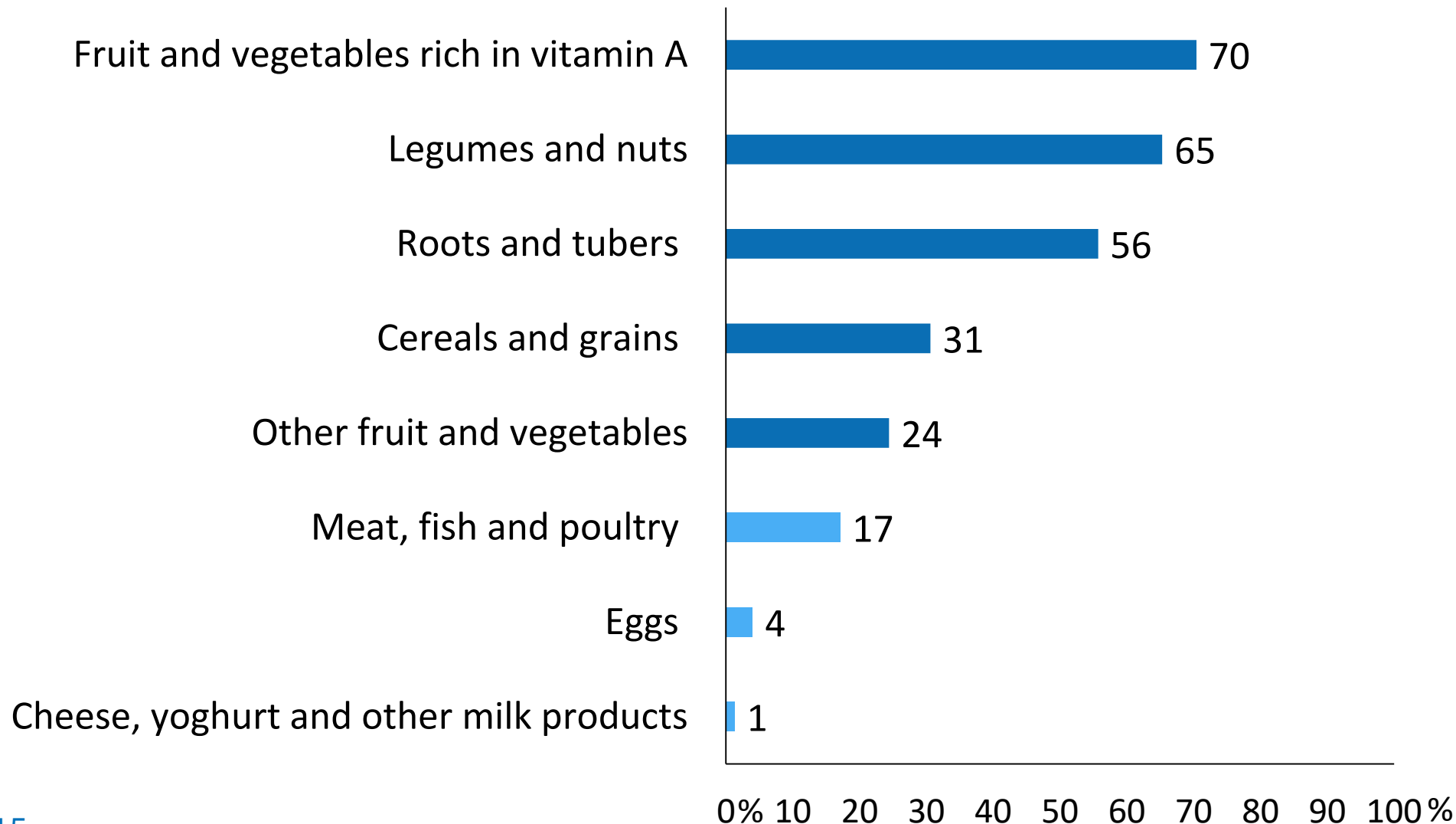
Only 18% of children 6-23 months are fed a Minimum Acceptable Diet



Minimum Acceptable Diet in particular Dietary Diversity improves with increased wealth BUT is still low



Nearly three quarters of children 6-23 months are fed vitamin A rich foods, legumes and nuts BUT few are fed animal source foods



What stops children being fed optimally?

Affordability of
nutritious foods

Limited food
availability

Food habits,
culture and
beliefs

Time constraints
of mothers



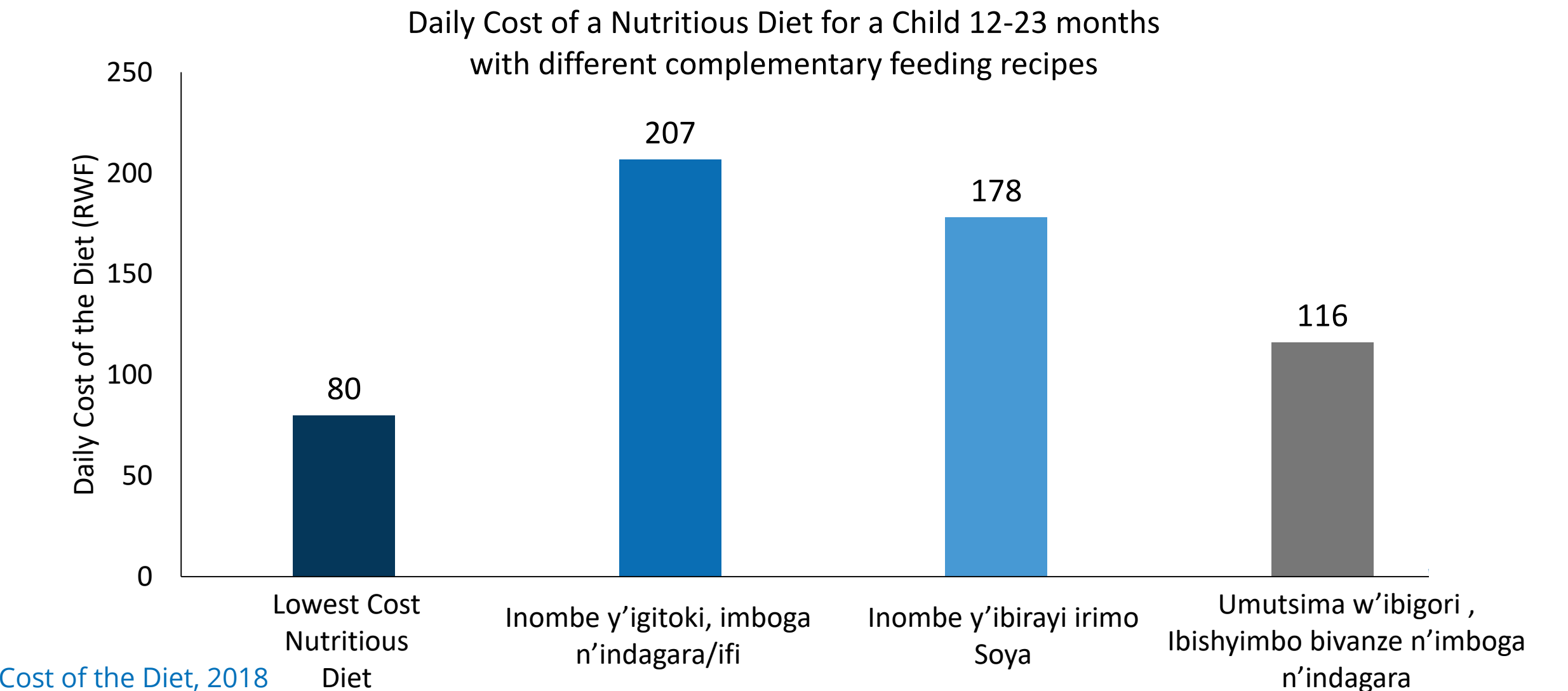
What stops children being fed optimally?

Affordability of nutritious foods

- Poor households cannot afford sufficient nutritious foods.
- Complementary feeding recipes recommended by the Ministry of Health are very nutritious but also expensive.



Foods recommended in complementary feeding recipes may be too expensive for households to buy



What stops children being fed optimally?



Limited food
availability

Suboptimal food
system (production,
supply and demand)
result in low variety
and quantities of
nutritious foods.

What stops children being fed optimally?



- Caretakers are economically unable to take the time to feed their children frequently or prepare the right foods for them.
- Mothers are primarily responsible for feeding small children and have high workloads - both in and outside of the home.
- Further engagement of men in housework and childcare could play an enabling role in improving complementary feeding.

Time constraints
of mothers

What stops children being fed optimally?



Food habits,
culture and
beliefs

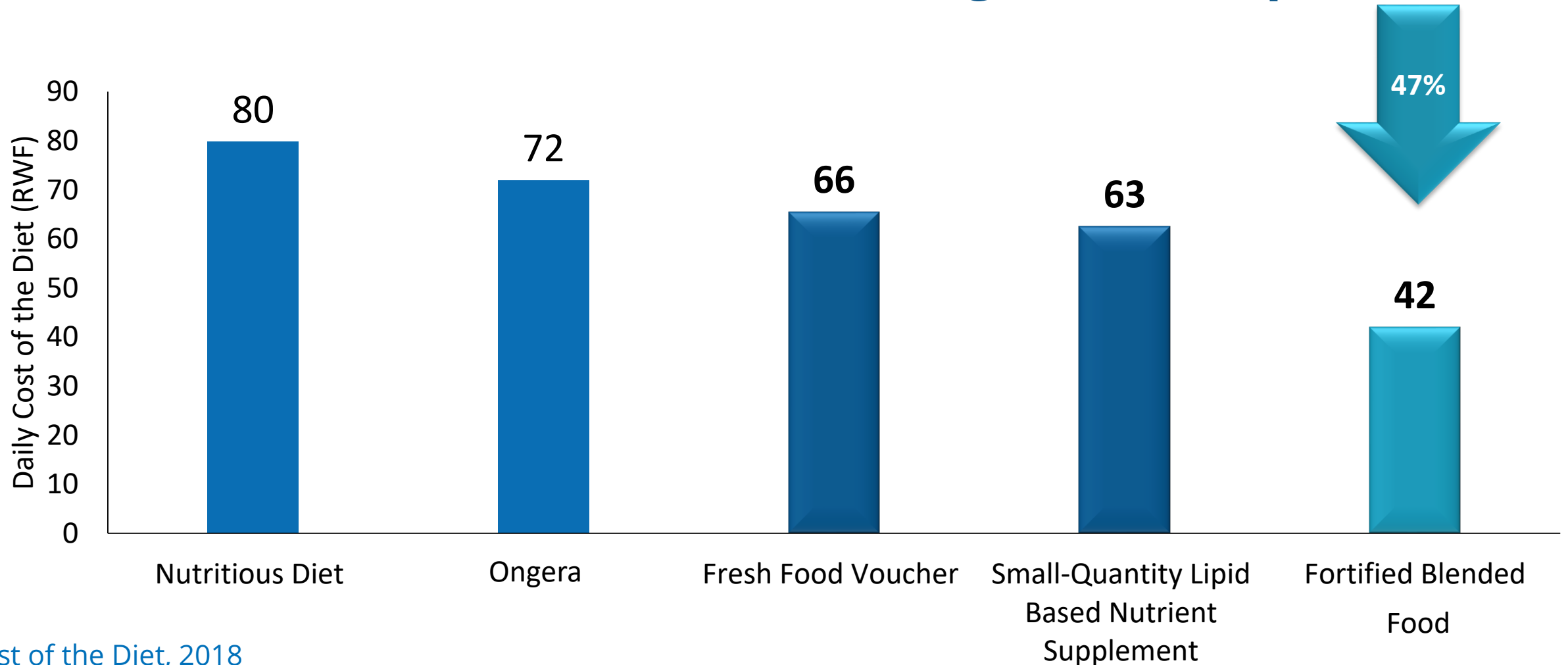
- Water is important for the baby's health.
- HIV-positive mothers should not breastfeed.
- Infants should be given liquids instead of semi-solid foods.
- Vegetables are still perceived by some as *"Ingredients for the poor that you cook if you don't have enough of the rest"*.
- Pregnant women should not breastfeed.
- Some nutritious foods are deemed inappropriate for small children, e.g. indagara, groundnut powder.
- The only ingredients considered suitable for combining with porridge are milk and sugar.

Modelling to improve access to nutrients

Children under 2 years of age

Intervention	Transfer Modality	Possible Entry Points
Fortified Blended Food 60g/day	Voucher/In-kind	<ul style="list-style-type: none">• Health• Social Protection
Ongera Multiple Micronutrient Powder		
Small-quantity lipid based nutrient supplement 20g/day		
Fresh Food Voucher 110g eggs + 235g dodo leaves /week	Voucher	<ul style="list-style-type: none">• Agriculture• Markets• Social Safety Net

Child 6 to 23 months:
Both a fresh food voucher and specialised nutritious foods
have the potential to reduce the cost of a nutritious diet.
Fortified Blended Food has the greatest impact





FNG

KEY MESSAGE 4

Nutrient needs of **women** and **adolescent girls** are **high**.

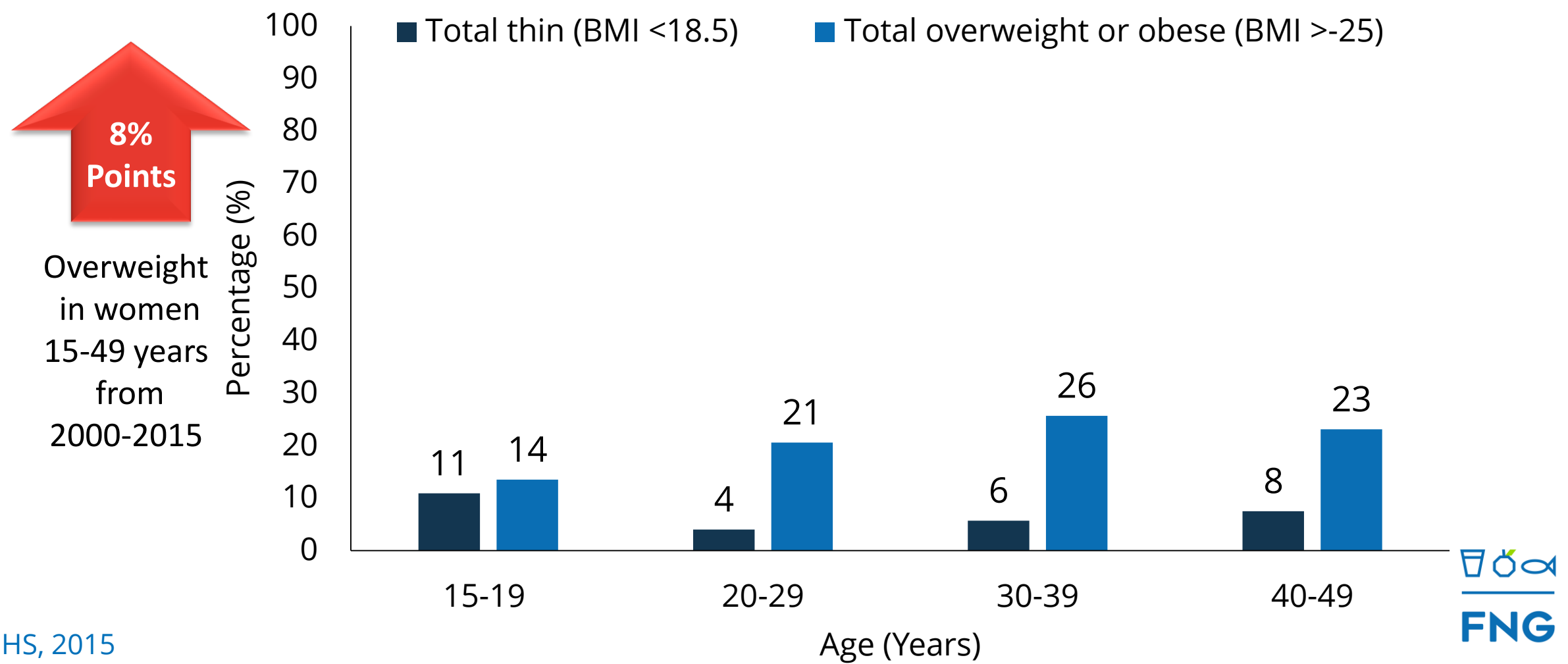
Although the rate of **thinness is decreasing**, **overweight and obesity** in women is **rising**.

Data on women and adolescent girls' diets, micronutrient deficiencies and the causes of overweight and obesity **is lacking**.





Gender inequality at household level may be negatively impacting women, girl's and children's nutrition.

Thinness in women of reproductive age has declined to 6%

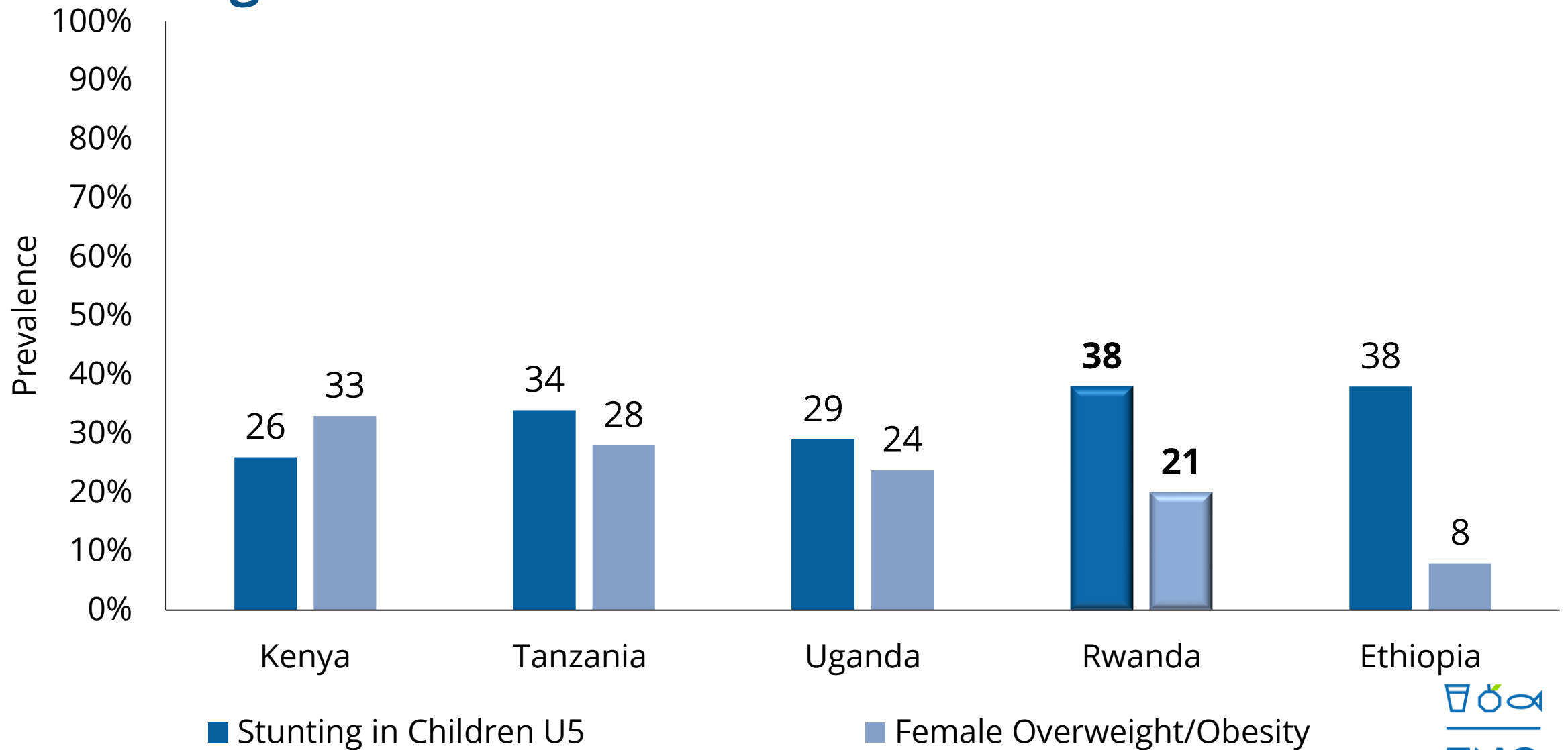
Overweight and Obesity has increased to 21%



Dietary risk factors related to increasing overweight and obesity are on the rise

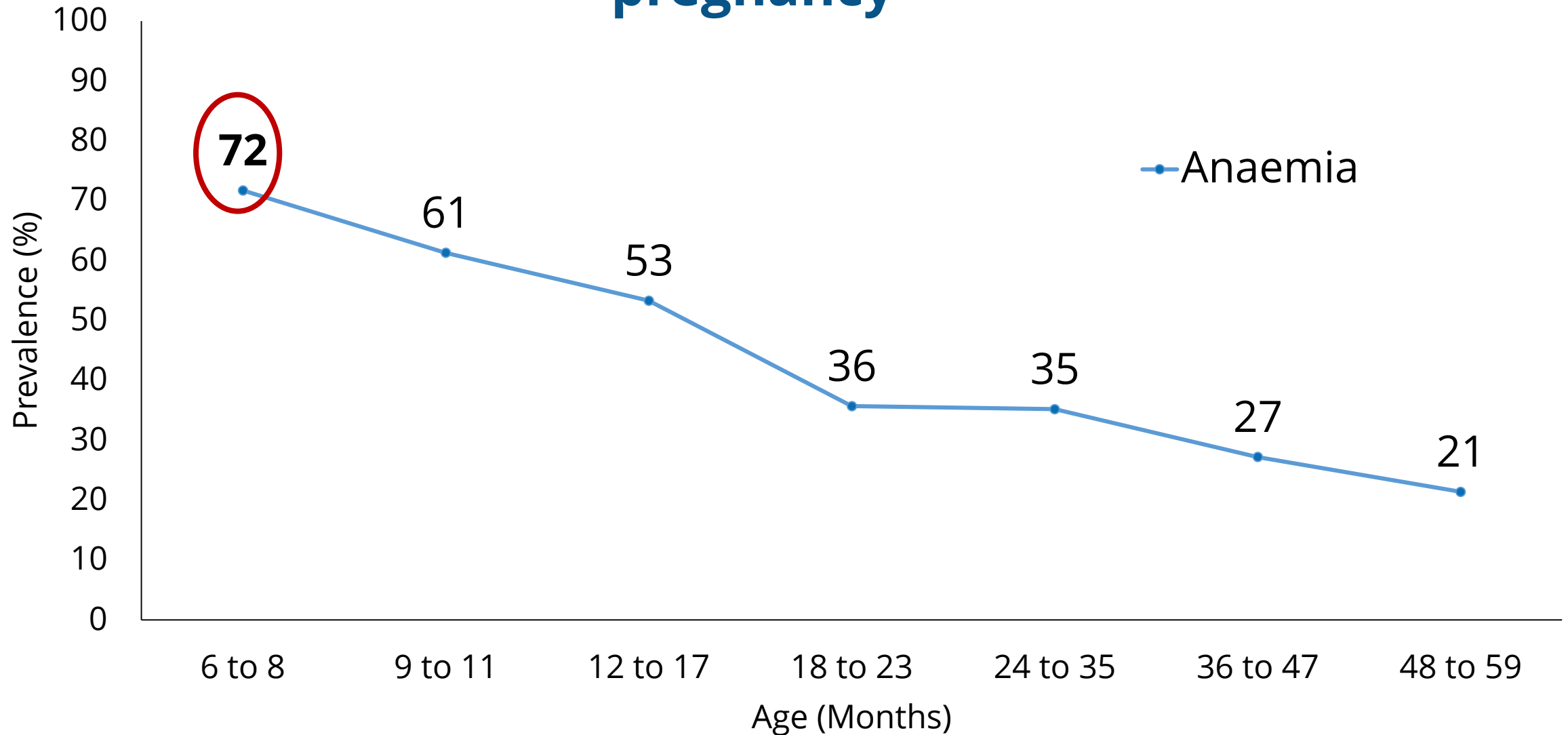
2016 ranking		% change 2005-2016
1	Malnutrition	 -52.3%
2	Air pollution	-40.3%
3	WASH	-59.1%
4	Alcohol & drug use	-1.6%
5	Unsafe sex	-69.3%
6	High blood pressure	 27.5%
7	Occupational risks	12.2%
8	Dietary risks	 20.5%
9	High fasting plasma glucose	 31.7%
10	Tobacco	-12.8%

Rwanda must start taking preventative actions against the double burden of malnutrition



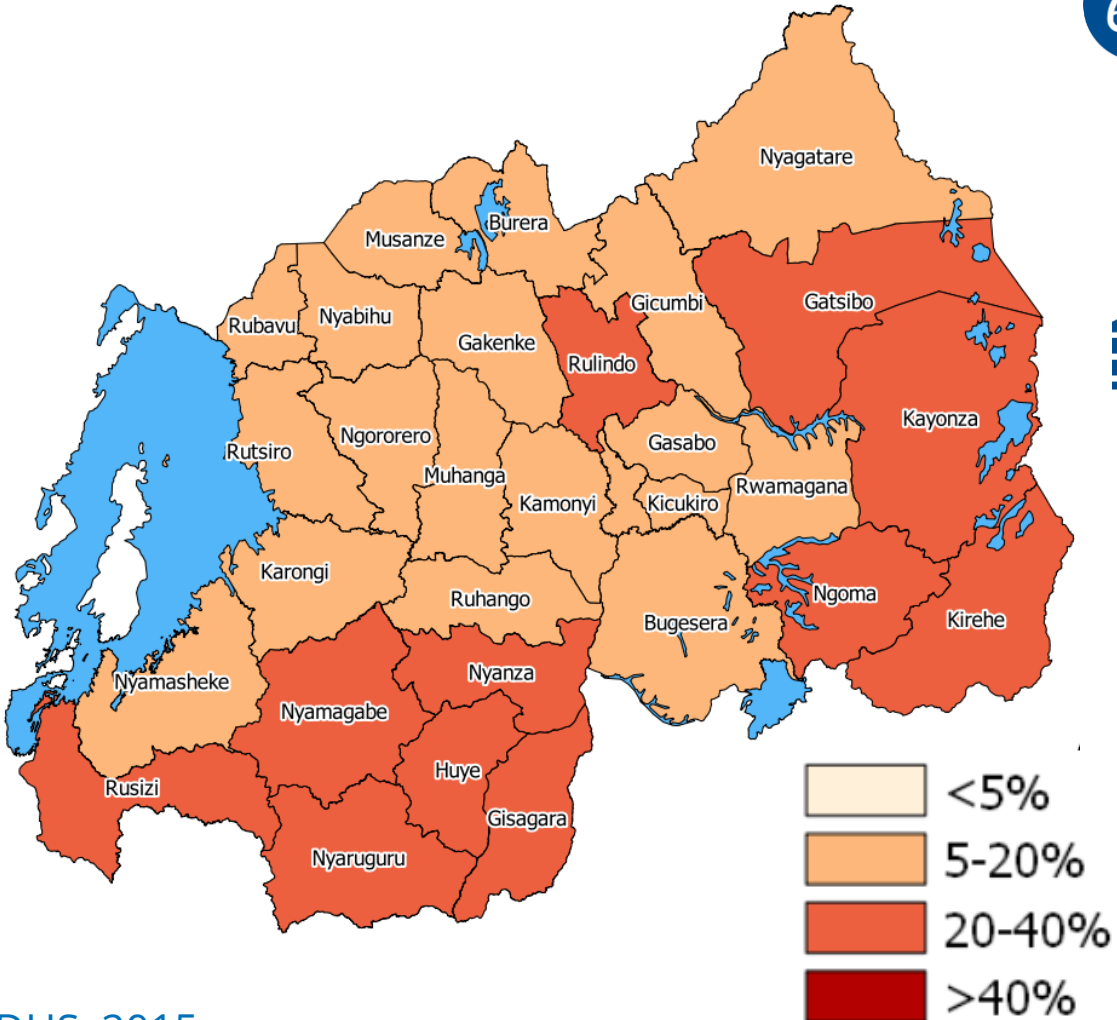
DHS 2016 (Uganda, Tanzania, Ethiopia), 2015 (Kenya), 2014 (Rwanda)

Prevalence of anaemia by child's age suggests that poor iron stores are laid down during pregnancy



Anaemia in women: Moderate to severe public health problem

Women of Reproductive Age



Deworming during pregnancy:
49%



Slept under mosquito net during pregnancy:
73%

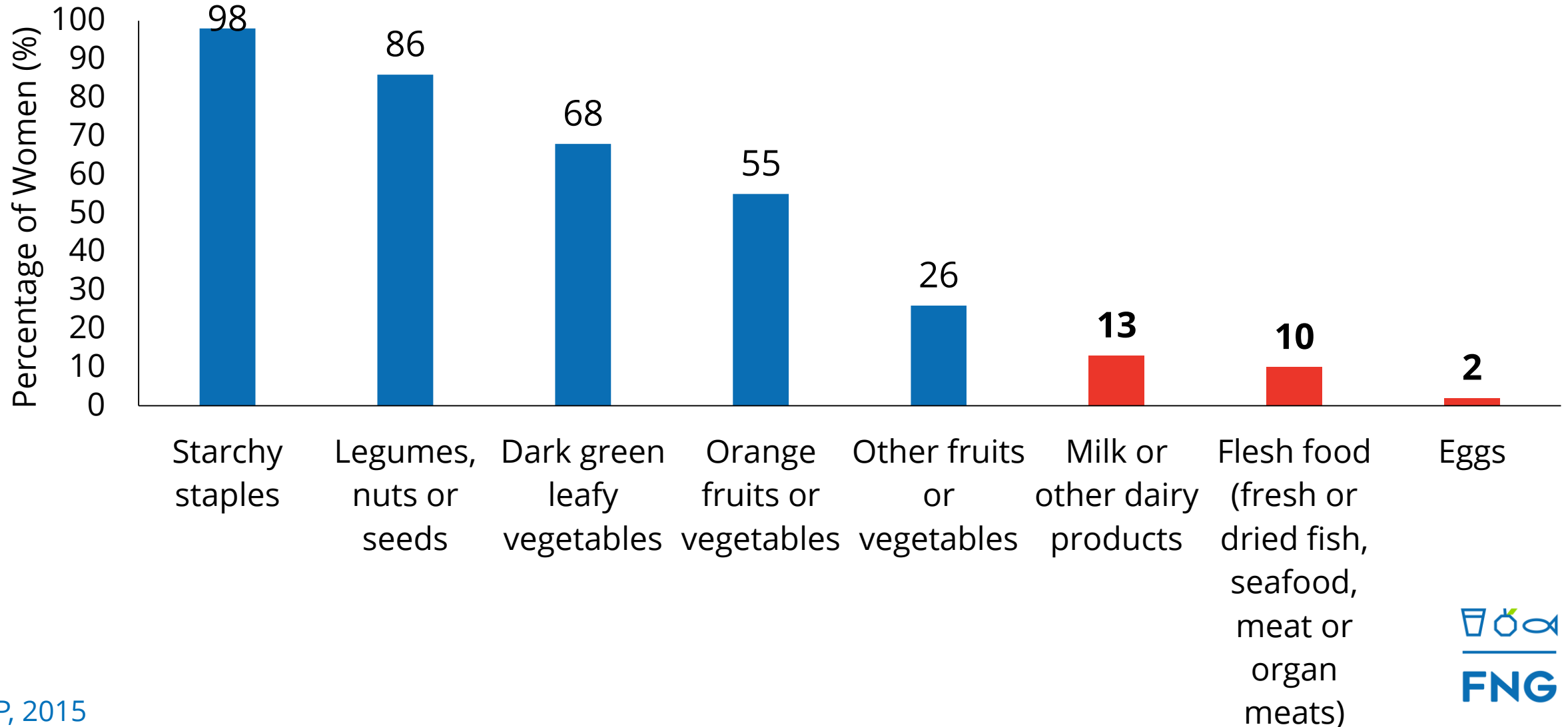


Supplements:
49% women received vitamin A supplement postpartum.

Only 3% of women took iron tablets / syrup as recommended (≥ 90 days) during pregnancy

Reduction of anaemia only 7% points from 2005-2015

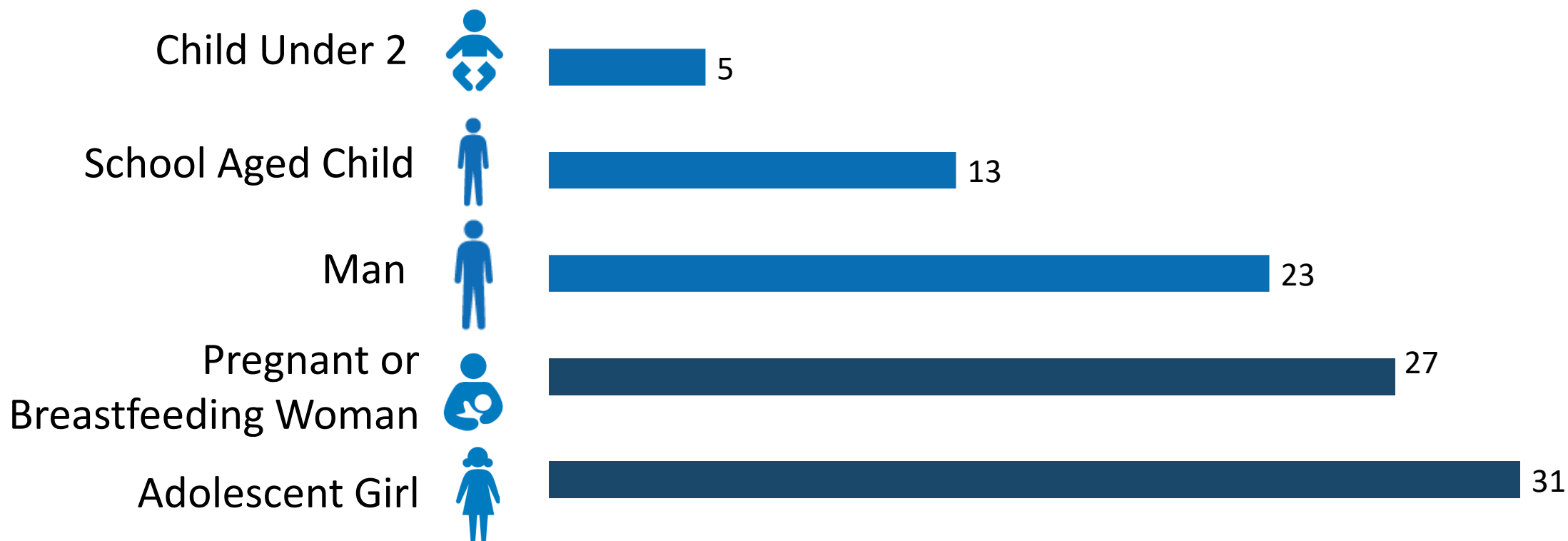
Diets of women: Made up mainly of staple foods and contain little animal source foods



Cost of the Diet results

emphasise the need for nutrient dense foods for pregnant and lactating women and adolescent girls

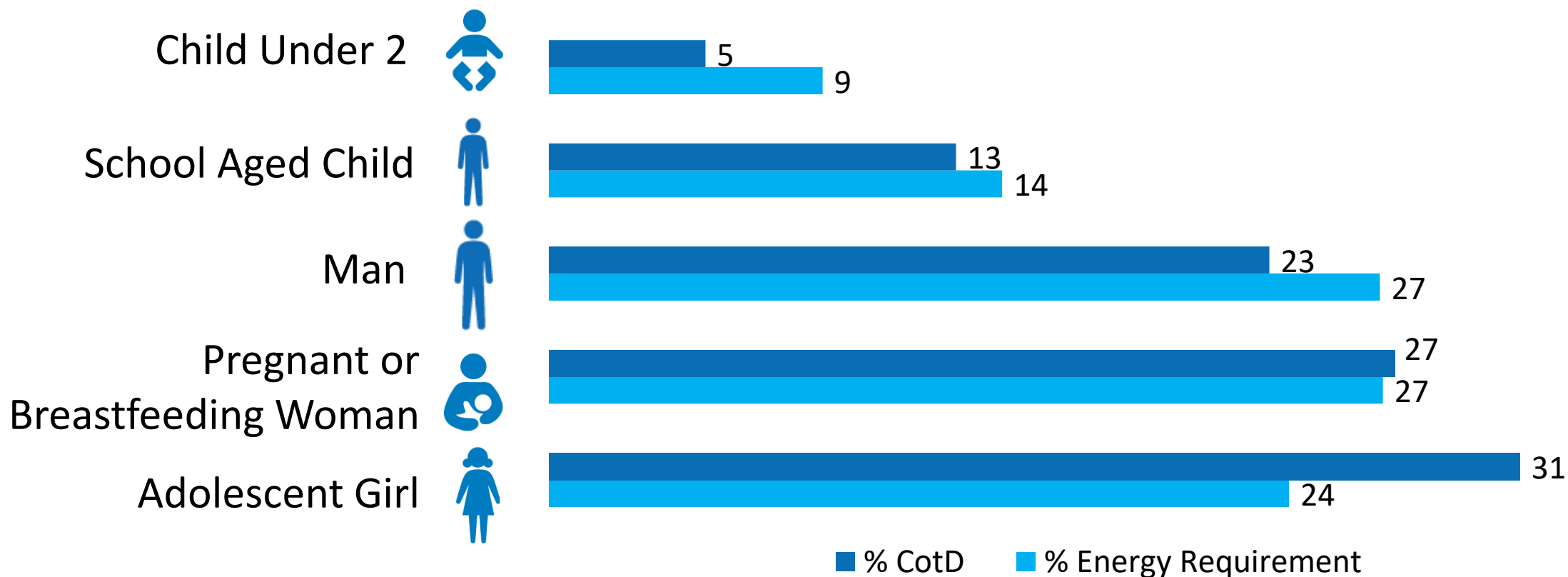
Proportion of household cost of the nutritious diet



Cost of the Diet results

emphasise the need for nutrient dense foods for pregnant and lactating women and adolescent girls

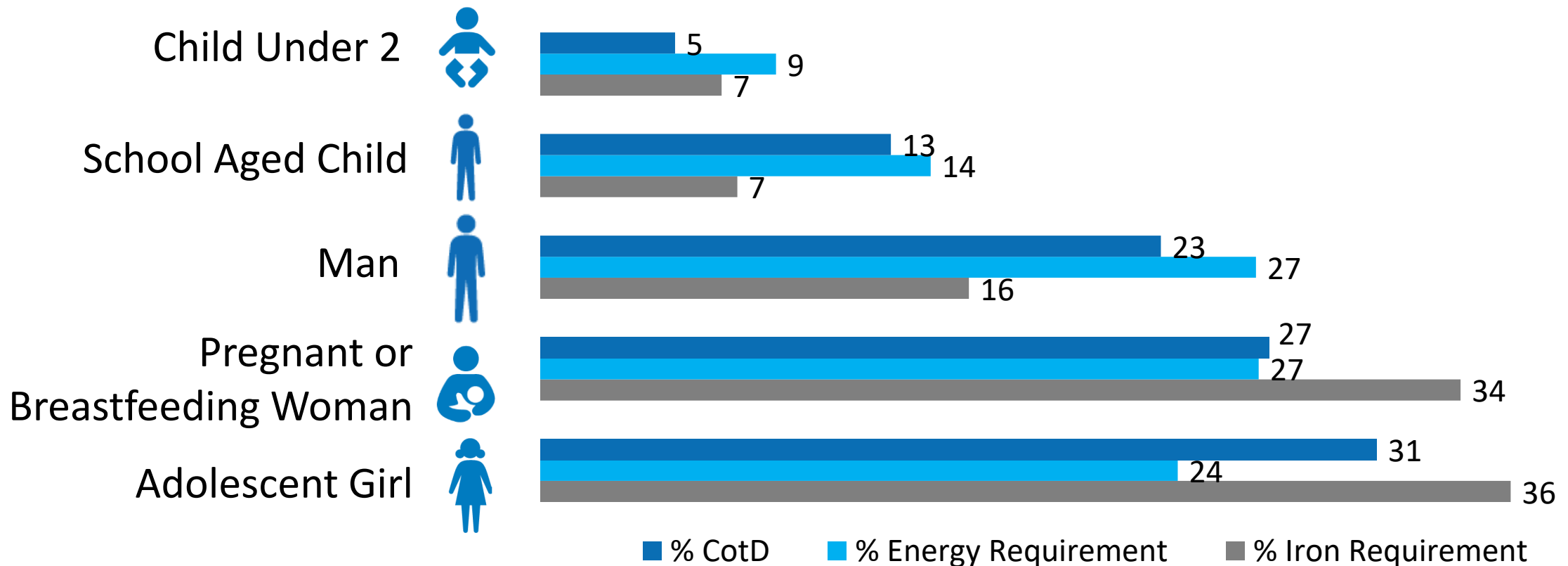
Proportion of household cost of the nutritious diet



Cost of the Diet results

emphasise the need for nutrient dense foods for pregnant and lactating women and adolescent girls

Proportion of household cost of the nutritious diet



Rwanda is a global example on gender equality in government BUT gaps at the household level may be negatively impacting on woman's nutrition



Women hold the primary responsibility to care for and feed children.

Mean hours spent on unpaid domestic work per week:
F 25h, M 8h.



Men's role in nutrition is mostly limited to provision of money to purchase foods.

Mean hours per week spent on cooking:
F 10h, M 3h.



Government ministerial positions: **F 40%, M 60%**
Mayors: **F 16.7%, M 83.3%**

Girls and women remain underrepresented in decision-making in communities and households.



Gender-based violence persists: **F 22%, M 5%** have experienced sexual violence at least once.



Labour force participation for >16 yrs:
F 87.5%, M 87.2%

Nevertheless, culturally men are often seen as the breadwinners for the family.

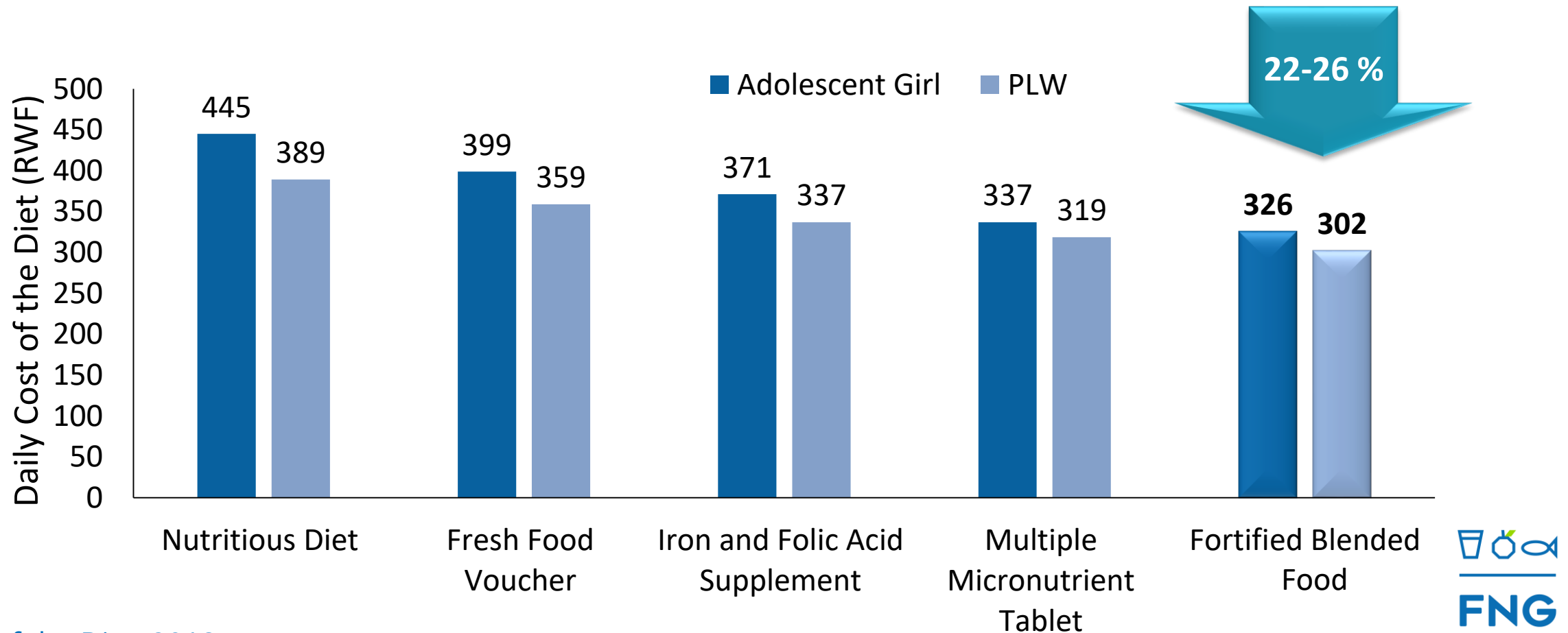
Rwandan women who are unable to decide on daily tasks and take charge of their time are **18.6% more likely to have stunted children.**

Modelling to improve access to nutrients

Adolescent Girl and Pregnant and Lactating Woman

Intervention	Transfer Modality	Possible Entry Points
Iron and Folic Acid Supplement	Voucher In-kind	<ul style="list-style-type: none">• Health• Agriculture• Social Protection• Markets (Private Sector)• Education (adolescent girls)
Multi-Micronutrient Tablets		
Fresh Food Vouchers Adolescent girl: 175g eggs and 375g leaves per week Pregnant and lactating women: 150g eggs and 330g leaves per week		
Fortified Blended Food		

**Adolescent girl and pregnant & lactating woman:
a fresh food voucher, micronutrient supplements and
fortified blended food all have the potential
to reduce the cost of a nutritious diet.
Fortified blended food has the greatest impact.**



Questions

1. What could be done to reduce women's workload and enhance IYCF?
2. What could be potential entry points to address adolescent nutrition?



FNG

KEY MESSAGE 5

Efforts to **prioritize** children's **primary education** have been **successful**.

However, **secondary enrolment** remains low.

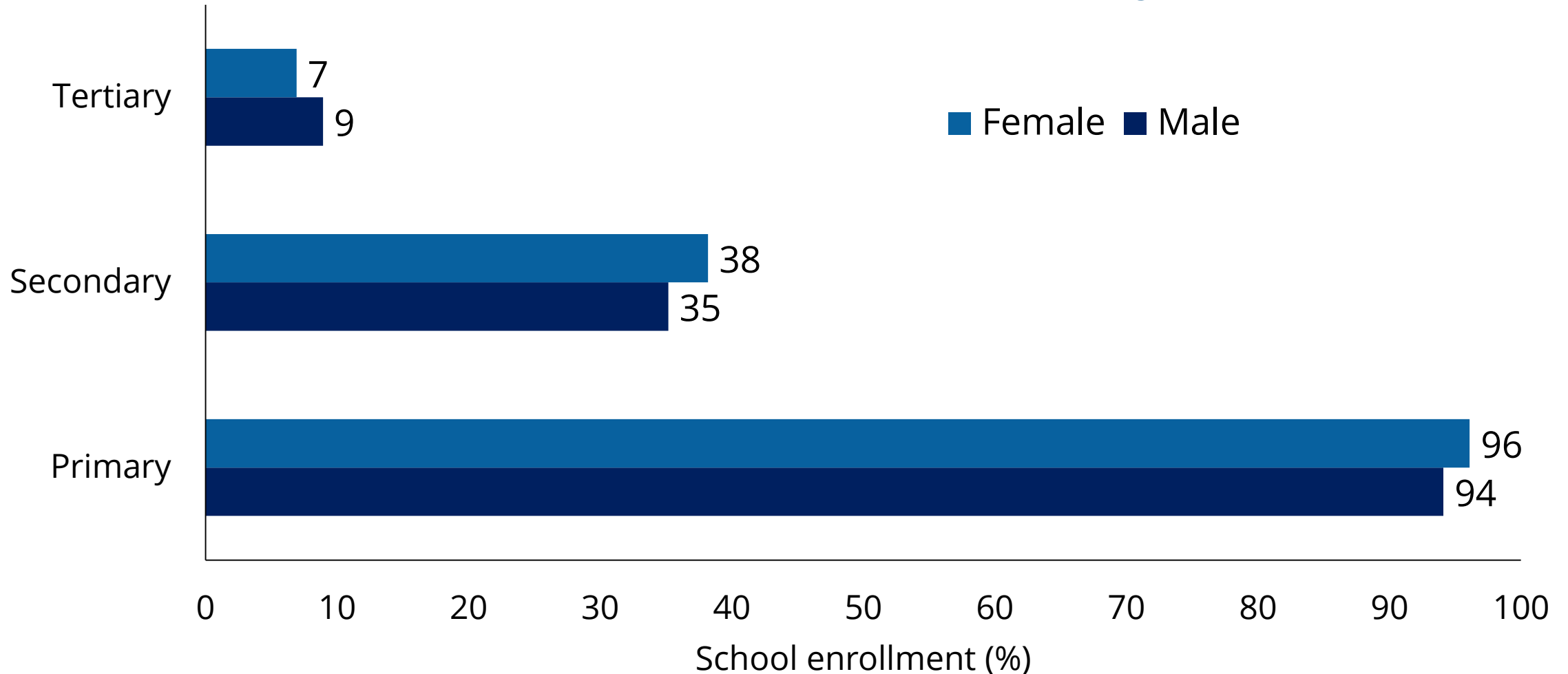
As **girls** enter adolescence, **persisting gender inequalities** puts them at **academic disadvantage**. Given the associations between **maternal education** and **child malnutrition**, keeping **girls in school** is an **important priority**.

School meals are a **promising platform** to **improve the nutrient intakes** for school aged children.

School enrolment substantially drops after primary school

Girls slightly outnumber boys in primary and secondary school

BUT fall somewhat behind in tertiary education



Girls' drop-out rate at secondary level is higher than boys' and their national exam scores are lower



Pass lower secondary national leaving exam:
91% of boys
83% of girls



Pass upper secondary school leaving exam:
92% of boys
85% of girls



Domestic work:
girls do **4-6 hours more** per week than boys.

Gender-based violence en route to/from and at school.

A national survey found:
1/3 of men admitted having sexually abused an adolescent girl while in school.

Pregnancy: adolescent fertility rate has **increased** from **4%** in 2005 **to 7%** in 2014/2015 .

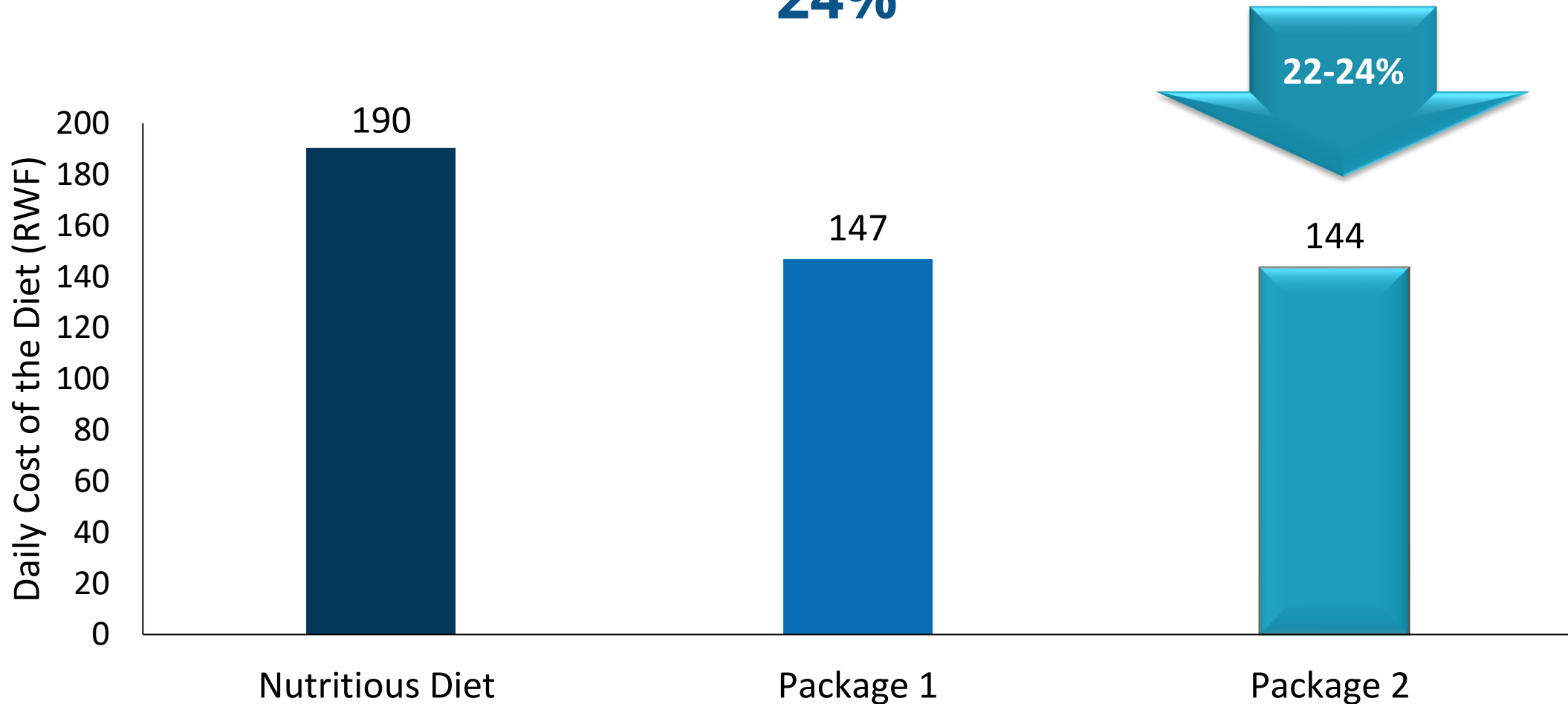
Modelling to improve access to nutrients

School aged child

Intervention	Transfer Modality	Possible Entry Points
Nutrition sensitive school meals Package 1: Fortified blended food and sugar Package 2: Fortified maize flour, beans and fortified oil	In-kind	Education

School Aged Child:

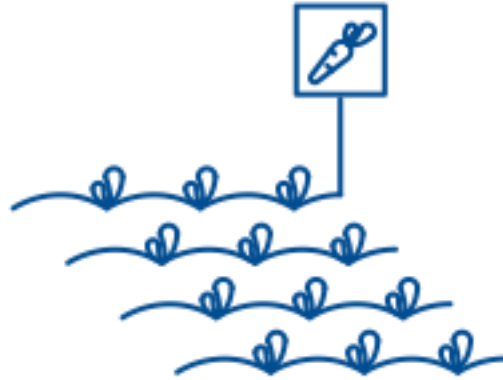
Basic school meals provision could reduce the cost to the household of a nutritious diet for the child by 22-24%



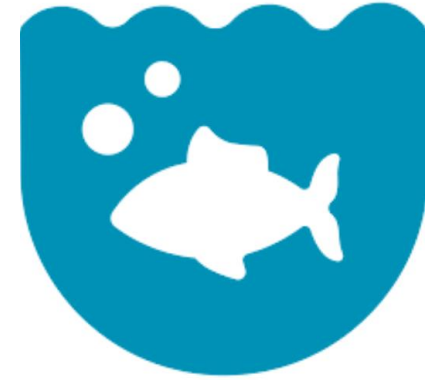
How the basic school meal could be made more nutritious?



2 cups of milk / week

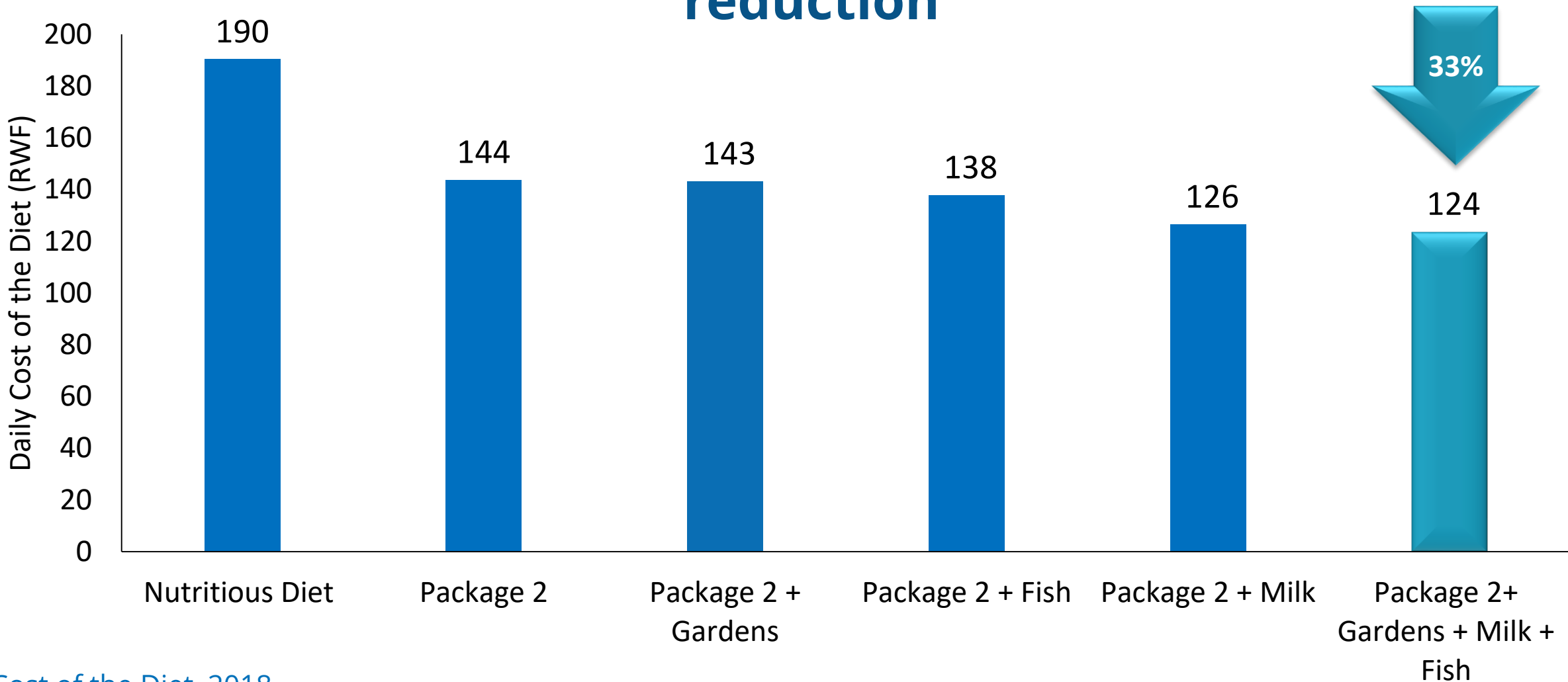


Community led
school
vegetable
garden



School
fish pond

Adding milk to the basic ration could reduce the cost of a nutritious diet for a school aged child by 33%. The interventions in combination have the greatest cost reduction





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KEY MESSAGE 6

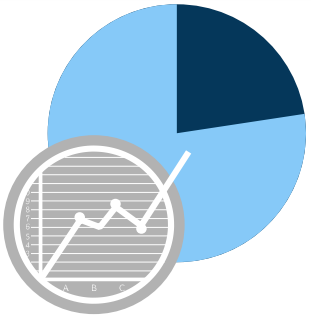
Despite being the **main economic livelihood**, **agriculture** is negatively impacted by **low crop** and **animal productivity**.

Staple food production **dominates** agricultural production. Increasing **crop diversification** is critical to **support better nutrition**.

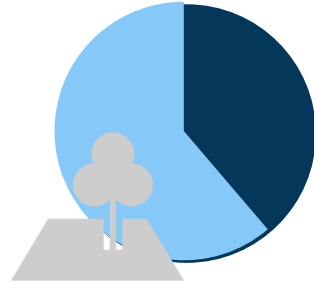
Fortified and biofortified foods together with **nutrition sensitive smallholder initiatives** could contribute to better nutrition at household level.

Agriculture is key to livelihoods: It provides three quarters of all employment...

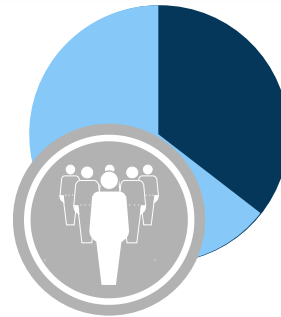
33% of GDP



67% of households own land. Of these, 79% own plot <1ha



75% of total employment in agriculture (F 84%, M 65%)



73% of land used for agriculture



...BUT agricultural productivity is low and is facing important challenges:



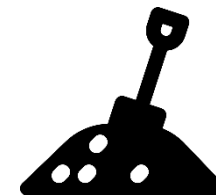
**Shrinking
biodiversity**



**Seasonal
shocks,
exacerbated by
climate change**



**Poor access to
markets, post-
harvest initiatives
and extension
services**

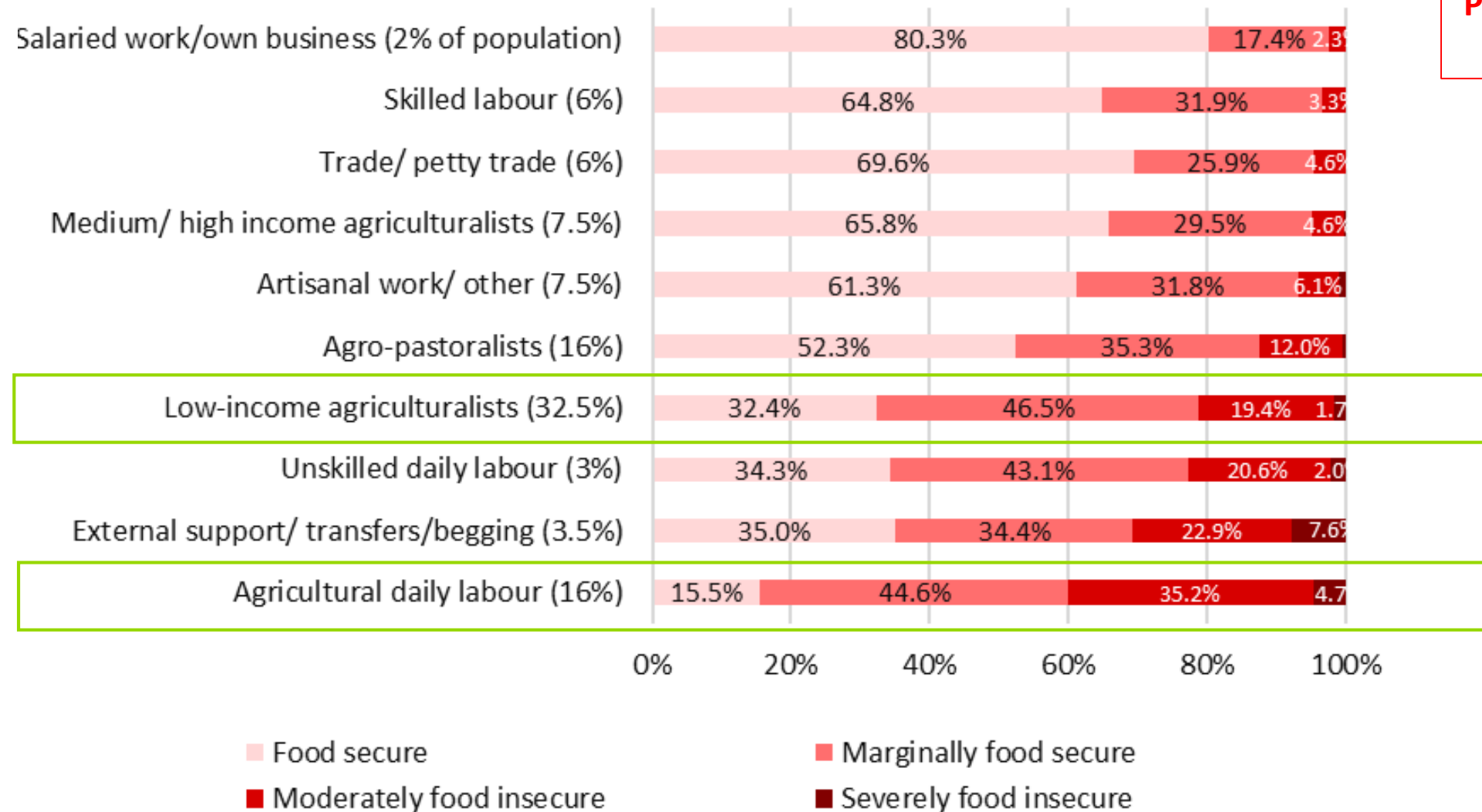


**Small plot size,
degrading soils
and natural
resources**

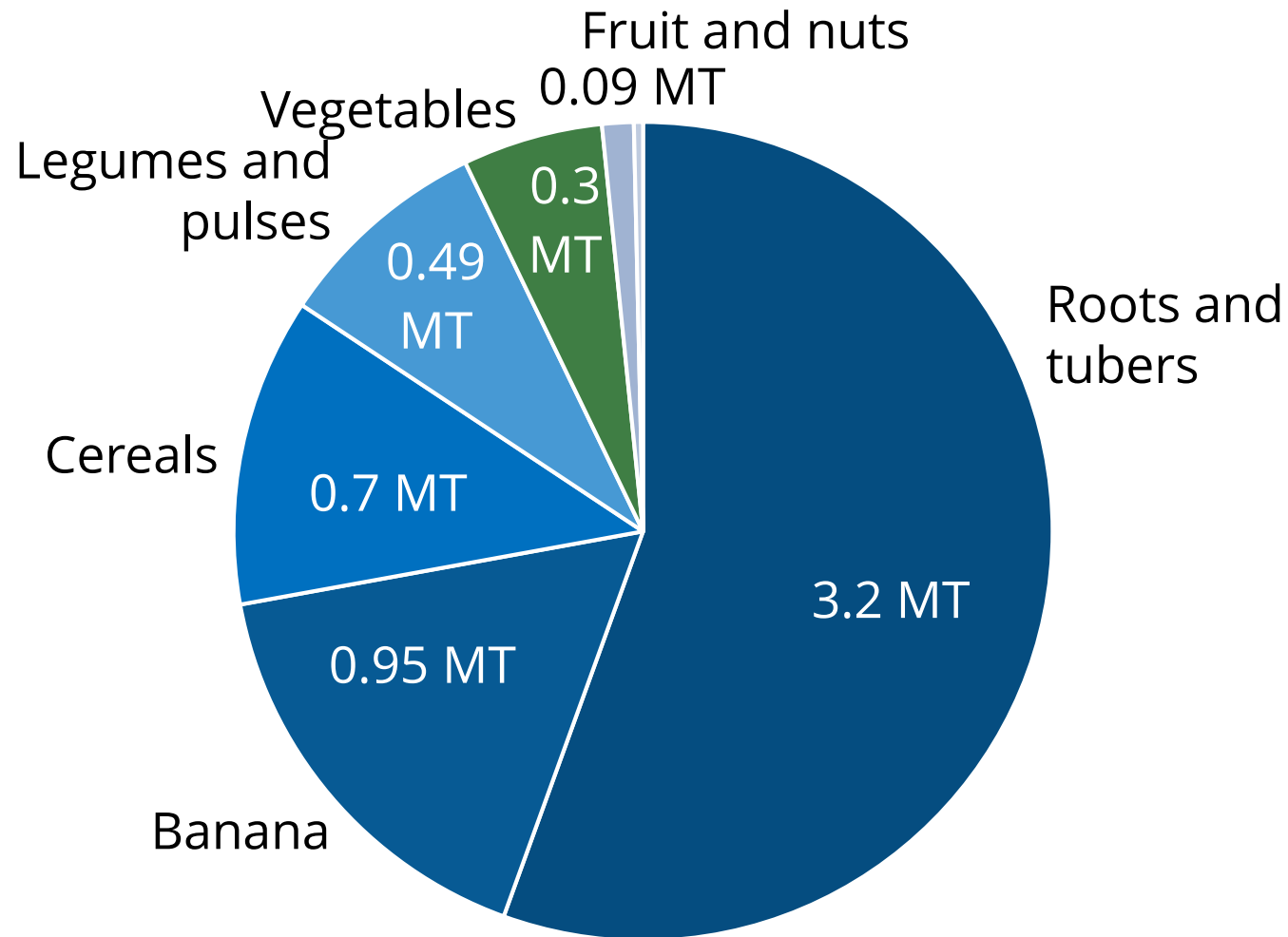
Consequently, food insecurity predominantly impacts smallholder farmers and agricultural workers

Food security status by livelihood groups

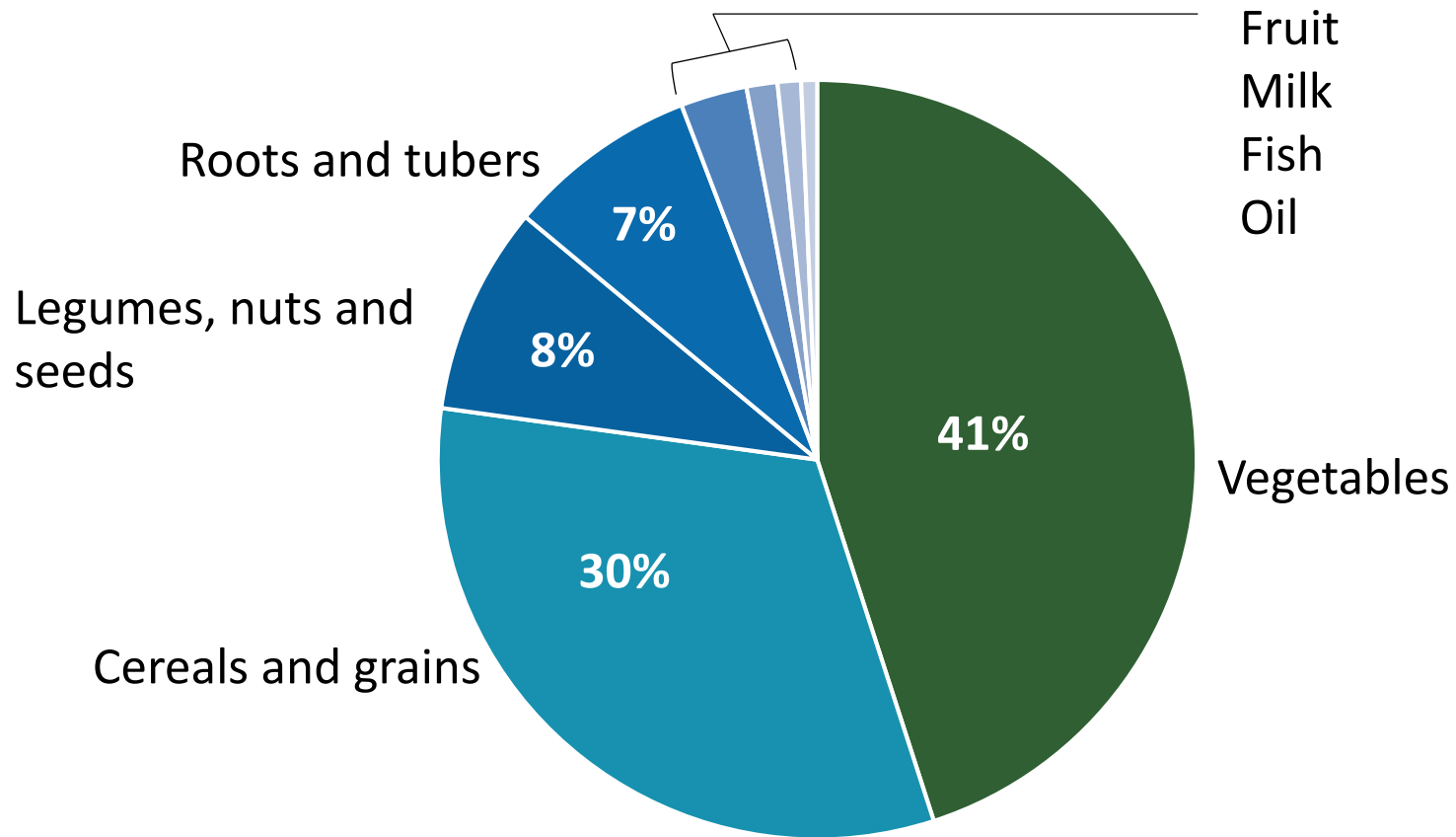
**CFSVA 2018
Preliminary
Results**



Banana, roots and tubers dominate annual agricultural production



The Cost of the Diet analysis emphasizes the importance of diversifying the food supply chain



Percentage Quantity of a Nutritious Diet

Fortification and biofortification could be cost-effective opportunities for improved nutrition

Fortification

MNPs are suitable for infants and can be easily added to porridge.

Staple food fortification could be suitable for the adult population.



However, widespread concern about food adulteration among consumers presents **a potential barrier** to commercial fortified foods.



Biofortification

Could be **effective, inexpensive, and sustainable**, but fewer micronutrients than fortification.

Study has shown that consumption of iron-biofortified beans and orange flesh sweet potato improved nutritional status.

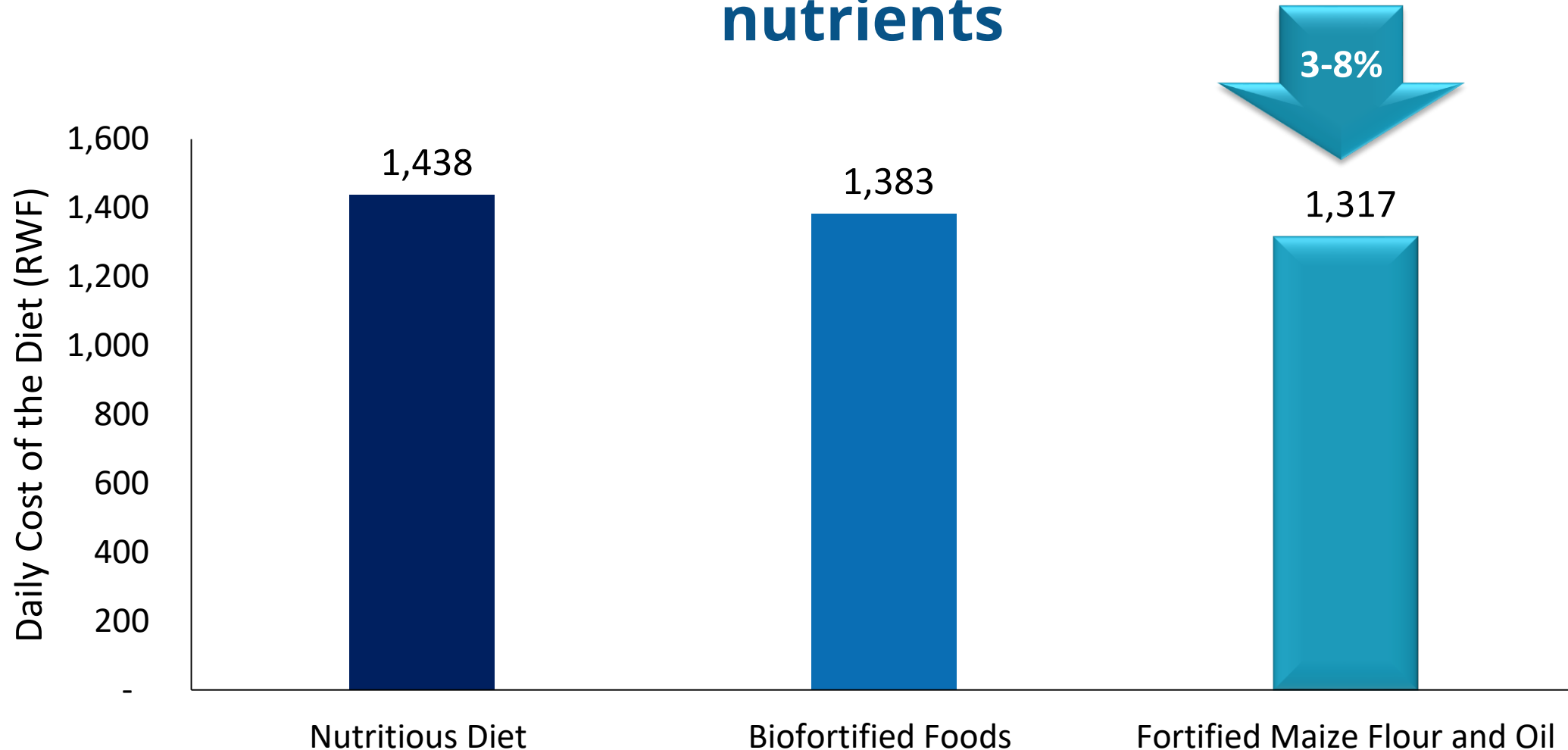
Phytic acid in beans **limits the absorption** of additional iron bred into beans, thus limiting efficiency.

Modelling to improve access to nutrients

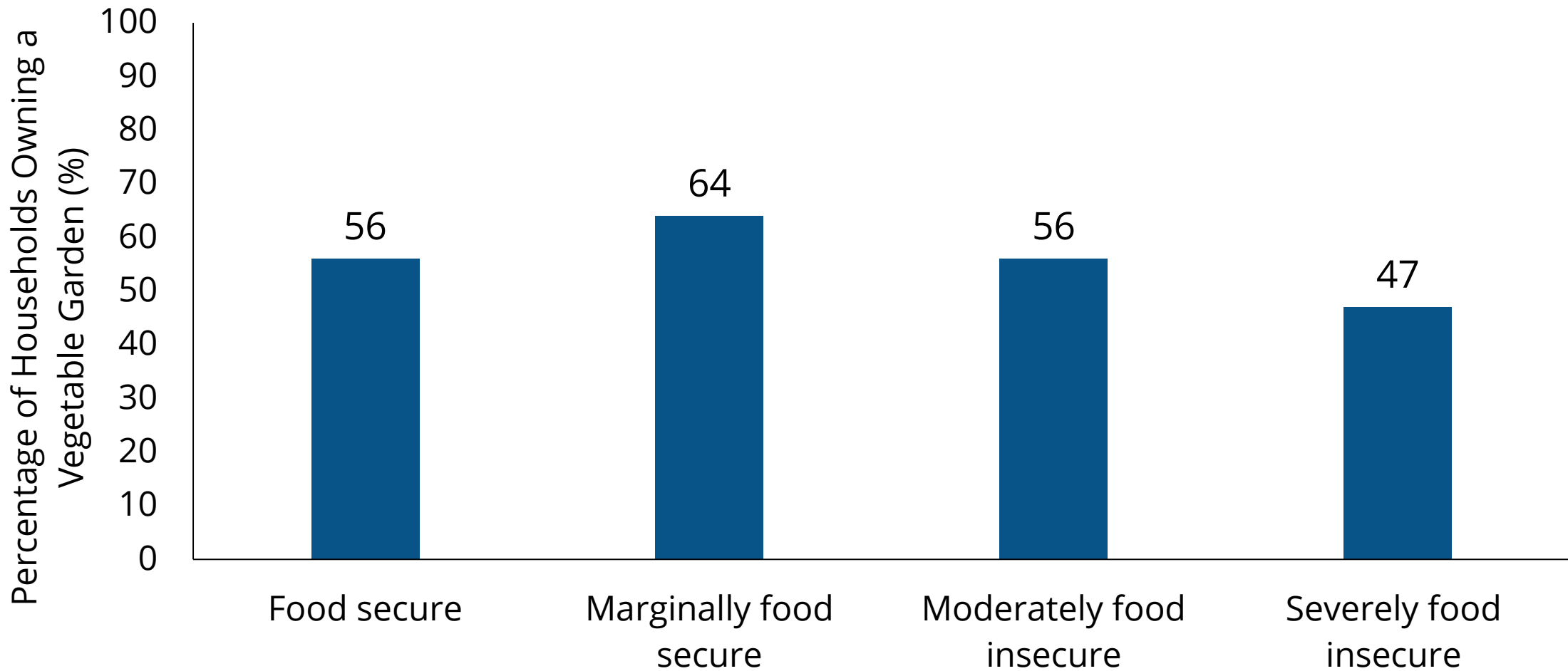
Households

Intervention	Transfer Modality	Possible Entry Points
Fortified Foods Maize flour and oil	Market (at same price as unfortified/ biofortified counterpart)	<ul style="list-style-type: none">• Agriculture• Market• Private Sector
Biofortified Foods Orange flesh sweet potatoes and high iron beans		

Household: Availability of fortified and biofortified foods available at the markets could improve access to nutrients



Most households have access to a kitchen garden to supplement their diet



Kitchen gardens increase the availability of nutritious foods **BUT** may not improve dietary diversity

- **Increased availability** of nutritious foods.
- Amaranth and squash are the most widely grown.
- Production mostly **consumed by the household**.
- Direct influence on **school meals** composition.
- Allows households to eat **vegetables** more regularly.

- **Limited quantity and variety** of vegetables grown.
- On average only **2 types** of vegetables are grown per garden.
- Households perceive that the garden requires substantial amount of **labour and financial investment** (initial and maintenance).



One cow per household programme (GIRINKA) offers opportunities BUT also risks

Studies show
**potential positive impact
on household dietary
diversity** and nutritional
status.



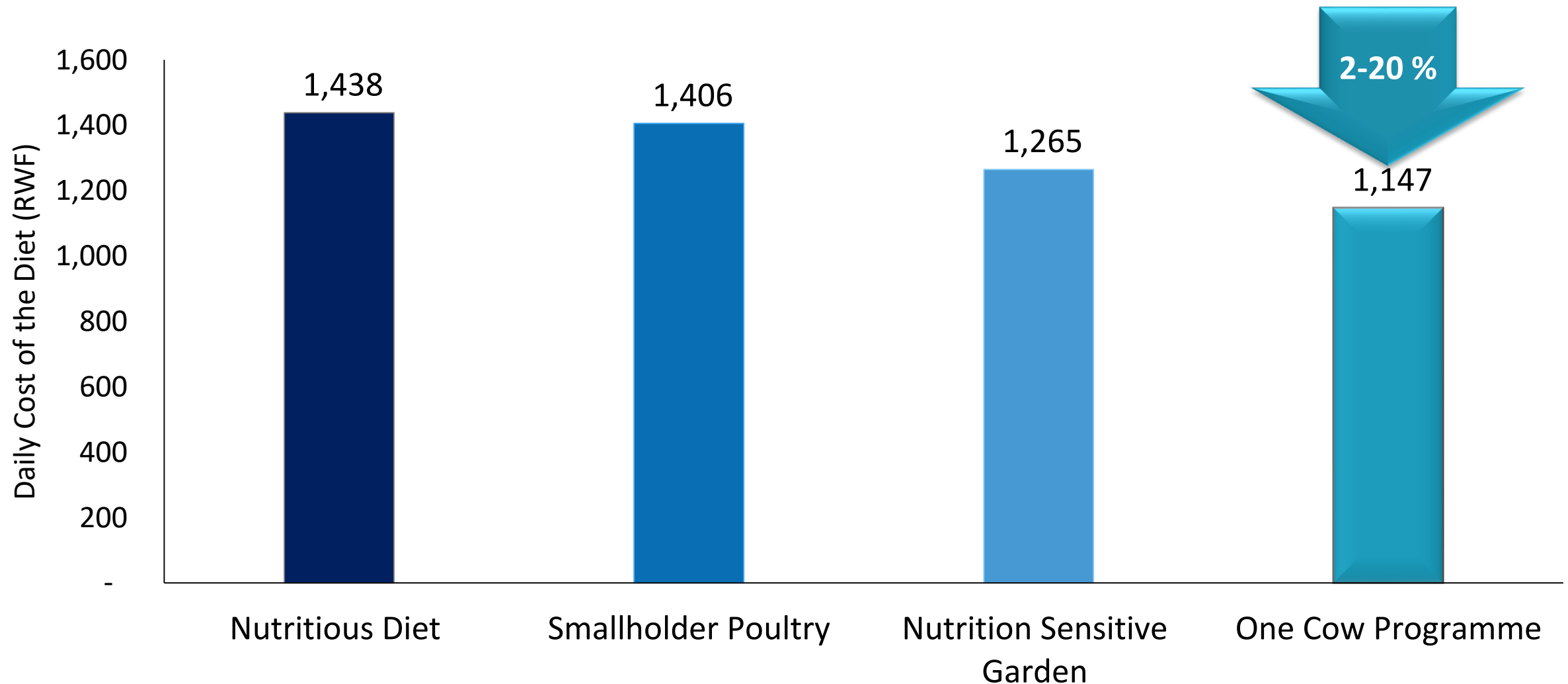
- Quality of **targeting and training** impacts results.
- Potential livestock mismanagement brings risks to **health and sanitation**.
- **Extension services** can reinforce gender inequalities if women cannot access.
- Whether milk is **sold or consumed** can make a difference to nutrition outcomes.

Modelling to improve access to nutrients

Households

Intervention	Transfer Modality	Possible Entry Points
Nutrition sensitive kitchen garden 0.2 hectares of land produces total of 40kg/month: maize, OFSP, banana, dodo, kale, pumpkin, pumpkin leaves and onion	Own production	Agriculture
Poultry intervention 21 eggs a week		
Girinka programme 5 litres of milk consumed by household per day		

Household: Smallholder initiatives could improve the availability of nutritious foods at the household level



Food safety is also a concern BUT there is not enough research available

Main concerns:



Policy gap on food quality and safety management.



Aflatoxin contamination of maize samples collected in markets commonly exceeded legal limits. Levels of contamination varies by food product and region.



Lack of awareness amongst vendors about the possible contamination of their products.



Aflatoxin contamination of **animal feed** has impact on dairy, egg, and meat products.

Questions

1. What could be done to keep adolescent girls in schools longer?
2. What role can agriculture and private sector play in ensuring access to safe and nutritious food?



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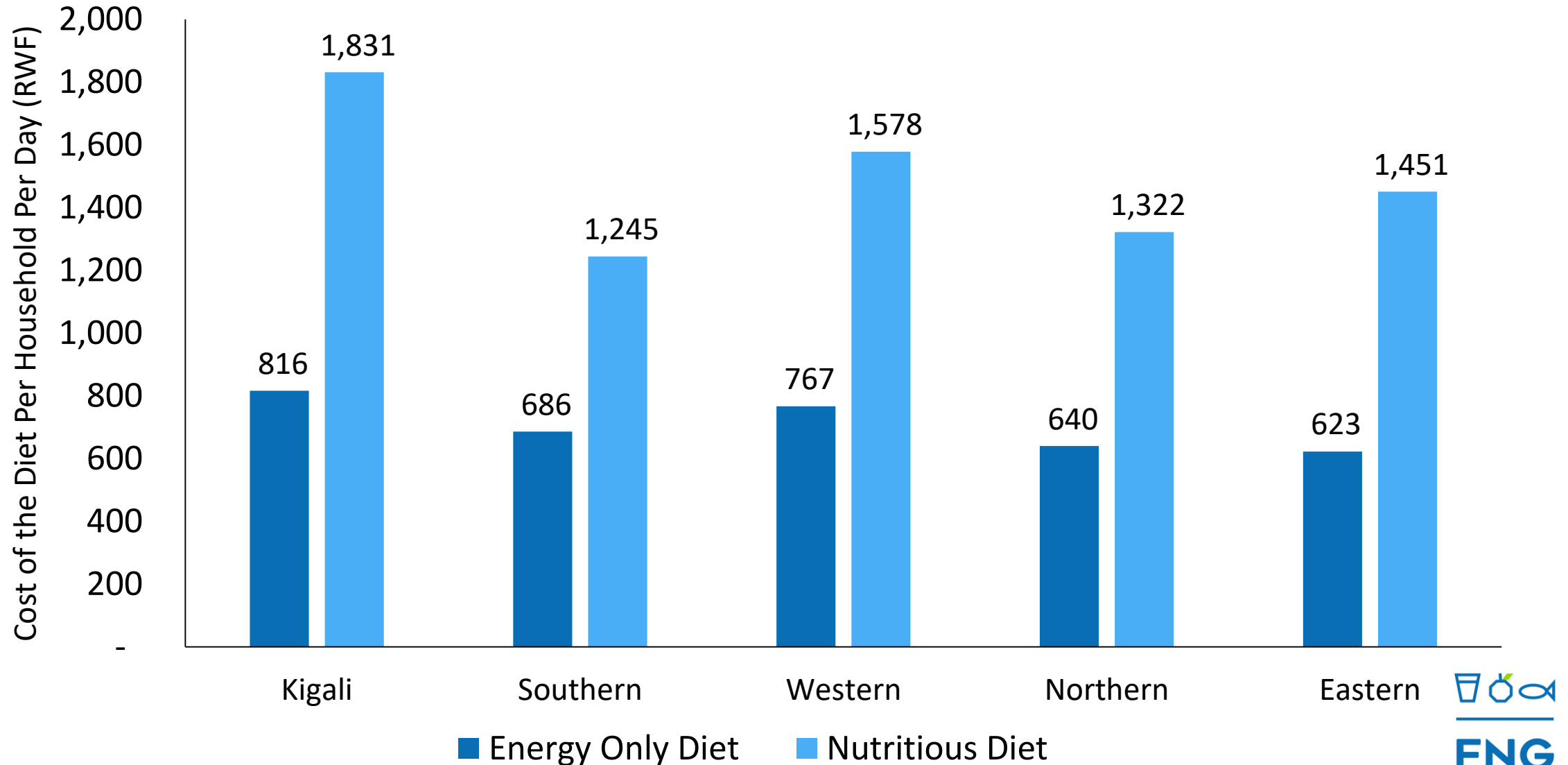
KEY MESSAGE 7

It costs a household **twice as much money** to purchase a **nutritious diet** compared to a diet that only meets **kilocalorie** needs.

Economic access is a key barrier to households consuming a nutritious diet particularly in the **Western province**.

Animal products and **fish** provide essential micronutrients but are also the **most expensive commodities** to purchase.

It costs twice as much money to purchase a nutritious diet compared to a diet that meets only energy needs



...this is because a greater variety of foods are needed to meet micronutrient needs compared to just energy

Energy Only Diet

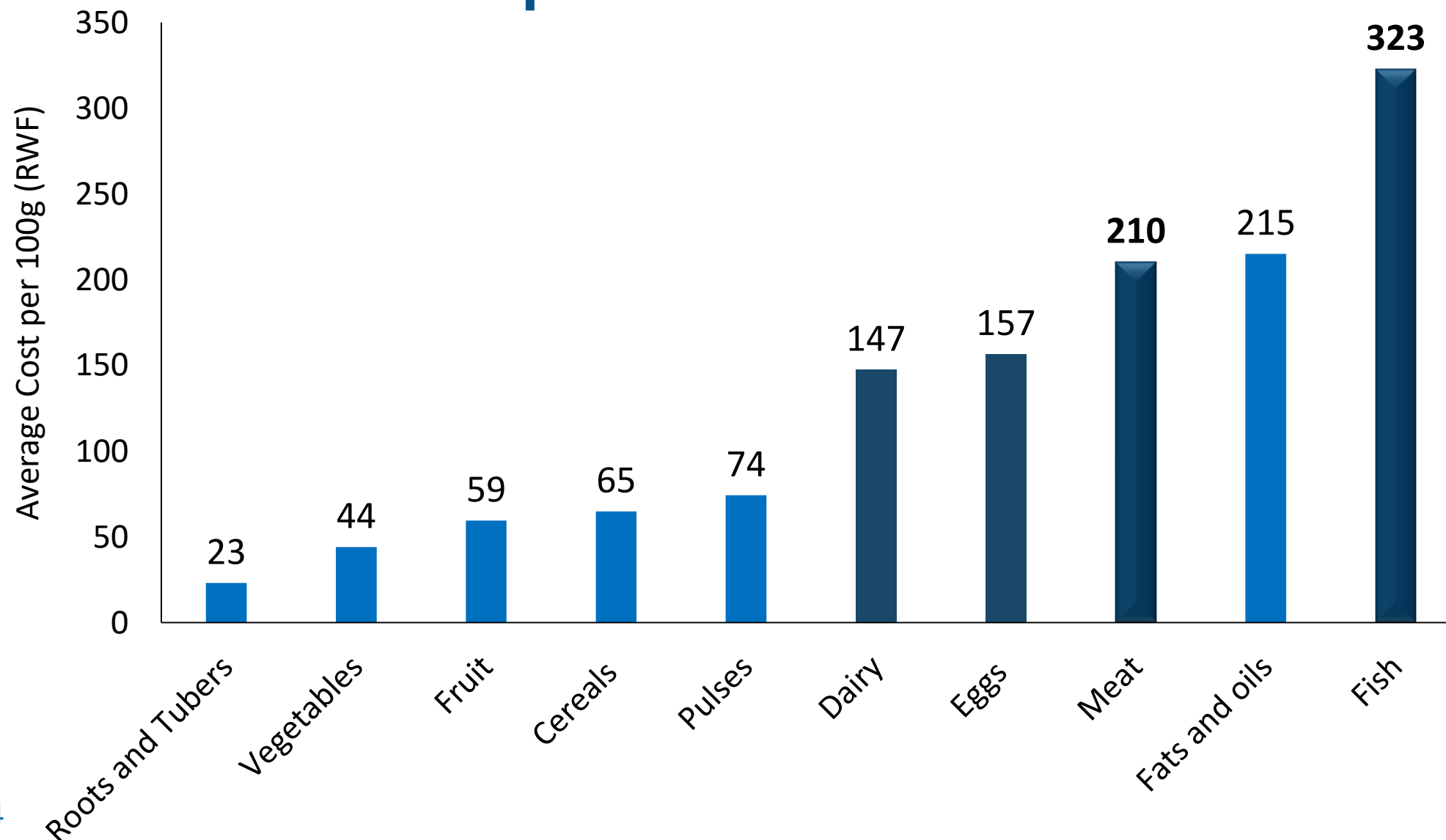
Sorghum
Maize
Cassava flour
Sweet potato



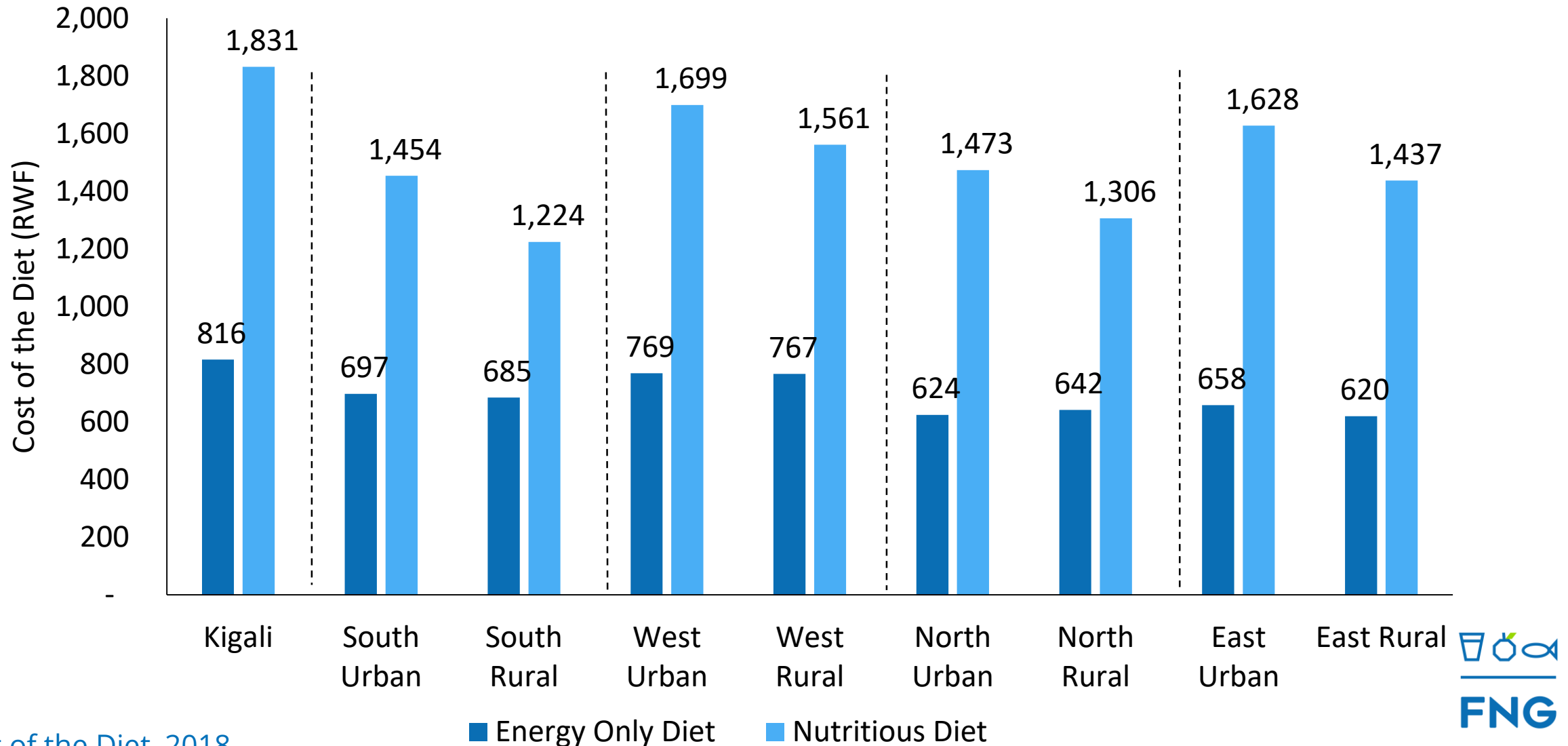
Nutritious Diet

Sorghum (red)	Dodo leaves
Maize	Spinach
Sweet potato	Onion
Irish potato	Tomato
Cooked bananas	Avocado
Beans	Small Dried Fish
Soybeans	Milk
Groundnuts	Oil

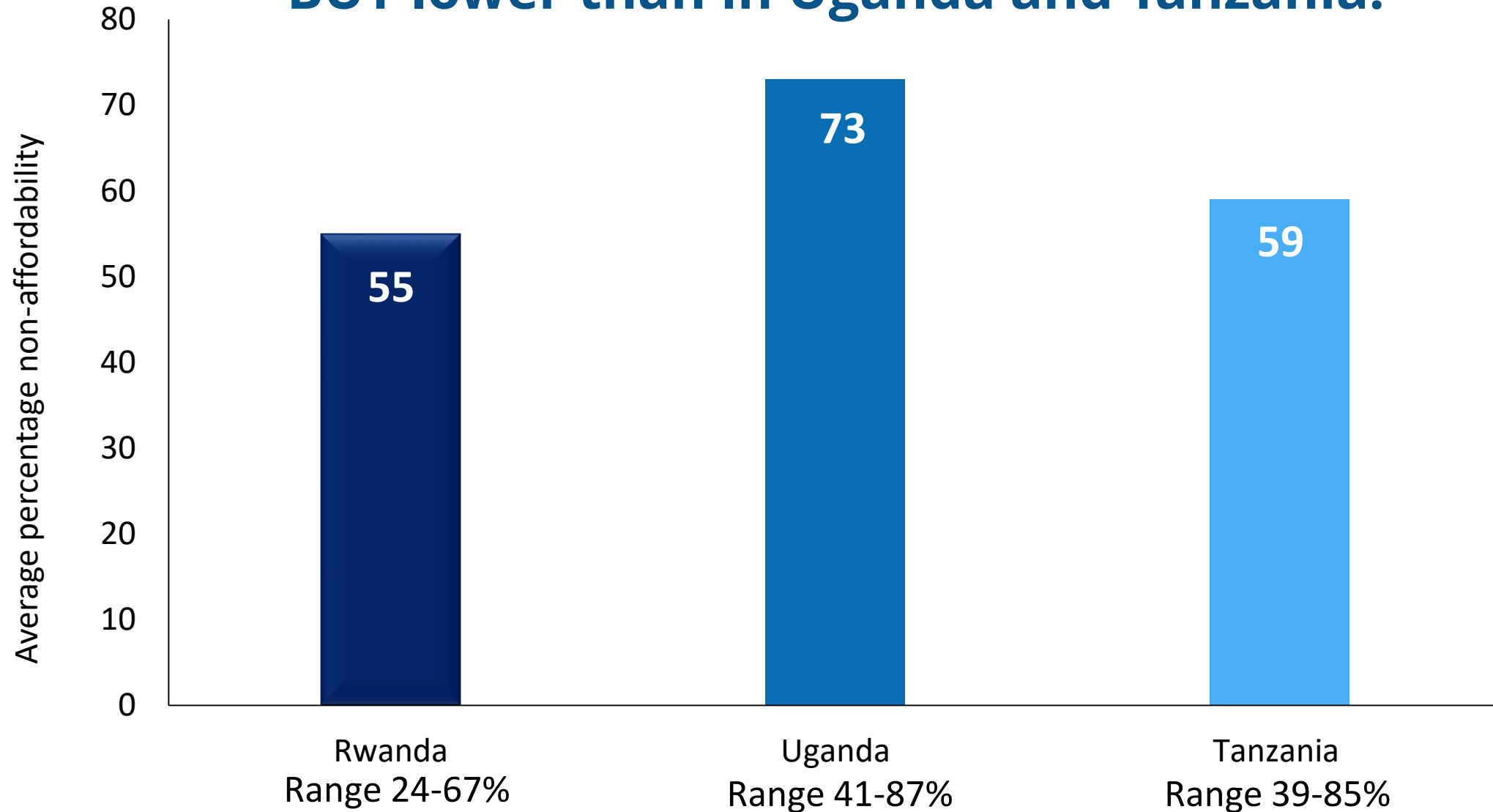
...and animal source foods and fish are expensive commodities



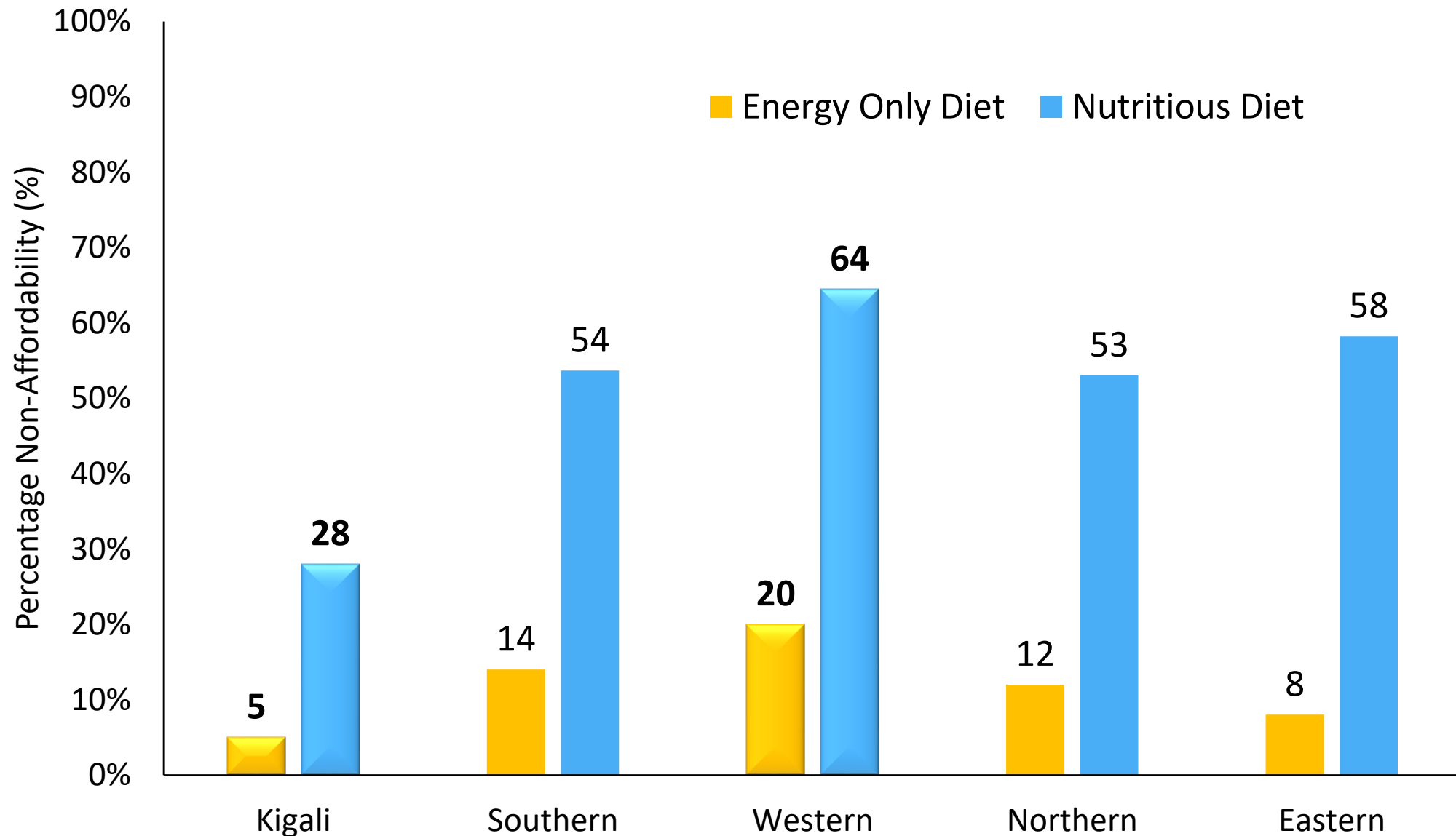
Nutritious diets are somewhat more expensive in urban than in rural areas **BUT** for energy only diets the difference is smaller...



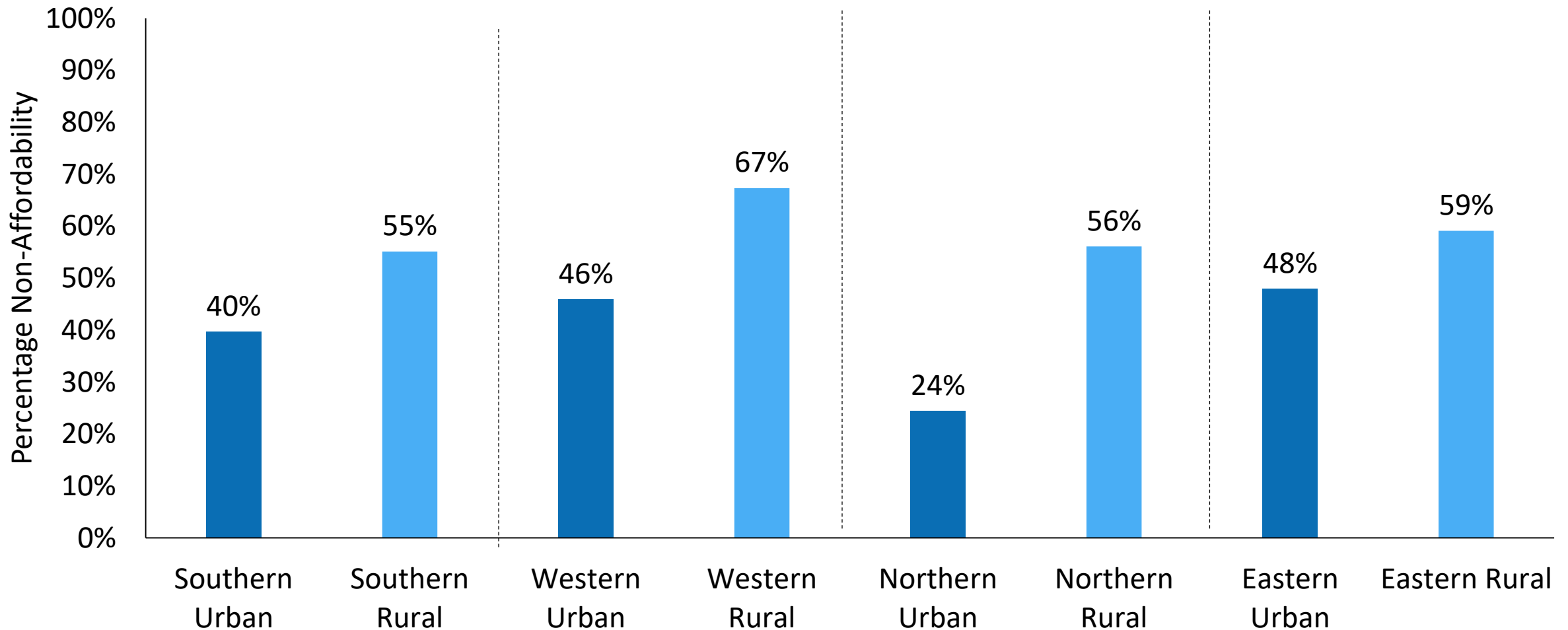
Over half of the population cannot afford a nutritious diet BUT lower than in Uganda and Tanzania.



Non-Affordability of an energy only diet and nutritious diet: Lowest in Kigali | Highest in the Western Province



The cost of a nutritious diet is higher in urban areas but non-affordability of this diet is higher in rural areas.





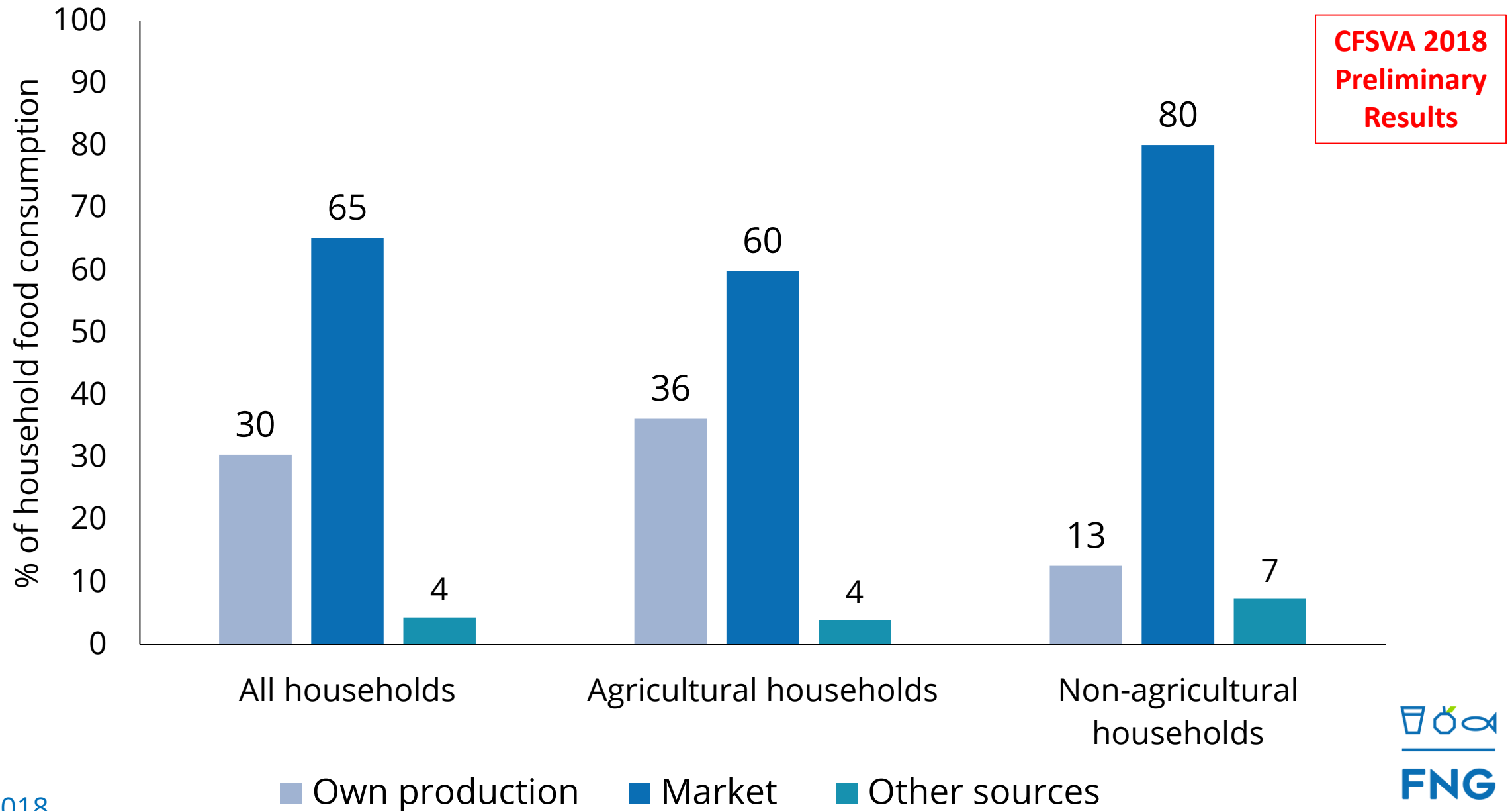
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KEY MESSAGE 8

Access to markets is good
and households **purchase**
the majority of their **food** from **markets**.

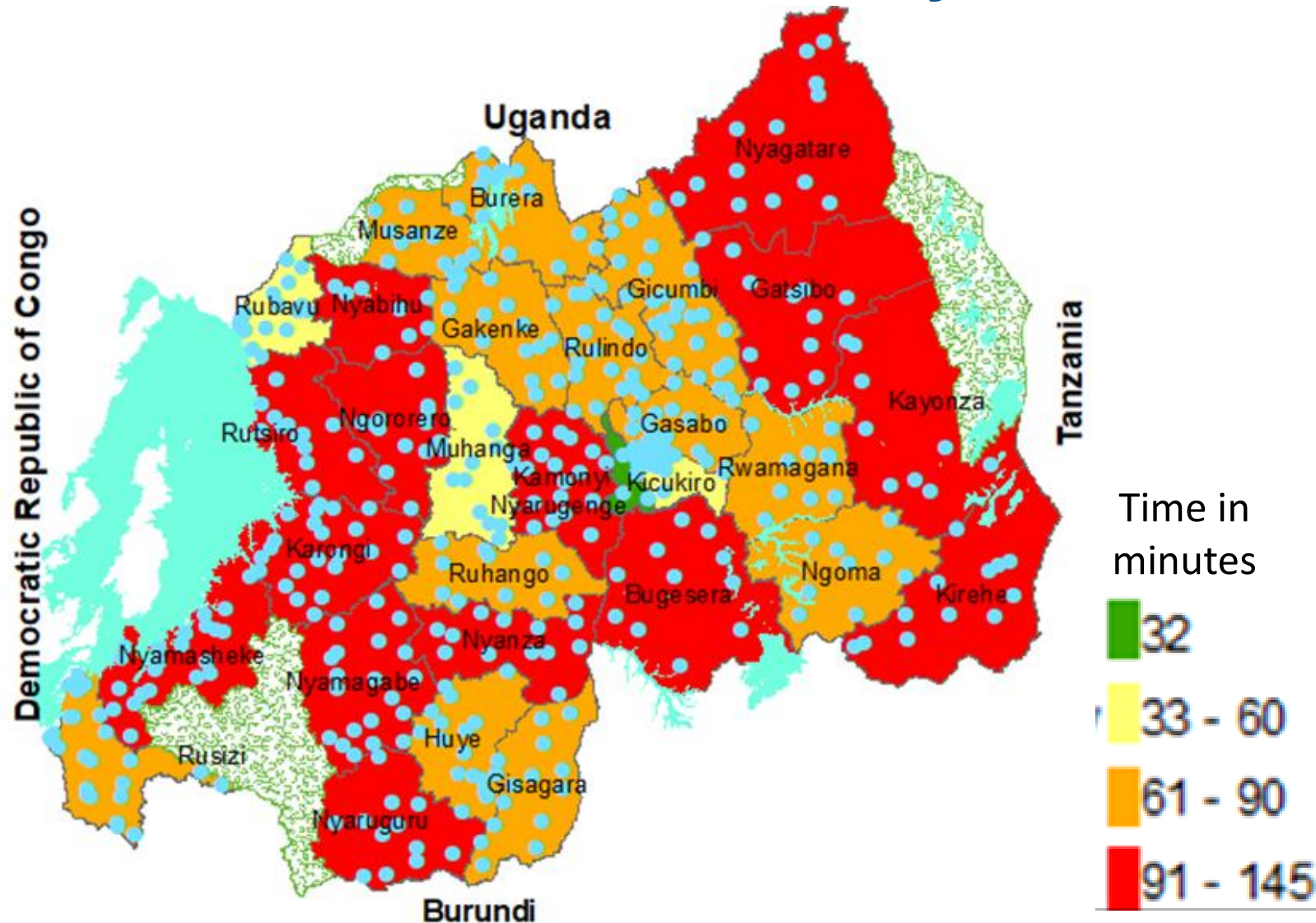
However, **reliance on markets**
also makes households vulnerable
to **food price volatility**.

65% of food is purchased from markets



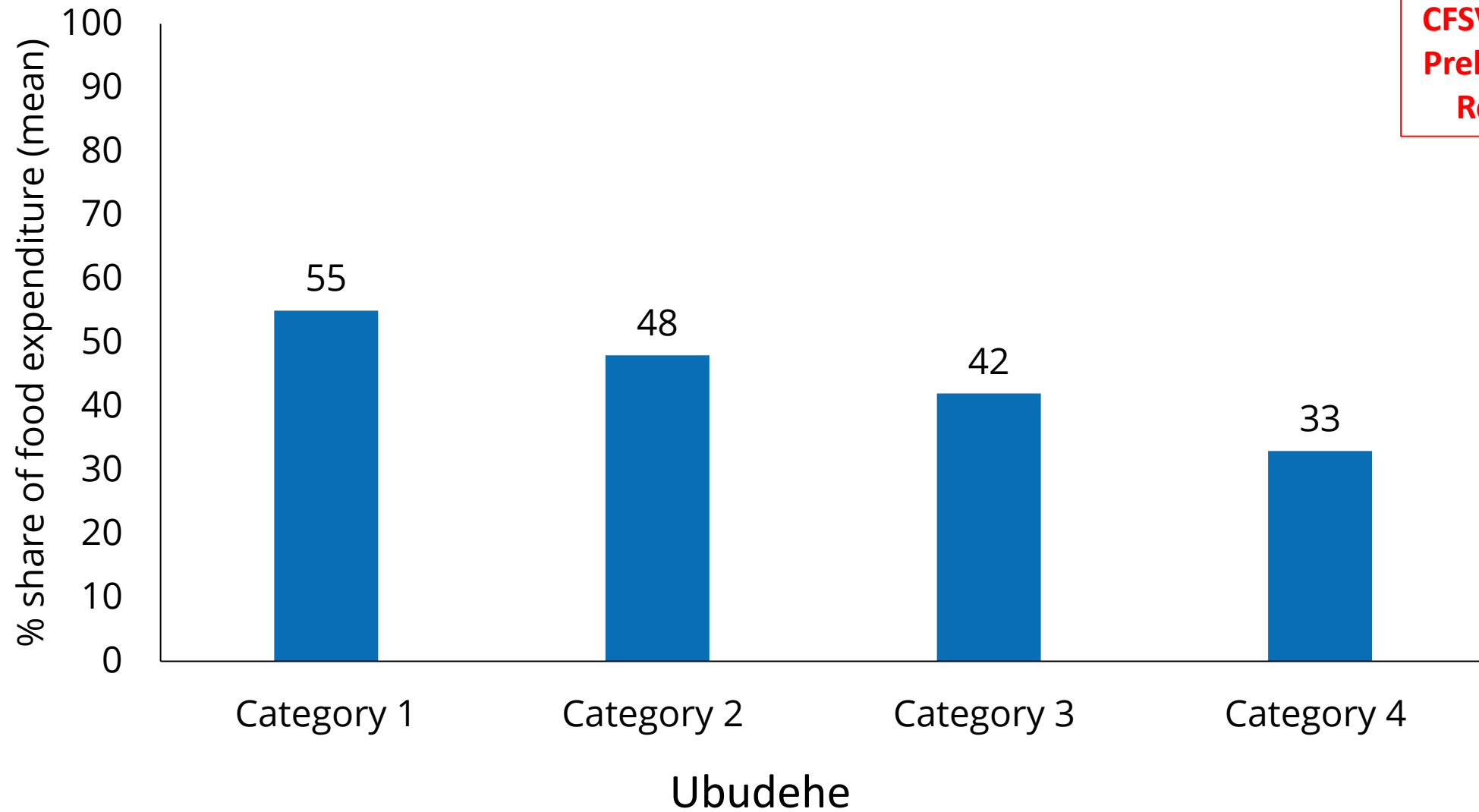
Despite the high number of markets average times to access a market is more than 1½ hours in many districts...

CFSVA 2018
Preliminary
Results



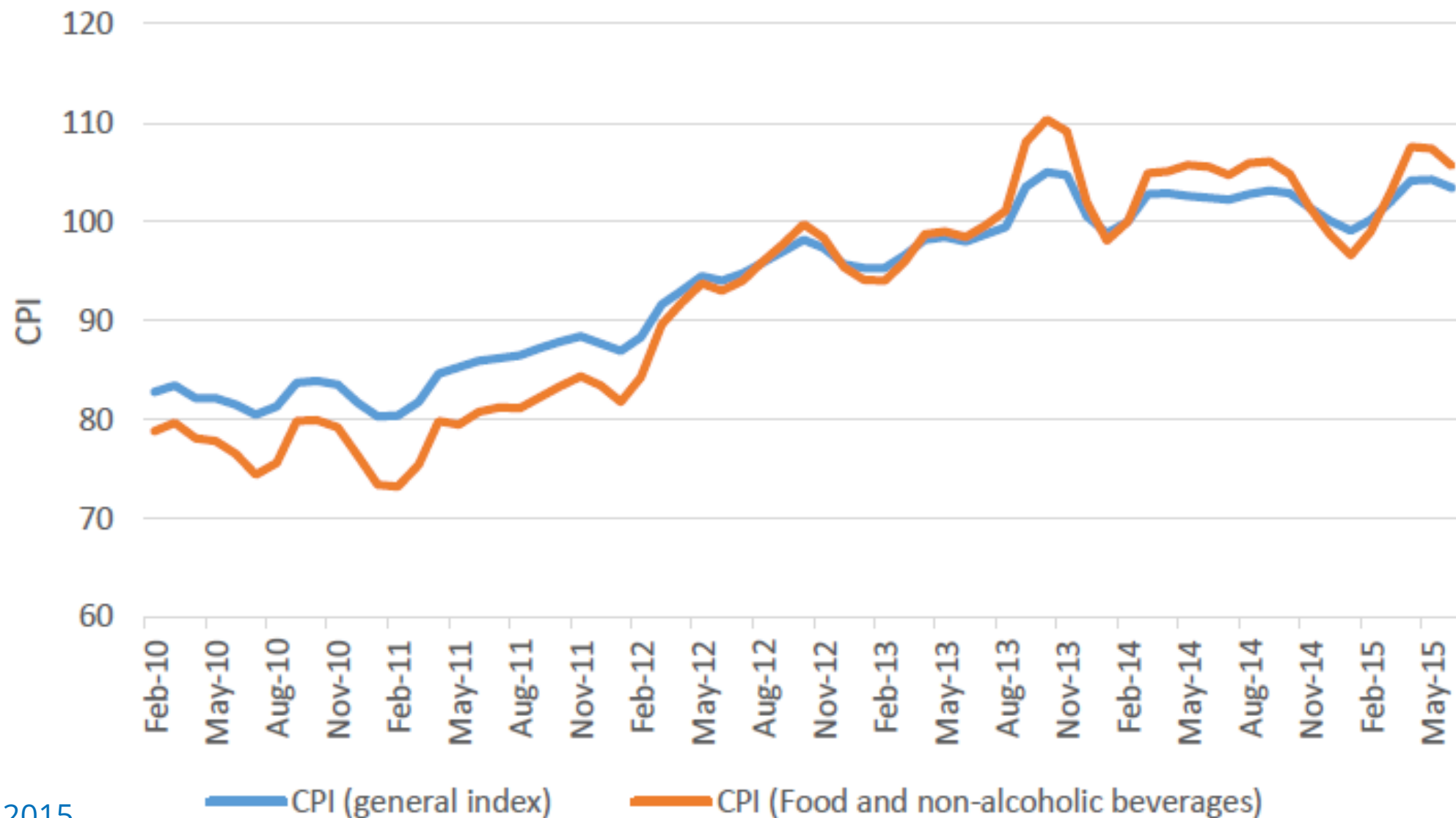
67% of households
faced food access
issues during the
12 months prior to
survey
(+16.5% compared
to 2015).

Poor households spend a large portion of their expenditure on food which makes them vulnerable to food price volatility

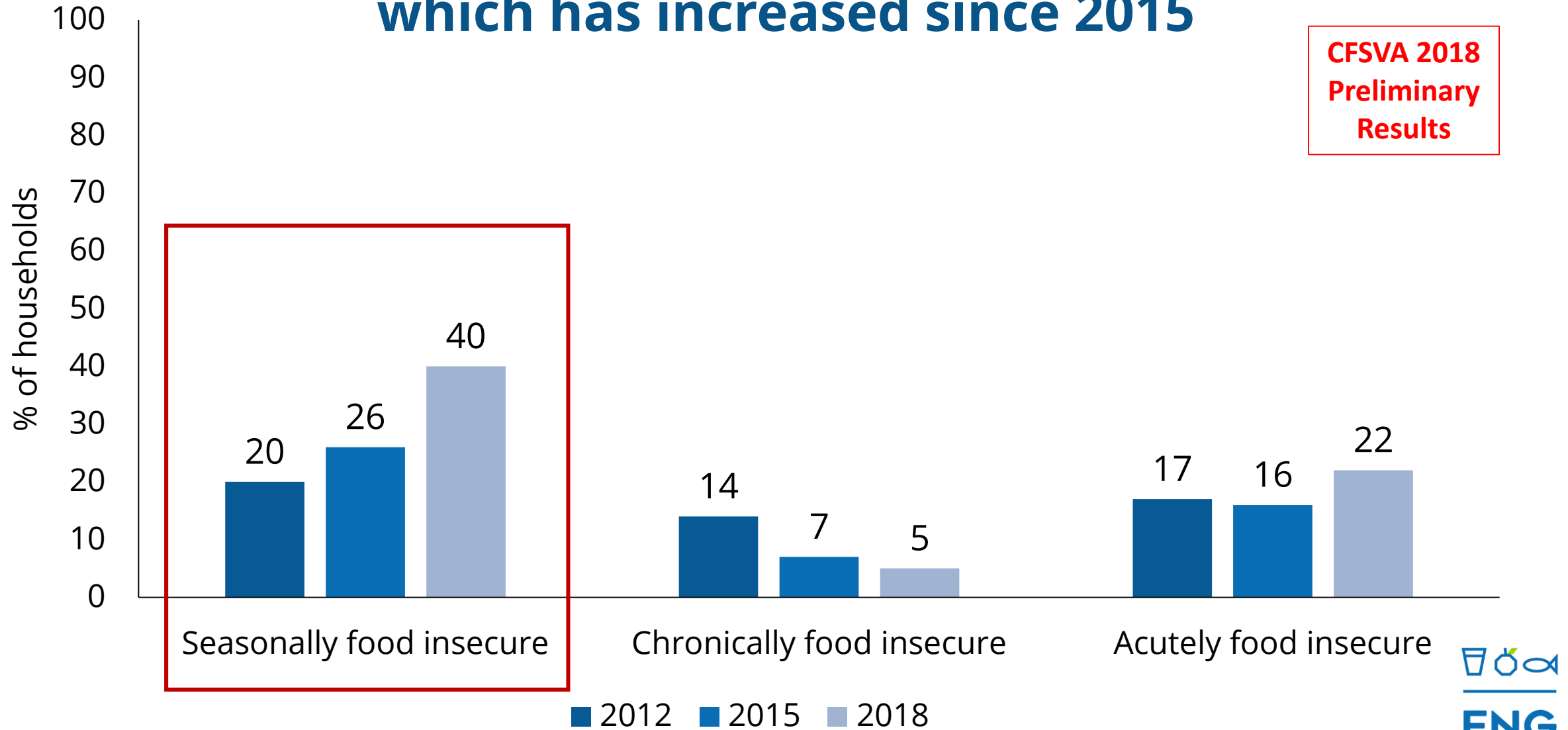


CFSVA 2018
Preliminary
Results

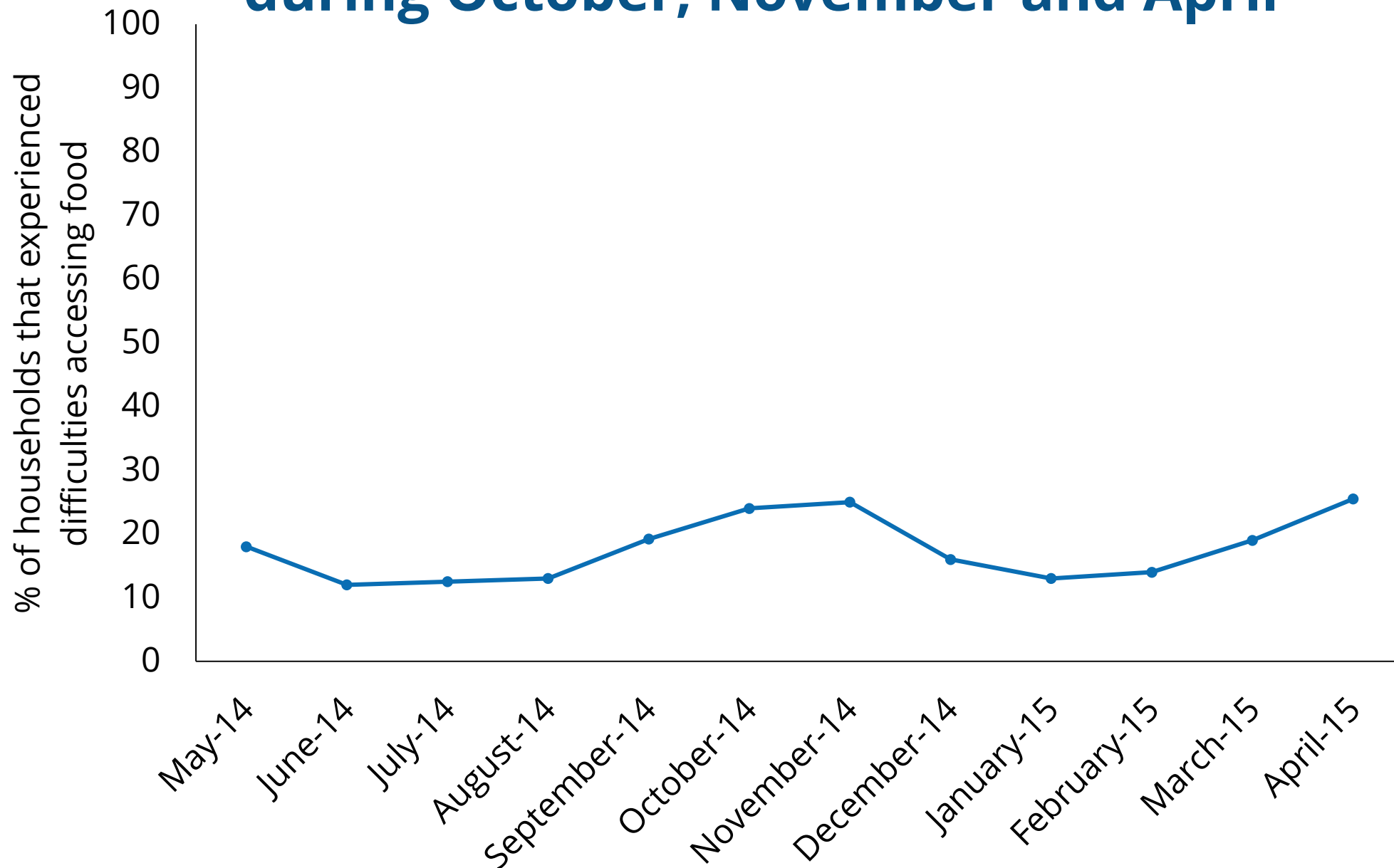
The price of food has steadily increased over the years and there is seasonal variation



This leads to households being vulnerable to seasonal food insecurity which has increased since 2015



Households are most vulnerable during October, November and April



Questions

1. What are the implications of the non-affordability results on the effectiveness of current interventions?
2. What role could social protection programmes play in improving access to a nutritious diet?



FNG

KEY MESSAGE 9

Context specific integrated packages
of interventions
have the **greatest potential**
to improve affordability
of a nutritious diet

Packages to be considered based on modelling results



Targeted interventions



Household interventions



Social Safety net (Cash transfer)



Social Behaviour
Change Communication

Package of Interventions



Fortified blended foods

(child under 2, adolescent girl, pregnant and lactating women)

Nutrition sensitive school meals



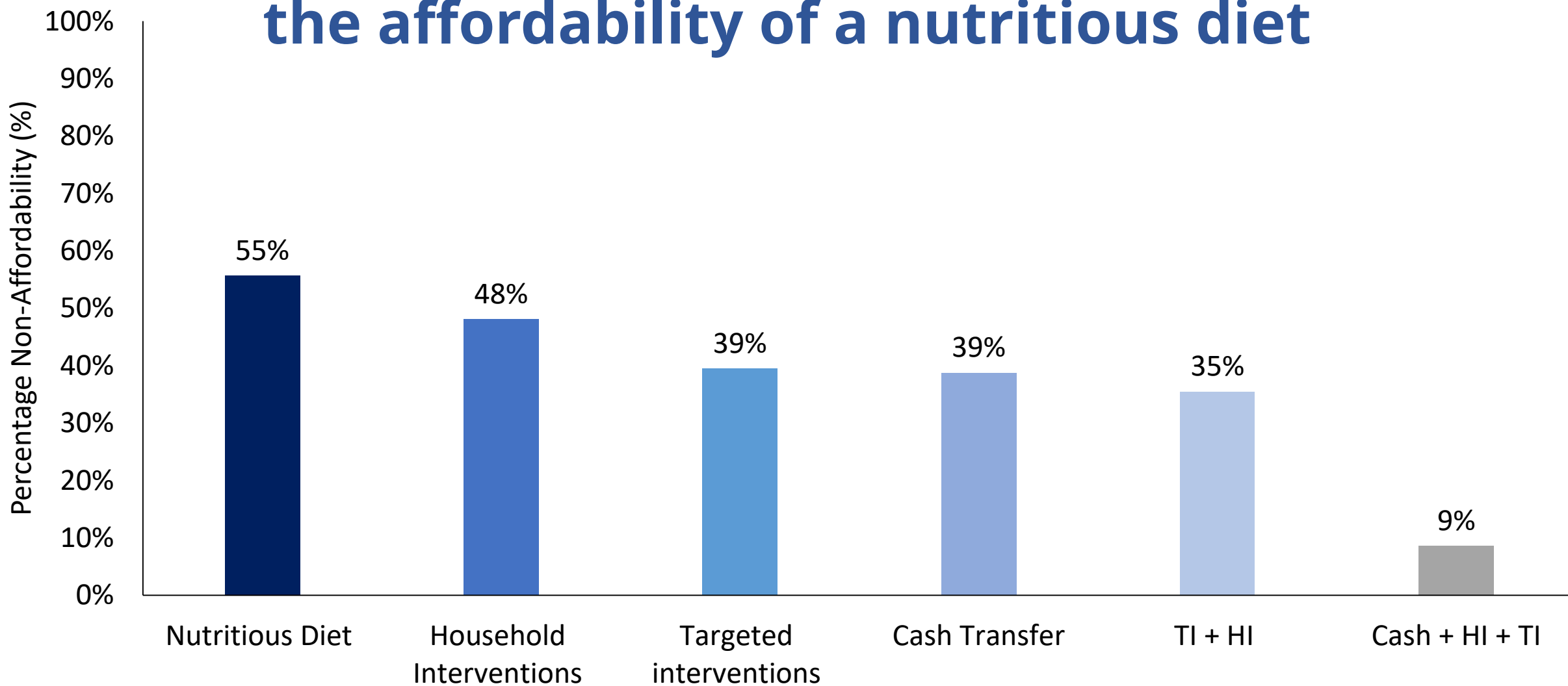
Fortified foods (maize flour and oil)
available in the market

Nutrition sensitive kitchen garden



Unconditional/Conditional Cash
(9,500 RWF/month)

A combination of interventions could greatly improve the affordability of a nutritious diet





Thank You