SAVING LIVES
CHANGING LIVES

1,000 Days of Social Protection for Central and Eastern Africa

Regional Study Report

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ABBREVIATIONS AND ACRONYMS

ASAL	Arid and semi-arid lands (Kenya)
BCC	Behaviour change communications
BRAC	Bangladesh Rural Advancement Committee
CCT	Conditional cash transfer
CSFVA	Comprehensive Food Security and Vulnerability Analysis
CT	Cash transfer
EPRI	Economic Policy Research Institute
GFA	General food assistance
GDP	Gross domestic product
HSNP	Hunger Safety Net Programme (Kenya)
IYCF	Infant and young child feeding
MEB	Minimum Expenditure Basket
MNCH	Maternal, newborn, and child health
MPI	Multi-dimensional Poverty Index
NCD	Non-communicable disease
NEC	Nutrition and Education Counseling (Rwanda)
NNP	National Nutrition Programme (Ethiopia)
P4P	Purchase for Progress
PSNP	Productive Safety Net Programme (Ethiopia)
RCT	Randomised controlled trial
SSN	Social safety nets
SUN	Scaling Up Nutrition
UCT	Unconditional cash transfer
USD	United States Dollar
WASH	Water, sanitation, and hygiene
WFP	World Food Programme
WFP-RBN	World Food Programme Regional Bureau for Central and Eastern Africa in Nairobi

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Executive Summary

THE FIRST 1,000 DAYS: WHY ARE THEY IMPORTANT?

The 1,000-day window of opportunity (hereafter referred to as "the first 1,000 days"), roughly demarcated as lasting from the time of conception to a child's second birthday, are internationally recognised as the most critical time for cognitive, neurological, and physical development. Malnutrition and undernutrition, prolonged periods of illness, and general poor performance on health and nutrition indicators during the first 1,000 days can have lasting and detrimental impacts on a child. Moreover, stunting, which often occurs due to insufficient intake of key nutrients in utero and during the first 1,000 days, exerts irreversible and negative effects on a child's cognitive and physical development, thereby hindering a child's future educational performance and human capital development. High prevalence of stunting and malnutrition also have macroeconomic consequences, and the cost of malnutrition can range from 2 to 3 per cent of Gross Domestic Product (GDP) in global estimates and to as much as 16 per cent in countries most affected by malnutrition. As such, attention to good nutrition throughout pregnancy and ensuring that a child accesses sufficient levels of nutrients directly following birth and up to his or her second birthday are imperative.

In recognition of the critical period of the first 1,000 days, countries have introduced a variety of approaches to safeguarding maternal and child nutrition and health, and tackling the various causes of malnutrition. These approaches oftentimes feature diverse efforts, actors, and sectors working together, some of which include nutrition-sensitive interventions and social protection programming, the combination of which in the form of nutrition-sensitive social protection offers the potential to effectuate long-term and sustainable improvements vis-à-vis health, nutrition, and food security. As such, this study reviews the applicability of nutrition-sensitive social protection programming in improving results over the first 1,000 days, specifically within the Central and Eastern Africa region, which is characterised by high levels of childhood stunting and acute and chronic malnutrition, but which is simultaneously the site of expanding national social protection systems.

PURPOSE AND SCOPE OF STUDY

The World Food Programme Regional Bureau for Central and Eastern Africa in Nairobi (WFP-RBN) requested the Economic Policy Research Institute (EPRI) to conduct a study into the subject of nutrition-sensitive social protection and its potential to enhance nutrition outcomes across the first 1,000 days. The study aims to understand how social protection policies and programmes in the region, with a particular focus on social cash-based and in-kind transfers, can be utilised to positively impact nutritional indicators relevant to the first 1,000 days. The study is intended to respond to the following questions:

1. How can existing nutrition-sensitive interventions and social protection programmes, particularly cash transfers, that do not necessarily have explicit nutrition objectives be used to achieve nutritional outcomes and impacts during first 1,000 days?
2. As part of this, how can existing social protection programmes be linked to complementary interventions to maximise their impact on nutrition outcomes during the first 1,000 days? In line with this, the study will explore the applicability of the 'cash plus' model for the region, wherein cash transfers are linked to complementary, capacity building components.
3. With one of the most challenging design components being the targeting approach, how can programmes best identify and reach the most nutritionally vulnerable women and children under the age of two years?
4. What examples and common elements can be developed for social protection programming to achieve nutritional outcomes and impacts during the first 1,000 days, whilst recognising that all countries have different entry points and objectives for their existing social protection policies and programmes?

In order to achieve the above aims, this study constructs a theoretical framework; presents an overview of international best practices in programming addressing the first 1,000 days, as well as existing evidence on nutrition-sensitive social protection programming; outlines the Central and Eastern Africa region's performance on maternal, child health, and nutrition indicators relevant to the first 1,000 days, as well as the current social protection environment in the region; develops overarching principles and recommendations for future programming in

the region, targeted at policymakers and other involved actors, particularly the WFP-RBN and WFP country offices in the region; and finally, presents a 'cash plus' model for the WFP-RBN.

INTERNATIONAL BEST PRACTICES FOR THE FIRST 1,000 DAYS

As part of addressing malnutrition's three causes – basic, underlying, and immediate – two types of interventions have been introduced: nutrition-specific, which focus on the immediate causes relating to nutritional deficiencies; and nutrition-sensitive, which focus on the underlying and basic causes. In terms of registering positive outcomes on key nutrition and health indicators over the first 1,000 days, a combination of the two types of interventions has proven effective, though nutrition-sensitive interventions generally have more relevance for achieving long-term and more sustainable improvements. Within the portfolio of nutrition-sensitive interventions, behaviour change communications (BCC), if administered in culturally appropriate ways and working through community-level structures, cover a range of topics relating to the first 1,000 days, and international evidence points to the efficacy of BCC in maximising programme impacts.

Going beyond traditional nutrition-sensitive interventions, however, nutrition-sensitive social protection stands to truly bring a multi-sectoral approach to tackling the complex and interrelated factors behind malnutrition and poverty. Nutrition-sensitive social protection, for the purposes of this study, is defined as comprehensive interventions that target the most vulnerable and address the causes of malnutrition, and which can include social safety nets (SSN) to reduce vulnerability; protect income, crops, and assets; ensure basic needs are met; and secure access to nutrition diets, healthcare, and improved WASH conditions. The objectives and design of nutrition-sensitive social protection programming are essential to realising success, and in particular, there are various options in which to sensitise these elements to a first-1,000 days approach. In terms of targeting, nutrition-sensitive social protection programmes should target nutritionally vulnerable populations, such as pregnant women, lactating mothers, and children under the age of two, while also designating women as the primary programme beneficiaries. Additionally, international evidence underscores the potential of the 'cash plus' model, in which cash transfers (CTs) coupled with complementary trainings are delivered to beneficiaries, to exert more sustainable and long-term impacts on beneficiaries' socioeconomic growth and resilience; if more nutrition-sensitive elements are added to a 'cash plus' programme, beneficiaries' health and nutrition status stand to improve, thereby enhancing impacts over the first 1,000 days.

Finally, within CTs, it is imperative that programme implementers set transfer values that are sufficient and that enable beneficiaries to meet programme objectives. In the context of nutrition-sensitive social protection interventions with a first-1,000 days' focus, various data and information sources on, *inter alia*, performance on nutrition and health indicators, local markets, disaggregated poverty levels, and surveys on household food and nutrient consumption can all contribute to setting appropriate transfer values.

RECOMMENDATIONS FOR NUTRITION-SENSITIVE SOCIAL PROTECTION IN CENTRAL AND EASTERN AFRICA

While programme implementers should tailor nutrition-sensitive social protection interventions to be context-specific, the above points and others, highlight some best practices in improving results across the first 1,000 days. The Central and Eastern Africa region may find more nutrition-sensitive social protection programming applicable to its contexts, given that the region performs poorly on child and maternal nutrition and health indicators but features some of the continent's more advanced social protection systems. Furthermore, national governments in the region have shown commitment to further improving health and nutrition, introducing various programmes and policies for doing so, and international partners also can provide important support to the fight against malnutrition.

For its part, the WFP-RBN and WFP Country Offices have long-standing involvements in SSNs, school feeding programmes, and nutrition programming, and thus can use these experiences as entry points for greater participation in nutrition-sensitive social protection programming in Central and Eastern Africa. With a high-level landscaping of international best practices for nutrition-sensitive social protection and WFP's own strategic documents, expertise, and mission as a backdrop, this study offers the following recommendations and principles:

1. Advocate for the inclusion of nutrition-related objectives, actions, and/or goals into national social protection programmes.
2. Orient transfer programme targeting towards identifying the most nutritionally insecure populations.
3. Design and implement transfer programmes to pursue a 'cash plus' model.
4. Set transfer values that are sufficient to achieve nutrition and health-related objectives.
5. Support other sectoral interventions to become more nutrition-sensitive.
6. Enhance cross-sectoral cooperation as part of the implementation of more nutrition-sensitive social protection programmes.

7. Incorporate nutrition-sensitive social protection interventions into regional humanitarian responses.

Reducing malnutrition and reaching sustained progress over the first 1,000 days is a multifaceted and long-term process, which will require the continued commitment of national governments and international and national partners in pursuing comprehensive interventions that tackle all three of malnutrition's secondary causes. The Central and Eastern Africa region is already well-positioned to carry forward the fight against the complex and interrelated sources of malnutrition, poverty, and vulnerabilities, given the region's ever-expanding set of national social protection systems and multi-sectoral policies addressing health and nutrition. The fight against malnutrition not only has ramifications for improving performance on key indicators related to the first 1,000 days of development, but for enabling a country's citizens to realise their full human capital potential and a country to realise greater and more sustained overall development.

1. The First 1,000 Days: Why Are They Important?

The 1,000-day window of opportunity (hereafter referred to as "the first 1,000 days"), roughly demarcated as lasting from the time of conception to a child's second birthday, are internationally recognised as the most critical time for cognitive, neurological, and physical development. Although the human brain continues to change throughout a person's life, the last trimester of pregnancy and first two years of a child's life constitute the most rapid periods of brain growth, characterised by the brain's highest level of plasticity.[1] Malnutrition and undernutrition, prolonged periods of illness, and general poor performance on health and nutrition indicators during the first 1,000 days can have lasting and detrimental impacts on a child. These impacts include greater risks for chronic and/or non-communicable diseases (NCDs), such as high blood pressure, diabetes, heart disease, and obesity; and reduced performance and learning in school, leading to lower levels of scholastic achievement. Moreover, poor prenatal health and nutrition amongst pregnant women produce adverse outcomes on a child, as under and/or malnutrition during pregnancy is a major determinant of stunting and can lead to chronic diseases and NCDs during adulthood.[2] Stunting, or inadequate height for age occurs due to insufficient intakes of key nutrients both *in utero* and during the first 1,000 days of life, and the effects of stunting on a child's cognitive and physical development are irreversible; stunting is often a reflection of the cumulative effects of transgenerational poverty, poor maternal and early childhood nutrition, and repeated incidences of childhood illness.[3] Consequently, attention to good nutrition throughout pregnancy and ensuring that a child accesses high levels of nutrients directly following birth and up to his or her second birthday are imperative.

The above mentioned health and education consequences of stunting are also connected to impacts on socioeconomic development, particularly considering the linkages between school achievement and future earning potential. At a microeconomic level, it is estimated that a 1 per cent loss in adult height as a result of childhood stunting equals a 1.4 per cent loss in productivity of the individual;[4] other studies suggest that the loss of human potential resulting from stunting is associated with 20 per cent less adult income on average.[5] At a macroeconomic level, the cost of malnutrition can range from 2 to 3 per cent of Gross Domestic Product (GDP) in global estimates and to as much as 16 per cent in countries most affected by malnutrition; in the Central and Eastern Africa region, specifically, the *Cost of Hunger in Africa* (COHA) studies estimates these losses from 5.6 per cent in Uganda, 11.5 per cent in Rwanda, and up to 16.5 per cent in Ethiopia.[6] And, considering that nearly half of deaths of children under the age of five are related to undernutrition,[7] the combined effects of the loss of life and productivity due to malnutrition and undernutrition represent a substantial loss to a nation's future human capital and overall development.

Given the importance of the first 1,000 days to a range of development sectors, countries have introduced a variety of approaches to safeguarding maternal and child nutrition and health, and tackling the various causes of malnutrition. Considering the complexity of achieving positive outcomes during the first 1,000 days, there is no ideal model for doing so, though a multi-sectoral, comprehensive response that addresses the various underlying causes of malnutrition is needed, and internationally, there are promising examples of countries that have accomplished progress in improving outcomes during this critical period. These examples oftentimes feature diverse efforts, actions, and sectors working together, some of which include nutrition-sensitive interventions and social protection programming. Nutrition-sensitive interventions and social protection as separate entities are designed to address complex issues through multi-sectoral response mechanisms, but the combination of the two in the form of nutrition-sensitive social protection has the potential to effectuate long-term and sustainable improvements vis-à-vis health, nutrition, and food security. In particular, this study treats the applicability of nutrition-sensitive social protection programming in improving results over the first 1,000 days,

1 Cusick & Georgieff.

2 U.S. Agency for International Development, 2017.

3 United Nations Children's Fund.

4 European Union, 2014.

5 Save the Children, 2012.

6 African Union Commission; New Partnership for Africa's Development; UN Economic Commission for Africa; World Food Programme, 2013.

7 World Food Programme, 2017.

specifically within the Central and Eastern Africa region, which is characterised by high levels of childhood stunting and acute and chronic malnutrition, but which is simultaneously the site of expanding social protection systems.

1.1 PURPOSE AND SCOPE OF STUDY

Recognising the potential for social protection programmes to positively influence the vital period of the first 1,000 days, as well as the need to better understand how different sectoral policies can address the underlying causes of malnutrition, therewith maximising nutrition outcomes and impacts, the World Food Programme Regional Bureau for Central and Eastern Africa[8] in Nairobi (WFP-RBN) requested the Economic Policy Research Institute (EPRI) to conduct a study into the subject. The study aims to understand how social protection policies and programmes in the region, with a particular focus on social cash-based and in-kind transfers, can be utilised to positively impact nutritional indicators relevant to the first 1,000 days. Building on this assessment, the study endeavours to shed light on how social protection, specifically targeting households with children under the age of two years, pregnant women, and lactating mothers, can be designed to achieve positive outcomes. The study is intended to respond to the following questions:

1. How can existing nutrition-sensitive interventions and social protection programmes, particularly cash transfers, that do not necessarily have explicit nutrition objectives be used to achieve nutritional outcomes and impacts during first 1,000 days?
2. As part of this, how can existing social protection programmes be linked to complementary interventions to maximise their impact on nutrition outcomes during the first 1,000 days? In line with this, the study will explore the applicability of the 'cash plus' model for the region, wherein cash transfers are linked to complementary, capacity building components.
3. With one of the most challenging design components being the targeting approach, how can programmes best identify and reach the most nutritionally vulnerable women and children under the age of two years?
4. What examples and common elements can be developed for social protection programming to achieve nutritional outcomes and impacts during the first 1,000 days, whilst recognising that all countries have different entry points and objectives for their existing social protection policies and programmes?

8 The WFP-RBN covers Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, and Uganda; therefore, for the purposes of this study, these countries constitute the Central and Eastern Africa region.

In order to achieve the above aims, this study first constructs a theoretical framework for how nutrition-sensitive social protection programming can be applied to the first 1,000 days in order to guide the study's assessment of best practices in nutrition-sensitive social protection. Next, the study presents an overview of international best practices in programming addressing the first 1,000 days, as well as existing evidence on nutrition-sensitive social protection programming. Afterwards, after having established a high-level landscaping of international best practices and examples of nutrition-sensitive social protection, the study narrows its focus to the Central and Eastern Africa region. Specifically, the study outlines the region's performance on maternal, child health, and nutrition indicators relevant to the first 1,000 days, as well as the current social protection environment in the Central and Eastern Africa region. As a means of synthesising the key points and considerations presented, the study develops overarching principles and recommendations for future programming in the region, targeted at policymakers and other involved actors, particularly the WFP-RBN and WFP country offices in the region.

Finally, these recommendations feed into the construction of a model for 'cash plus' for the WFP-RBN, which visualises how the WFP-RBN and WFP country offices can more practically pursue 'cash plus'.

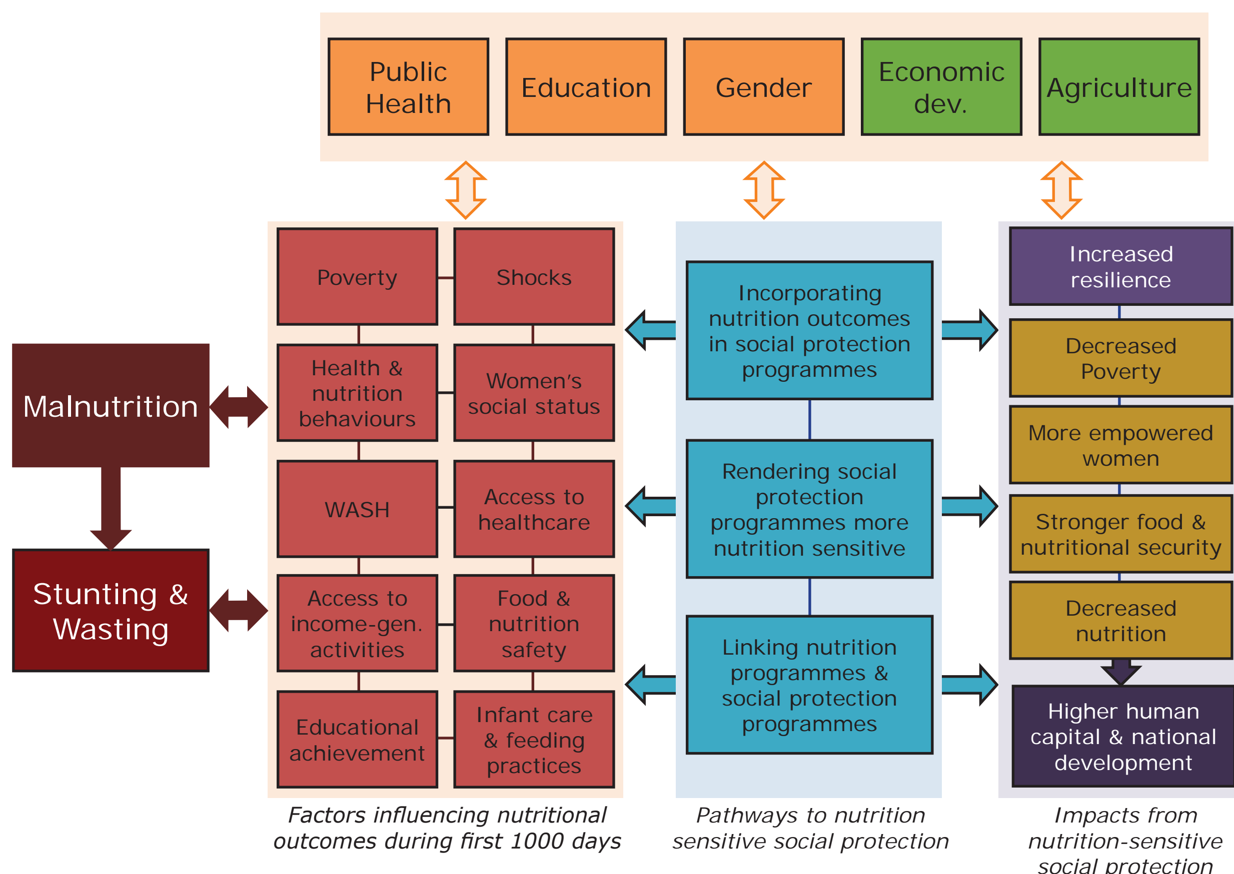
1.2 THEORETICAL FRAMEWORK FOR NUTRITION - SENSITIVE SOCIAL PROTECTION

In order to guide the assessment and interpret key findings, a theoretical framework is developed. The framework explores to what extent nutrition-sensitive social protection interventions can serve as a means to impact nutrition indicators over the long run, and through which intermediate pathways in the short- to medium- term these impacts can be achieved.

Through exploring such pathways and linkages, the framework constructs how to better realise nutrition-sensitive social protection programming that positively contributes to a first-1,000 days approach. This framework is built upon existing frameworks, such as WFP's Food and Nutrition Security Conceptual Framework (2013),[9] and literature on social protection, nutrition, and nutrition-sensitive interventions and is presented below in ***Figure 1***:

Figure 1. Theoretical framework for nutrition-sensitive social protection

Cross-sectoral collaboration in nutrition-sensitive social protection



9 The conceptual framework figure is found in Annex A.

As depicted in the theoretical framework, there are five main components that have relevance to nutritional outcomes over the first 1,000 days and to employing nutrition-sensitive social protection as a pathway to improving these outcomes. The components are described as follows:

1. **Malnutrition, and stunting and wasting:** Malnutrition encapsulates both chronic and acute forms, which are then manifested in the sub-sets of stunting and wasting, respectively.

2. **Factors influencing nutritional outcomes during the first 1,000 days:** The boxes above this heading reflect some of the immediate, basic, and underlying causes of malnutrition during the first 1,000 days, which both affect and are affected by prevalence of malnutrition, and stunting and wasting.

3. **Pathways to nutrition-sensitive social protection:** The pathways to nutrition-sensitive social protection represent various options for achieving and implementing such programmes. The three boxes broadly encompass these pathways, with each pathway comprising of a variety of policy options and actions; the pathways are based on WFP's guidance on nutrition-sensitive programming. In particular, 'incorporating nutrition outcomes in social protection programmes' can denote including explicit nutrition objectives, actions, and goals into social protection programming; 'rendering social protection programmes more nutrition-sensitive' can denote incorporating nutrition-sensitive elements into social protection programmes, such as through the 'cash plus' model, and/or targeting nutritionally vulnerable populations; and 'linking nutrition programmes and social protection programmes' underscores the need for more cross-sectoral coordination in nutrition-sensitive social protection, such as through capitalising on such linkages in order to maximise results. Moreover, nutrition-sensitive social protection can be used to positively address the factors influencing nutritional outcomes during the first 1,000 days, as well as lead to longer-term impacts.

4. **Cross-sectoral coordination in nutrition-sensitive social protection:** The top of the figure shows the various sectors (health, education, economic development, gender, agriculture) whose inputs and participation are essential to successful nutrition-sensitive social protection, but which also stand to experience effects from negative outcomes over the first 1,000 days, and nutrition-sensitive social protection interventions and their impacts.

5. **Impacts from nutrition-sensitive social protection:** At the far end of the figure sit ultimately desired impacts from successful nutrition-sensitive social protection, which, taken together, can contribute to long-term progress in enhancing an individual's human capital development and a nation's own development through increased resilience, decreased poverty, high levels of women's empowerment, stronger food and nutritional security, and decreased malnutrition.

The above factors influencing nutrition over the first 1,000 days, nutrition-sensitive social protection options, and long-term impacts underscored in the theoretical framework serve as primary topics that will be touched upon by the study, thereby steering the study's discussions and, ultimately, its recommendations for nutrition-sensitive social protection programming for the Central and Eastern Africa region.

1.3 STUDY METHODOLOGY

The primary research methodology for this study is a literature review, conducted through desk research, and relying on reports, journal articles, demographic and household surveys, and vulnerability mapping exercises on such topics as nutrition, social protection, food insecurity, and best practices for achieving positive outcomes during the first 1,000 days, both internationally and within the Central and Eastern Africa region.

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2. International Best Practices for Nutrition-Sensitive Social Protection for the First 1,000 Days

2.1 INTRODUCTION TO KEY TERMS AND CONCEPTS

Before examining international best practices, defining some key terms and concepts around malnutrition, nutrition, health, and the first 1,000 days is necessary. First, there are three causes of malnutrition – immediate, underlying, and basic –, which influence and contribute to each other[10] and which are defined below[11].

1. **Immediate causes,** such as deficient food and nutrient intake and incidence of diseases/ illness (e.g. diarrhea).
2. **Underlying causes**, such as food insecurity; inadequate care practices; and unhealthy household environment, including limited access to and availability of health services, and poor sanitary and hygiene conditions.
3. **Basic causes**, such as structural and/ or systemic conditions at societal levels, including existence of social safety nets, gender relations, demand-side and supply-side constraints to education and other services, conflict, environmental factors, and the overall political situation in a country.

In the fight against malnutrition, there are two types of interventions that explicitly target nutrition outcomes: nutrition-specific and nutrition-sensitive. **Nutrition-specific interventions** address the immediate causes relating to nutritional deficiencies, while **nutrition-sensitive interventions** address the underlying and basic causes. In other words, nutrition-specific interventions are designed to exert more immediate, short-term effects on individual beneficiaries, whereas nutrition-sensitive interventions are designed to be farther reaching and longer-term, considering the complexity of changing behaviours, societal conditions, and attitudes vis-à-vis nutrition. Examples of nutrition-sensitive interventions include initiatives addressing food security and agricultural production, women's empowerment, water, sanitation, and hygiene (WASH), child protection, education, and social safety nets (SSN)[12] and social assistance.

Box 1. Definitions of malnutrition and related terms

Discussions on malnutrition use a variety of terms to describe the various dimensions and conditions therein. These terms are not interchangeable and are defined for the purposes of clarity. Malnutrition refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients. The term itself addresses three broad groups of conditions, which are: 1) undernutrition, which includes wasting (low weight-for-height, which is associated with acute malnutrition), stunting (low height-for-age, which is associated with chronic malnutrition), and underweight (low weight-for-age); 2) micronutrient-related malnutrition, such as micronutrient deficiencies (a lack of important vitamins and minerals) or micronutrient excess; and 3) overweight, obesity, and diet-related NCDs (World Health Organization, 2017).

10 The UNICEF Nutrition Causal Framework is attached in Annex B and reflects the relationships between each of malnutrition's three causes.

11 Food and Agriculture Organisation, 2015.

12 Ruel & Alderman.

Box 2. 10 essential nutrition-specific interventions

1. Management of severe acute malnutrition (SAM)
2. Preventive zinc supplementation
3. Promotion of breastfeeding
4. Promotion of complementary feeding
5. Management of moderate acute malnutrition (MAM)
6. Periconceptual folic acid supplementation or fortification
7. Maternal balanced energy protein supplementation
8. Maternal multiple nutrient supplementation
9. Vitamin A supplementation
10. Multiple calcium supplementation

In terms of nutrition-specific interventions, *The Lancet* journal highlights ten essential, evidence-based interventions[13] (see Box 2) that can reduce stunting and improve the health and nutrition statuses of women and children during the first 1,000 days, if implemented strategically and in a timely manner. It has been estimated that these 10 interventions, if scaled to 90 per cent coverage worldwide, could reduce stunting by 20 per cent and severe wasting by 60 per cent.[14] Moreover, nutrition-specific interventions are considered some of the most cost-effective, with a theoretical investment of USD 70 billion over 10 years achieving the potentially impactful results of saving 3.7 million children's lives and of preventing stunting in 65 million children, with a USD 4 to USD 35 return on every dollar invested.[15] However, if nutrition-specific interventions produce such significant impacts and yield such high returns on investment, why are 165 million children under five still stunted globally?

Addressing the many causes of malnutrition during the first 1,000 days is not as simple as improving mothers' and children's immediate nutrient intake, or elevating a country's and individual's ability to invest in more nutrition-specific interventions. For instance, India's economy has undergone impressive growth and its GDP per capita is nearly USD 1,600;[16] however, 48 per cent[17] of Indian children are stunted, making India's population of stunted children the highest in the world. In comparison, Senegal, with a GDP per capita of about USD 900,[18] maintains a national stunting rate of 19 per cent, one of the lowest in sub-Saharan Africa. Certainly, there are a host of geographical, political, cultural, and other differences between India and Senegal that also affect chronic malnutrition, but this comparison is presented to demonstrate that economic growth alone is not enough to improve a country's performance on key childhood anthropometric indicators. Furthermore, it is the cultural, demographic, geographical, and social contexts within a country that complicate addressing chronic malnutrition, given that malnutrition is affected by complex and interconnected causes, thereby necessitating comprehensive, creative, and long-term responses.

To address these causes, nutrition-sensitive interventions, combined with nutrition-specific interventions, have more relevance, as nutrition-sensitive interventions can be multi-sectoral, more context-specific, and better equipped to tackle the range of contributory causes to malnutrition. Nutrition-sensitive interventions tend to require higher investment of time and resources, but the outcomes can have transgenerational effects. For example, consider Senegal's success in reducing stunting in children under five from 30 per cent in 2000 to 19 per cent. This success is due in part to the Senegalese government's strategic shift to a more nutrition-sensitive approach, in which a package of services is offered to targeted communities. These services include health education, breastfeeding promotion, infant and young child feeding (IYCF) counseling, monthly weighing sessions, micronutrient supplementation, conditional cash transfers (CCTs), targeted food security support and more, all done through a community-based service delivery model that is adaptable to local contexts.[19] Anecdotal evidence from targeted community members reveal changed attitudes towards the importance of proper maternal and early childhood health, attitudes that, if permanently shifted, will influence future generations during the first 1,000 days.

13 The Lancet, 2013.

14 U.S. Agency for International Development, 2017.

15 Shekar, Kakietek, Dayton Eberwein, & Walters, 2017.

16 World Bank, 2017.

17 United Nations Children's Fund.

18 World Bank, 2017.

19 World Bank, 2017.

Box 3. Complementary feeding

Beyond six months of age, children become more active and have higher nutrient and energy requirements. Exclusive breastfeeding during the first six months of life is critical, but breastmilk only provides half of a child's required energy and nutrients between 6-12 months of age, and one third between 12-24 months (World Health Organization, 2009). So, even if a child is exclusively breastfed for the first six months, the child could still be at risk of acute malnutrition and undernutrition between 6-24 months of age, thereby endangering development during the first 1,000 days. As such, complementary feeding of protein-rich foods (e.g. fruits, vegetables, meat) should be introduced to supplement breastfeeding and to ensure that children beyond six months of age meet energy and nutrient requirements. While complementary feeding is a fundamental nutrition-specific intervention, its promotion should form part of nutrition-sensitive interventions.

Adopting a forward-looking perspective to nutrition-sensitive interventions is essential to achieving lasting effects on reducing chronic malnutrition. Poorly nourished women who become pregnant are not able to pass on needed nutrients to their growing foetuses, which puts the unborn child at risk of being underweight *in utero* and stunted. Indeed, as much as half of stunting occurs even before birth[20] due to malnourished pregnant women, many of whom were malnourished prior to pregnancy. Therefore, nutrition-sensitive interventions must reach multiple levels of society to ensure that women and girls maintain high levels of health and nutrition long before becoming pregnant, certainly as it may take several weeks to detect a pregnancy. Behaviour change communications (BCC), if administered in culturally appropriate ways, is a nutrition-sensitive intervention that has the potential to influence uptake of better health and nutrition practices before, during, and after the first 1,000 days. Topics of BCC can include the importance of exclusive breastfeeding during the first six months, ingesting fortified foods and micronutrients to improve nutritional status, maintaining a healthy and diversified diet, and establishing health-seeking behaviours. Based on evidence from international evaluations,[21] community-level structures have proven to be most effective in directing BCC, with community health workers, mobilisers, and volunteers key players in disseminating nutrition messages. In light of its ability to further maximise programme impacts through facilitating behavioural change, BCC is increasingly being integrated into social protection programmes across the world.

While community health workers, mobilisers, and volunteers are important parts of transmitting key messages on the first 1,000 days, integrating such initiatives into existing governmental projects, priorities, and systems helps ensure coherence and sustainability.

Given the multi-sectoral causes of basic malnutrition, a nutrition-sensitive approach to development involves stakeholders from the agriculture, education, public health, gender, and other sectors realising how they can contribute to alleviating these causes, concomitantly seeing how reduced malnutrition levels contribute to their own goals. **Social protection,** given its status as inherently multi-sectoral, can form and foster crucial parts of cross-sectoral coordination to reduce and prevent malnutrition, with the realisation of nutrition-sensitive social protection a goal for such coordination. Moreover, as will be elaborated later in this section, it is the causes of basic malnutrition that social protection programmes often already directly or indirectly address, further making the case for social protection to be nutrition-sensitive in such contexts.

For the purposes of this study the WFP definition of **nutrition-sensitive social protection** is used, which defines the latter as comprehensive interventions that target the most vulnerable and address the causes of malnutrition, and which can include SSN to reduce vulnerability; protect income, crops, and assets; ensure basic needs are met; and secure access to nutrition diets, healthcare, and improved WASH conditions.[22] Applying a nutrition lens to social protection programming has relevance for a variety of reasons, mainly due to several shared features between nutrition and social protection programming, such as:

- Social protection deals with the root factors influencing poverty, deprivation, and vulnerability, many of which overlap with the underlying and basic causes of malnutrition. And, as malnutrition disproportionately affects the poor and a multitude of social protection programmes are designed to target the poorest of the poor, providing social protection interventions can tackle demand-side constraints (i.e. the immediate causes of malnutrition) that persons experiencing poverty may face in accessing adequate and nutrient-rich food.

20 Save the Children, 2012.

21 See Annex B for a selection of evidence on the effectiveness of community-level outreach and BCC in reaching positive outcomes during the first 1,000 days.

22 World Food Programme, 2017.

- Social protection can adopt a life cycle approach to programming, meaning that it seeks to protect persons from socioeconomic shocks and stresses at each stage of their life – while recognising that these shocks and stresses differ over the course of a person's life – in addition to building an individual's resilience to deal with shocks and stresses. Nutrition, too, opens from a life cycle perspective given an individual's evolving nutritional needs depending on his or her age, health status, and other considerations. Additionally, nutrition is a necessary input for resilience building as individuals and households affected by malnutrition are more vulnerable to shocks and stresses.[23]
- Effective social protection programming is comprehensive, multi-sectoral, and is intended to realise results over the long-term. Effective nutrition-sensitive programming is aimed at the first 1,000 days and at reducing chronic malnutrition works within comprehensive packages and integrated service delivery, including BCC, and works best through multi-sectoral coordination.
- Social protection often targets the most socially marginalised groups, which, in many cases, include women and girls. Given the primary role that good nutrition amongst women and girls before, during, and after pregnancy plays in the first 1,000 days, empowering women and girls through more education, increased economic opportunities, and more control over household decision-making can have wide-ranging impacts on their health, nutritional, and educational status, as well as on that of their children.

The common features and goals of nutrition and social protection programming speak to the applicability of rendering social protection programming more nutrition-sensitive. As with any complex intervention, though, more nutrition-sensitive social protection must be designed in a comprehensive, long-term, and context-specific manner in order to optimise impacts and results. In terms of social protection programme design features, the targeting approach is a crucial consideration in any social protection intervention in terms of meeting objectives, and targeting from a more nutrition-sensitive perspective can enhance success within the first 1,000 days through ensuring the nutrition-sensitive nature of an intervention from the outset.

2.2 TARGETING FOR NUTRITION-SENSITIVE SOCIAL PROTECTION

In social protection programming, the fundamental role of targeting is to define who is to benefit from proposed policies and programmes, as well as to determine how the defined group is identified and reached in practice. Developing a suitable targeting approach in line with the programme's objectives, effectively reaching its intended beneficiaries, is one of the most complex design and implementation features of social protection programming. Typically, social protection programmes rely on one or a combination of various targeting approaches and mechanisms to identify its intended beneficiaries. No matter which targeting approach is chosen for a programme, it is vital that the approach and established eligibility criteria align with the programme objectives. For instance, programmes with explicit nutrition objectives would ideally use data on nutrition and food security indicators on which to base its targeting method, whilst programmes with poverty reduction objectives might use income data instead. Incorporating objectives and reliable data into the targeting approach is essential in making sure that the process and criteria are transparent; nonetheless, more nutrition-sensitive programmes, especially those that focus on improving outcomes over the first 1,000 days, may need to look beyond such data and consider other factors.

23 Food and Agriculture Organisation, 2015.

Box 4. How to target social protection programmes

Within social protection programmes, the targeting approach determines who is included. Approaches are either **universal**, in which all persons are unconditionally included in the programme; **geographical**, in which all persons living in a specified geographic area, typically associated with high concentrations of poverty types or vulnerabilities, are included; **categorical,** in which persons belonging to an identifiable group, typically associated with poverty or vulnerability, are included; or a combination thereof. Once an approach is selected, various targeting mechanisms further define who is eligible for inclusion. The most common targeting mechanism is **(proxy-)means testing**, which relies on income information from individuals/households or easily verifiable correlates of poverty. Other common targeting mechanisms include **community-based targeting**, which relies on wealth rankings developed by village committees and/or communities, and **self-targeting**, wherein the individual/household must proactively reach out to programme implementing agencies and actors.

In Africa, the *Ubudehe* programme, a long-standing social development initiative in Rwanda, constitutes an innovative example of combining different targeting approaches and mechanisms. Under *Ubudehe*, households are placed into numbered categories (e.g. Category 1, Category 2, etc.), based on socioeconomic characteristics and property ownership. These characteristics range from households who do not own a house and cannot afford basic means (Category 1), up to households in which members are employed by international organisations, own a large-scale business, and/or work for government (Category 4). In the spirit of the traditional meaning of *ubudehe*, communities lead targeting. First, households fill in questionnaires on their characteristics, and then community leaders cross-check the accuracy of the information provided. Once accuracy is verified, the community sends the questionnaires to the Ministry of Local Government for validation, and eventual categorisation. As of 2015, the *Ubudehe* Categorisation had captured over 10 million Rwandans nationwide, classifying them into Category 1, 2, 3, or 4, though new categories were released for fiscal year 2016/2017 (Ministry of Local Government, 2016).

First, targeting interventions, such as cash-based transfers, in line with households' food insecurity levels might not achieve outcomes vis-à-vis chronic malnutrition. This is due to the idea that simply providing food insecure households with more means (i.e. cash transfers) with which to purchase more food does not guarantee that household members' nutritional status improves, as stunting, wasting, and other conditions related to malnutrition can still occur in households that do *not* report food insecurity. Moreover, the designation of an area as either 'food insecure' or 'food secure' sets up a binary classification system that does not allow for the more subtle and complex causes of malnutrition to be taken into account. For example, households living in food secure areas, and the areas themselves, can still experience shocks that threaten this 'security'; or, food insecure households may exist in food secure areas but are excluded from coverage due to living in an area classified as 'food secure'.

Second, targeting should be careful not to conflate food insecurity with nutrition insecurity,[24] and first carefully assess what drives malnutrition in a certain context. As mentioned above, chronic malnutrition is a by-product of far more factors than a lack of or inability to access food. Targeting based on only food insecurity indicators, or poverty or vulnerability indicators may be misleading if the households or areas subsequently targeted face demand-side constraints such as high market prices for nutritious foods, or supply-side constraints for healthcare and/or nutritious foods. Demand-side, social protection interventions would not necessarily alleviate the latter constraints, particularly in the absence of complementary, supply-side interventions that can adequately handle enlarged demand for commodities or health services. Therefore, nutrition-sensitive social protection programmes should consider which set of criteria will ensure that the most nutritionally vulnerable populations/areas are targeted and ensure the biggest impacts achieved on the target population. These criteria could include targeting women and girls of reproductive age, pregnant women, lactating mothers, and children under the age of two, for programmes with an explicit 1,000 days focus; targeting areas with ongoing supply-side interventions aimed at agricultural strengthening, improvement of healthcare facilities, enhancing access to markets, and other infrastructural projects; and targeting areas with ongoing initiatives on women's empowerment.

24 Rajkumar, Gaukler, & Tilahun, 2012.

Box 5. Nutrition security

People are considered food secure when they have availability and adequate access at all times to sufficient, safe, nutritious food to maintain a healthy and active life (World Food Programme, 2017); nutrition security means adequate nutrition status in terms of protein, energy, vitamins, and minerals for all household members at all times (Weingartner, 2004). In Africa, although food availability has improved and the numbers of underweight children have decreased over the past 20 years stunting rates have stagnated. These seemingly contradictory statistics put the difference between food security and nutrition security into perspective, as the ability to eat more food does not automatically lead to reduced malnutrition.

Finally, once target groups and areas have been determined, the primary beneficiaries of the intervention are selected. Regarding cash transfer programmes, international evidence points to the benefits of designating women as the primary beneficiaries, as women are more likely to spend the cash on items benefiting the larger household. Designating women as the primary beneficiaries can also augment their economic and social standing within the household and community, thereby increasing levels of empowerment. But, while targeting and empowering women through nutrition-sensitive social protection programmes, is fundamental to reducing chronic malnutrition,[25] men, in their capacity as husbands, fathers, close relatives, or neighbours, should also be included in nutrition-sensitive interventions and educated on the importance of the first 1,000 days, where appropriate. Furthermore, programme implementers should be aware of the many responsibilities that women already have, which range from household food preparation – surveys across a wide range of countries reveal that 85 to 90 per cent of time spent on food preparation is women's time[26] – to childcare to farming. As such, overburdening women with activities or co-responsibilities related to their place as primary programme beneficiary can cause stress, which could negatively impact a woman's health status or the development of a child *in utero*. As such, more nutrition-sensitive social protection should include men in programme activities, both to alleviate pressure from female beneficiaries and to better engage them in the care of nutritionally vulnerable groups.

The targeting of a programme can further a more nutrition-sensitive stance towards social protection, sensitised to a first-1,000 days approach, and can take on many forms. While this section has discussed geographic and categorical targeting in more detail, universal targeting of social protection programmes can also bear relevance to improving outcomes over the first 1,000 days and bolster the realisation of a minimum social protection floor, though the actual programme design and execution ultimately determine success. Social protection programmes undertake many forms (e.g. social insurance and/or community-based health insurance schemes, old age pension funds, labor market interventions), this study focuses on the interaction between social transfers, namely cash transfers (CTs), and nutrition outcomes. This is not to negate the relevance that other forms of social protection policies and programmes have for combatting malnutrition, but to rather underscore the ability for CTs to serve as an entry point for more nutrition-sensitive social protection. The offering of CTs in nutrition-sensitive social protection can support improvements in diet quantity, quality, and diversity; decrease vulnerability to food insecurity; decrease child mortality; and help children reach their full potential.[27]

2.3 CASH TRANSFERS AND NUTRITION

Social transfers represent cash or in-kind transfers to programme beneficiaries and within the realm of social protection programmes are typically classified as social assistance programmes. Non-contributory in their nature, social assistance programmes do not assert or depend on any previous contribution from the beneficiary to the programme.[28] Social assistance can be more strictly targeted, for instance a cash transfer to households/individuals living in poverty or prone to certain vulnerabilities, or more universally targeted, such as a child grant provided to all households with children or a social pension for older persons.

Cash transfers, constituting one type of social assistance, have achieved measurable and positive outcomes in improving vulnerable households' resilience, social status, and standard of living in developing countries. Moreover,

25 Save the Children, 2012.

26 World Food Programme, 2017.

27 United Nations Children's Fund, 2014.

28 International Labour Organisation, 2017.

international evidence has revealed that cash transfers (CTs) have a multiplier effect, meaning that CTs' positive impacts on local economies extend beyond beneficiary populations. In Africa, many beneficiaries tend to spend the extra cash on purchasing food, thereby enabling households to enhance the quantity, quality, and diversity of their dietary consumption.[29] Furthermore, evaluations on Conditional Cash Transfers (CCTs), or CTs that attach the receipt of the cash to the fulfillment of co-responsibilities from the side of the beneficiaries, typically in the areas of health and/or education, have registered positive outcomes. Examples of cash transfers tied to co-responsibilities in health, such as seeking out maternal, newborn, and child health (MNCH) services, have shown positive outcomes on uptake of health services like antenatal care and child immunisations; improved performance in IYCF, including exclusive breastfeeding of infants; and reduced incidence of illness in children under the age of two. By comparison, unconditional cash transfers (UCTs), which provide cash to beneficiaries without enforcing the fulfillment of any co-responsibilities, have also reached similar results in increasing health-seeking behaviours and good health and nutrition practices. ***Table 1*** provides an overview of CTs' effects on nutrition outcomes within the first 1,000 days in selected countries, though additional global examples exist:

Table 1. Cash transfers and nutrition

COUNTRY	CASH TRANSFER DESIGN	NUTRITION-RELATED OUTCOMES
Nepal	**Cash Transfer:** Female beneficiaries in targeted villages attend monthly meetings, led by community health workers, on MNCH, IYCF, and good health practices at which they receive a CT; the CT is distributed for five months.	**Nutrient intake during pregnancy**: Increase in regular ingestion of iron tablets. **Exclusive breastfeeding**: Increased incidence of putting newborn baby to the breast within one hour of birth. **Newborn health**: Slight reduction in incidence of diarrhoea amongst infants.[30]
Zambia	**Child Grant Programme (CGP):** All households in three districts with children under five are given a monthly UCT – irrespective of household size – calculated to cover the purchase of one meal per day. The overrarching goal is to reduce extreme poverty, with specific objectives related to reduce mortality, morbidity, stunting, and wasting amongst children under five.	**Dietary diversity**: Increased consumption of meat, dairy, cereals, fruits and vegetables, sugars, fats, and oils. **IYCF**: 88 per cent increase over the baseline mean for beneficiaries.[31]
Nicaragua	***Red de Proteccion Social* (RPS):** All households in targeted districts received different types of bi-monthly CTs: 1) a food security transfer, contingent on attendance at educational workshops and taking children to healthcare appointments; and 2) two education transfers for school attendance and supplies, contingent on enrolment and regular school attendance. Children under two years of age were given free, monthly health appointments.	**Stunting and wasting:** Decline in stunting prevalence from 42 to 37 per cent amongst children aged 6-59 months. **Dietary diversity:** Increase in per capita consumption on food expenditure and improvement in beneficiary diets.[32]

Such promising outcomes demonstrate the utility of CTs in responses to food insecurity, nutrition, and health during the first 1,000 days. But, taking into account the multiple and complex causes of malnutrition, as well as the transgenerational efforts needed to address the causes thereof, CTs, given limitations to their scope and scale, may not be sufficient to effectuate long-term improvements within the first 1,000 days. However, CTs in combination with other comprehensive interventions may offer more significant outcomes.

29 UNICEF-ESARO/Transfer Project, 2015.

30 Levere, Acharya, & Bharadwaj, 2016.

31 Ibid.

32 Sridhar & Duffield, 2006.

Box 6. Conditional versus unconditional transfers

When deciding to distribute CTs, one of the first design considerations is the question pursuing a CCT, whereby beneficiaries do not receive the benefit unless they fulfill a set of co-responsibilities; or a UCT, whereby beneficiaries receive the benefit regardless. International evaluations have tested the outcomes of CCTs and UCTs, with findings suggesting that both produce positive results. Comparing the effectiveness of CCTs to UCTs is difficult but overall, international evidence points to little significant differences between the two models. The ability for UCTs and CCTs to perform equally well in terms of improving child nutritional status or school attendance, for example, does call into question an assumption on CCTs' supposed advantage in ensuring one overriding goal is achieved (Watson, 2016). Furthermore, it demonstrates that the goals targeted by CCTs (i.e. education, health, nutrition) are already highly valued by beneficiary populations, considering that UCTs likewise yield positive outcomes on programme objectives related to health, education, nutrition, and economic growth. In this regard, it may be that properly sensitising and training beneficiary populations on desired outcomes is what garners responses from beneficiaries, rather than strictly enforcing co-responsibilities.

A promising social protection model in terms of achieving sustainable, long-term, and positive results for beneficiaries' resilience is the **'cash plus'** model. Sometimes also referred to as the '**social protection plus'** model, this model has been implemented in Asia, Africa, and Latin America, and generally distributes cash in addition to complementary components, such as trainings, psychosocial support, BCC, and awareness-raising sessions, to beneficiaries. The rationale for supplementing cash with other services is that cash alone is not always adequate as a means to reduce the broad-based and interrelated social and economic risks and vulnerabilities that the targeted beneficiary populations face.[33] Moreover, the provision of complementary services also works to build beneficiaries' capacities to create their livelihoods and resilience following the end of the cash benefit or 'graduation' from the CT programme.

As such, the objective of the 'plus' in 'cash plus' is often to optimise the developmental outcome of interventions through these linkages, and deliver more sustainable, long-lasting change. As such, the 'plus' can constitute a range of additional services or linkages, and does not necessarily seek to limit itself to services directly benefiting the beneficiary of the cash itself. Moreover, as the term 'cash plus' can also be used to describe other interventions that seek to optimise the development outcome by adding layers of services for programmes with different modes of transfer (such as vouchers or food), the 'cash' in 'cash plus' can similarly encompass a range of transfer or programme modalities.

The abovementioned CT in Nepal is an example of 'cash plus', as the beneficiaries receive education and trainings on MNCH, IYCF, and other good health and nutrition practices in addition to the CT. Other examples of the 'cash plus' model in action in Africa include Ghana's Livelihood Empowerment Against Poverty (LEAP) programme, which provides CTs plus free health insurance to orphans and vulnerable children, older persons, persons with disabilities, pregnant women, and children up to 12 months of age in extremely poor households; Lesotho's Child Grant Program, which distributes UCTs plus services on home gardening and nutrition, community savings and lending groups, and income generation to poor households with children; and Tanzania's Productive Social Safety Net (PSSN) programme, which gives UCTs plus complementary components on financial capacity building, infrastructure development to improve the supply of basic services, and youth-focused activities on livelihoods, gender empowerment, and sexual and reproductive health.

Participatory research on social protection programmes in developing countries has revealed that beneficiaries would like CTs to be linked to complementary services, as the latter are expected to have more long-term impacts on income generation and growth.[34] The ability to sustainably influence and increase growth

33 Watson, 2016.

and resilience amongst vulnerable populations is a key objective of many social protection programmes, though accomplishments in this area depend on effective design and implementation efforts, particularly those that make necessary investments in institutional capacities to deliver interventions.[35] Evidence does exist on CTs' effectiveness in enhancing beneficiaries' absorptive capacity to shocks, specifically climate-based ones, though more research is needed on CTs' impacts over time on beneficiaries' adaptive and anticipatory capacities.[36] In the context of increased resilience's effects on nutrition, nutrition is both an input to and an outcome of strengthened resilience, and more food and nutrition secure households are generally better equipped to withstand, endure, and recover from shocks.[37] Recognising this linkage between better nutrition and enhanced resilience, CTs and 'cash plus' programmes with explicit objectives related to resilience can consider how to incorporate either nutrition-specific and/or nutrition-sensitive interventions into their designs, as part of holistic efforts on promoting and sustainably building resilience amongst beneficiaries.

Finally, the 'cash plus' model is also consistent with nutrition-sensitive social protection. Considering that 'cash plus' models seek to unravel the broad-based and interrelated social and economic risks that targeted populations face, thereby placing beneficiaries on long-term paths to resilience, nutrition-sensitive programming seeks to unravel the complex and interrelated underlying and basic causes of malnutrition. And, as mentioned before, a truly nutrition-sensitive first-1,000 days approach involves multi-sectoral actors recognising the key role that optimised developmental outcomes over the first 1,000 days play in achieving their own goals, as well as how multi-sectoral actors can contribute to safeguarding the first 1,000 days. For example, the agriculture sector has a role to play in nutrition-sensitive social protection. Many agriculture programmes already target smallholder farmers in order to enhance their production capacities, access to markets, and resilience, and there are avenues for making such interventions more nutrition-sensitive.

Box 7. The BRAC model for 'cash plus' programming

The Bangladesh Rural Advancement Committee (BRAC) model was first implemented in Bangladesh in 2002 and has since spread to other parts of the globe. It targets the ultra-poor with the aim of moving beneficiaries beyond receiving social transfers to engaging in sustainable and viable income-generating activities. The BRAC model works in five sequenced stages that cover 1) targeting, 2) regular income support to stabilise consumption, 3) support in savings and trainings in financial management, 4) skills trainings on assets management and business development, and 5) receipt of a subsidised assets transfer to enable beneficiaries to start enterprises. Impact assessments of past BRAC beneficiaries found that the programme has positive impacts on real income, food security, and asset accumulation, and that the impacts are mostly sustainable in the long run. Additionally, the percentage of households living on less than USD 1 a day fell from 89 per cent to 69 per cent, while the percentage of participants who reported going without food for entire days fell from 60 to 15 per cent. Graduated participants also have enjoyed higher access to land, reduced morbidity, and reduced vulnerability to chronic illnesses (Rabbani, Prakash, & Sulaiman, 2006).

Although the BRAC model has only been implemented since 2002 and transgenerational effects are not yet detectable, the initially strong outcomes on poverty, food security, health, resilience, and livelihoods creation lend credence to the effectiveness of 'cash plus' in achieving multi-sectoral development impacts. It is worthwhile to note some potential downsides related to 'cash plus', such as high operational costs and low uptake amongst national governments; but, overall, if resources and technical capacity are available, the 'cash plus' model can be a worthwhile pursuit.

34 Jones, Samuels, & Malachowska, 2013.

35 Slater & Ulrichs, 2017.

36 Absorptive capacity is the ability to cope with shocks and reduce immediate impacts, anticipatory capacity is the ability of social systems to actively anticipate and reduce shocks, and adaptive capacity is the ability of social systems to adapt to long-term and future shocks and learn from past experiences (Ibid.).

37 Food and Agriculture Organization, 2014.

2.4 NUTRITION-SENSITIVE AGRICULTURE

While rates of urbanisation are generally rising in developing countries, the majority of people still rely on agriculture as their main income-generating activity, with 75 per cent of the world's poor living in rural areas and working in agriculture.[38] Many of these agriculturalists are smallholder farmers engaged in subsistence farming, growing enough food to sustain their and their households' needs, or selling any excess produce on local markets. However, smallholder farmers oftentimes face demand- and supply-side constraints to improving their livelihoods, household income, and production levels, and as such, agriculture sector interventions and labour market interventions (LMI) can address such constraints while also raising smallholder farmers' socioeconomic status. These programmes do so by providing agricultural extension services, like trainings on crop production, harvesting, marketing, and other topics; asset transfers and/or provision of improved agricultural inputs; and empowerment and financial inclusion, such as through assisting in the formation of smallholder cooperative societies or linking farmers to more capital. The agriculture sector can look beyond simply increasing production capacities and reducing poverty amongst smallholder farmers to contributing to broader nutrition outcomes, and in recent years, **nutrition-sensitive agriculture** has emerged as a way to define agriculture investments made with the intent of improving nutrition.

Throughout agricultural interventions, there are entry points for more nutrition-sensitive elements. For example, prior to an expansion of local production capacities, assessments should generally be undertaken to measure the prices and availability of foods, food storage and transport systems, and existing expertise on cultivation. These assessments can become more nutrition-sensitive by incorporating studies on the nutritional context in targeted areas.[39] The nutritional context encompasses performance on nutrition indicators related to malnutrition and nutrient deficiencies (e.g. vitamin A, iron, folic acid, zinc); availability and supply chain of nutrient-rich foods or foods that address nutrient deficiencies; soil quality; local knowledge and practices on farming; availability of inputs; and prevailing local attitudes/habits towards nutrition, diets, and health. Based on these assessments, nutrition-sensitive agriculture programming can then tailor interventions to focus on the promotion of crops that fill nutrient gaps, the provision of inputs and trainings that improve the quality of crops and outputs, and the delivery of complementary interventions by community agricultural extension workers, like BCC on nutrition, food baskets, hygiene, and health. Additionally, such assessments provide insights into the pathways through which nutrition-sensitive agriculture programmes can promote better outcomes across health, nutrition, food security, and access to diverse diets.

Sustainably influencing a country's agricultural sector to be more productive and inclusive of smallholder farmers – and to further more diverse, nutritional, and affordable food baskets in the process – is a long and complex process. However, nutrition-sensitive social protection programmes cannot simply rely on CTs or 'cash plus' to improve multi-sectoral outcomes, particularly those relating to nutrition, if local markets cannot offer nutritious foods that are affordable and available to nutritionally vulnerable populations. The agricultural sector has an important role to play in making diverse diets and nutrient-rich foods more reachable to poor populations, both of which contribute greatly to enhanced food security,

Box 8. Supply inputs that promote nutrition-sensitive agriculture

Biofortification: the process by which crops are bred to have higher amounts of micronutrients (Chetail, Bergman, & Mottram, 2015). An example is orange-fleshed sweet potato, rich in Vitamin A.
Improved fertilisers: fertilisers devoid of harmful chemicals that can sap nutritional content from produce and have adverse side effects on consumers.
Sufficient storage facilities: improper storage facilities post-harvest can deplete nutrient content and can leave produce vulnerable to contamination by animals or pests, and to toxins (e.g. aflatoxins).

38 United States Agency for International Development, 2016.

39 Chetail, Bergman, & Mottram, 2015.

health, and nutrition. Furthermore, agriculture programmes that empower smallholder farmers and that are nutrition-sensitive can address the immediate and underlying causes of malnutrition, thereby reinforcing efforts to safeguard the first 1,000 days.

There is a real need to consider both the demand- and supply-sides in nutrition-sensitive social protection interventions, as they both affect access to sufficient and nutrient-rich foods. The demand-side of such interventions, though, extends beyond the delivery of cash-based assistance to purchase food, encompassing the setting of an appropriate transfer value that allows beneficiaries to meet their daily energy requirements, improve nutrient intake, and/or increase food consumption. How to set the transfer value within nutrition-sensitive social protection programming must account for a variety of factors, while also remaining flexible to changes within the circumstances and environments in which targeted populations live.

2.5 SETTING TRANSFER VALUES FOR NUTRITION-SENSITIVE SOCIAL PROTECTION

In social protection programmes that offer CTs, the transfer value should be calculated in line with what a household needs to fulfil the CTs' objective. Or, phrased another way, the value of the CT should enable beneficiaries to cover whatever gaps the programme intends to address. For nutrition-sensitive social protection programmes, particularly those operating from a first-1,000 days approach, CTs' objectives can include reducing chronic or acute malnutrition, as evidenced through childhood stunting and wasting prevalence rates, and nutrient levels; improving the quality and quantity of beneficiaries' nutritional intake and diets; or increasing the uptake of good IYCF practices and MNCH care, among others. There is no exact science to calculating the transfer value, but the objectives of the CT should guide the setting of the transfer value and, where possible, programme implementers should consult available and accurate data on local markets, services, poverty levels, and other relevant indicators. For example, a health-focused CT may base its value on the costs of certain medical treatments and/or transport to reach healthcare facilities, while a CT aimed at enhancing the livelihoods of households in extreme poverty may base its value on enabling households to cover their basic needs (e.g. food, shelter, clothing) in order to stabilise consumption or promote recovery. Regardless of a CTs' focus, ensuring a sufficient and appropriate transfer value is essential to the beneficiaries' and the programme's success in meeting its objectives and in ultimately producing positive and long-term impacts.

In the case of nutrition-sensitive social protection, programmes must first consider whether market economy concerns could impede the full effectiveness of the intervention, as areas in which markets or services are not accessible or in which nutritious foods are not available/affordable may require different interventions, like vouchers or in-kind donations. Once it is determined that the environment in which the CT will be delivered is conducive to the programme's objectives, the programme should then build a **needs assessment**, consulting available and accurate data on a range of topics. ***Table 2*** shows the different sources and considerations that can feed into a needs assessment, with these multiple sources ideally constructing a multi-faceted needs assessment:

Table 2. Sources in building a needs assessment for setting transfer values

SOURCE	CONSIDERATIONS
Local (market) price indices	Oftentimes, a national Ministry, Department or Agency (MDA) keeps a record of the average market prices of foodstuffs and other commodities, while public health facilities charge standardised rates for basic services and care. Such records can help programme implementers calculate a transfer value that covers the costs of buying specific foods or food baskets, for programmes with objectives on nutrition; or accessing MNCH care, for programmes with objectives related to improving health outcomes over the first 1,000 days.
Recommended energy requirements	Consumption of 2,100 calories per day is the standard energy intake recommendation for adults, and existing data, such as household surveys, can reveal the average food and calorie consumption amongst intended beneficiaries and gaps in nutrient intake and average daily calorie consumption. Based off of this data, the programme can adjust the transfer value in order to increase overall consumption and consumption of more nutritious foods, targeted at filling nutrient gaps (e.g. deficiencies in vitamin A, iron, folic acid). Additionally, CTs targeting nutritionally vulnerable groups within the first 1,000 days, like pregnant women and children under two years of age, should consider the special energy and nutrient requirements for these groups and factor those into the transfer value.
Average household income and data on poverty levels	Programmes should assume that beneficiary households can cover a portion of their basic needs, though the levels of poverty and average household income amongst targeted populations should be considered in order to determine the percentage of coverage to be offered by the CT. For example, the value of the CT may be calculated to cover 80 per cent of the monetary value of a household's food needs, though there is international evidence that a transfer value of 20 per cent of per capita consumption produces widespread impacts.[40] Furthermore, and where possible, programmes should consult disaggregated data on poverty and income, reflective of the targeted area, as national figures can hide regional economic disparities and differences between rural and urban areas.
Access to local markets and services	Beneficiaries of programmes operating in remote, rural areas may face long distances and/or constrained access to local markets or necessary health services, both of which can result in higher transportation costs for the beneficiary. As such, CTs distributed in these areas should factor transportation costs incurred by beneficiaries into the value, or can offer complementary transport vouchers to offset these costs.
Individual versus average household size	Most CTs are delivered at the household level, but programme implementers must decide whether to calculate value based on the average household size, i.e. all beneficiary households receive the same amount; or on average individual costs, i.e. each individual in the household receives a set amount and the total number of individuals within the household determines the total transfer value. As mentioned above, CTs specifically targeting groups like pregnant women and children under two years of age may need to adjust average individual costs to account for increased nutrient needs and accessing MNCH care.
Seasonal and/or market volatility	In drought-prone areas – many of which experience food and nutritional insecurity – local markets may experience price shocks due to food scarcity. Or, prevailing political or macroeconomic crises in a country may lead to price inflation. In both scenarios, CTs for nutrition-sensitive social protection should build in plans for responding to such shocks, such as temporary increases to the value to allow beneficiaries to continue accessing necessary commodities and services and safeguard their wellbeing.
Other ongoing programmes	Transfer programmes being implemented in the same area and with similar objectives can provide a reference point for transfer values. Programme implementers should consult each other on transfer values in order to avoid major discrepancies between transfer values in different programmes and to share insights on how to set a transfer value. Moreover, ongoing programmes that affect intended beneficiaries, such as food distributions, can influence the value of the CT. A CCT in South Sudan, for instance, targeted at internally displaced persons (IDPs) served as a complement to WFP food rations, which covered 50 per cent of households' daily food needs, thereby supporting the CCT's objectives to alleviate negative coping strategies, such as the selling of food rations, and to build resilience amongst food insecure IDPs.[41]

As mentioned above, the above list of data and information sources that assist in setting a transfer value is not exhaustive, and nutrition-sensitive social protection programmes should use available resources and conduct additional research, if necessary, to compose a comprehensive needs assessment that treats all three causes of malnutrition. For example, in the absence of disaggregated data on poverty levels or food insecurity, programmes can administer their own household surveys to targeted areas/households in order to set baseline figures and begin calculating average household or individual costs to meet identified needs against average income levels. Or, if market data are scarce, programmes can carry out their own surveys of local vendors to establish average commodity prices. Furthermore, analytical tools, such as WFP's Filling the Nutrient Gap (FNG) tool, can form complements to other situational assessments through modeling the effects of various interventions, like differently valued CTs, thereby enhancing stakeholders' understanding of local food systems, barriers to nutrient intake and access, local practices, and food affordability.[42]

40 Food and Agriculture Organization, United Nations Children's Fund, 2016.

41 Mercy Corps, n.d.

42 World Food Programme, 2017.

Conscientiously and objectively formulating the transfer value is an important step in CT design, and programme implementers should exhibit flexibility in adjusting the value in line with changings needs and situations. Flexibility within the transfer value can present particular value to nutrition-sensitive social protection programming, given the shock-prone contexts in which many food and nutritionally insecure populations live, shocks that can lead to acute or chronic malnutrition, which then lead to stunting and/or wasting, both of which have negative implications for the first 1,000 days. Furthermore, programme implementers for nutrition-sensitive social protection interventions may need to contemplate trade-offs in coverage levels versus transfer value, as a lower value can enable greater levels of coverage, but lead to lower levels of success in meeting programme objectives.

Box 9. Methodologies for setting cash transfer values

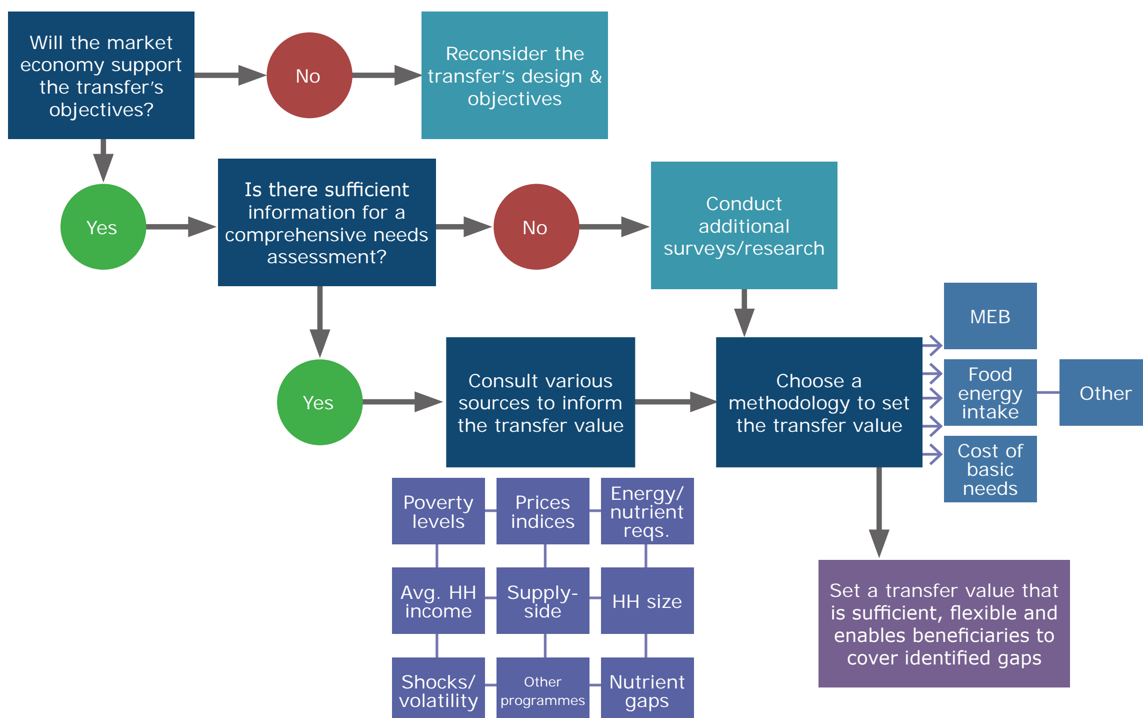
Given the ever-growing popularity of CTs to address a variety of development objectives, several methodologies for calculating transfer values have been developed, which require specific data sets and information. Methodologies with relevance to nutrition-sensitive social protection interventions include:

The **cost of basic needs approach** estimates the cost of acquiring enough food for adequate nutrition, typically based on a diet of 2,100 kcal/person/day, and then adds other costs for essentials like clothing and shelter. Price information is needed for this approach, but in the absence of such information, the **food energy intake method** can be used. This method plots expenditure (or income) per capita against food consumption (in calories per person per day) to determine the expenditure (or income) level at which a household acquires enough food (Haughton & Khandker, 2009).

Predominantly used in setting transfer values for humanitarian and emergency situations, the **Minimum Expenditure Basket (MEB)** quantifies recurrent needs for goods and services by defining what a household needs, on a regular and seasonal basis, and the average cost over time. It is a basis for multi-purpose cash grants, as it categorises household spending across more traditional expenses like food security education, nutrition, health, clothing, WASH, and shelter, as well as non-traditional expenditures like communications and transport. Broad consensus on MEB categories can also inform transfer values for sector-specific interventions (Cash and Learning Partnership, n.d.).

However the transfer value is calculated, a nutrition-sensitive social protection programme's primary concern should be to set a transfer value that enables beneficiaries to meet programme objectives and allows for maximum coverage. As elaborated in this section, best practices for setting the transfer value, including for programmes that function from a first-1,000 days approach, involve undertaking needs assessments of beneficiaries vis-à-vis such factors as gaps in their food and/or nutrient intake levels, specific nutritional needs for nutritionally vulnerable groups, market conditions, and climate and/or economic shocks, among others; basing transfer values on objective, up-to-date, and accurate data; and accounting for the special food and nutrition needs of particular groups. ***Figure 2*** below visualises the process for setting transfer values for nutrition-sensitive social protection interventions.

Figure 2. Setting transfer values for nutrition-sensitive social protection



As this chapter on international best practices in nutrition-sensitive social protection closes, the paper reflects on the topics discussed and lessons learned, as part of constructing a framework for how to design effective nutrition-sensitive social protection interventions.

2.6 CONCLUDING THOUGHTS ON INTERNATIONAL BEST PRACTICES FOR NUTRITION-SENSITIVE SOCIAL PROTECTION

The above sections present some of the main points in designing, targeting, and implementing programmes that work to maximise developmental outcomes and ensure success during the first 1,000 days. International research and evidence confirm the importance of the first 1,000 days on a child's future, and on a country's human capital development, as well as the negative and often irreversible effects that chronic malnutrition and undernutrition, including stunting, exert on children's cognitive and physical development. These effects go beyond an individual's anthropometric measurements and affect educational achievement, health status, and potential earnings and income. As such, interventions that promote sufficient intake of essential nutrients and vitamins during the first 1,000 days for children under two, pregnant women, and lactating mothers – and for women and girls of reproductive age – are valuable components of national development strategies, given the bearing of this window of opportunity on a child's and nation's future.

However, as chronic malnutrition is influenced by complex and interrelated immediate, underlying, and basic causes – and is often a by-product of transgenerational poverty – countries should adopt nutrition-sensitive interventions that are multi-sectoral and function from a life cycle approach. Social protection, through its promotion of a multi-sectoral and life cycle approach, and potential to target the most excluded and marginalised populations, many of whom are nutritionally vulnerable, constitutes a viable format for more nutrition-sensitive programming, with nutrition-sensitive social protection the realisation of programmes that target the most vulnerable and provide avenues to alleviate the various causes of malnutrition. In particular, the 'cash plus' model through its coupling of CTs with complementary services has produced promising results vis-à-vis beneficiaries' long-term resilience and improved uptake of good health, nutrition, dietary, and education behaviours. Therefore, interventions that are able to effectuate long-term, transgenerational impacts on poverty alleviation and resilience, such as the 'cash plus' model, have vital roles to play in reducing malnutrition, thereby safeguarding development during the first 1,000 days. However, nutrition-sensitive social protection, including CTs and the 'cash plus' model, should remain cognisant of supply-side conditions within the agricultural, local economic, and health sectors, and the ability of existing conditions to support efforts to increase demand for and production of more nutritious and diverse foods, and for more healthcare.

Thus far, this study has provided a theoretical framework and high-level landscape of international evidence, best practices, and research on both the importance of safeguarding the first 1,000 days as well as how social protection programmes can become more nutrition-sensitive and promote progress within this period. Taking all of the above into account, the study now narrows its focus to the Central and Eastern Africa region, specifically outlining this region's performance on indicators related to the first 1,000 days; the social protection environment; and finally, guiding principles and recommendations for future programming and on potential entry points for stakeholders, including WFP, to contribute to success during the first 1,000 days.

3. Nutrition and Social Protection in Central and Eastern Africa

3.1 REGIONAL PERFORMANCE ON NUTRITION AND HEALTH INDICATORS RELEVANT TO THE FIRST 1,000 DAYS OF DEVELOPMENT

Globally, sub-Saharan Africa performs poorly on nutrition indicators, housing one third of stunted children and one quarter of wasted children worldwide.[43] Additionally, even though Asia has more stunted and malnourished children in absolute terms, the continent's stunting rate has declined twice as quickly since 2000 than Africa's. And within Africa, the Central and Eastern Africa region is particularly prone to high rates of wasting, stunting, and micronutrient deficiencies, all of which reflect high rates of chronic malnutrition. Its regional stunting rate for children under the age of five of 36.7 per cent[44] exceeds that of all other regions within sub-Saharan Africa. Moreover, more than half of the countries within the region maintain serious (10-14 per cent) or critical (above 15 per cent) wasting rates, per World Health Organization (WHO) standards. ***Table 3*** below breaks down each country's stunting and wasting rates, as a means of measuring chronic malnutrition and as a way of landscaping the region's performance on the first 1,000 days, based on data collected by the WFP Comprehensive Food Security and Vulnerability Analysis (CSFVA) mappings:[45]

Table 3. Stunting and wasting rates per country (Central and Eastern Africa region)

COUNTRY	% OF STUNTED CHILDREN < 5 YEARS	% OF WASTED CHILDREN > 5 YEARS
Burundi	52.7	8.4
Djibouti	33.5	17.8
Eritrea	50.3	15.3
Ethiopia	44	10
Kenya	26	4.1
Rwanda	37	1.7
Somalia	25.3	15
South Sudan	25	20.9
Uganda	34	5

The above numbers strongly suggest that many children in the region experience chronic and/or acute malnutrition, thus leading to high stunting and wasting rates. It is necessary, however, to examine the range of factors contributing to the immediate, underlying, and basic causes of malnutrition in the region. In order to do so, data on food insecurity, poverty, exposure to shocks and resultant coping strategies, healthcare, and education are beneficial.

43 UNICEF, WHO, World Bank Group, 2017.

44 Ibid.

45 Data on stunting and wasting rates for Somalia and Eritrea, and for stunting in Djibouti, are taken from the JME Dataset (UNICEF, WHO, World Bank Group, 2017).

The CSFVA mappings collect information on such topics and more, and some of the main themes that emerge from the Central and Eastern Africa region regarding the immediate, underlying, and basic causes of malnutrition include:

- High levels of poverty in rural areas, with a primary income-generating activity of subsistence farming;
- High consumption of inadequate and/or undiversified diets low in essential nutrients;
- High levels of undernourishment/malnutrition amongst women and girls of reproductive age in rural areas;
- Vulnerability to shocks, such as drought, crop failure, death of a family member, rise in commodity prices, with a main coping strategy to shocks to reduce food consumption/ purchasing across the household;
- Limited access to safe water sources in rural areas; and
- Urban households generally better off in terms of income; eating more nutritious and diverse diets; access to markets, education, and healthcare; and better insulation from shocks than rural counterparts.

The CSFVA mappings also corroborate international evidence that links lower levels of education with higher levels of poverty, as well as lower levels of maternal education with higher levels of malnutrition amongst her children.

Considering the above information, it is possible to create a general landscaping of the Central and Eastern Africa region as a region with high prevalence of chronic malnutrition influenced by high levels of rural poverty, exposure to shocks, negative coping strategies primarily involving reduction in food consumption, poor quality of diets vis-à-vis diversity and nutrition, and constrained access to essential services in rural areas. Certainly, the great environmental, geographic, demographic, and political diversity within the region translates to unique contexts and problems facing only one or two countries (e.g. low levels of domestic food production in South Sudan,[46] low uptake of exclusive breastfeeding for the first six months in Djibouti[47]) that contribute to malnutrition. But, as the focus of this study is regional, familiarisation with some of the overarching factors that affect malnutrition is crucial to understanding how to safeguard the first 1,000 days in Central and Eastern Africa.

46 World Food Programme, 2012.

47 World Food Programme, 2014.

Despite, or perhaps because of, the serious state of malnutrition, regional policymakers have enacted a series of social protection policies, programmes, initiatives, and strategies aimed at alleviating poverty, improving nutrition and health amongst communities, and strengthening resilience. Indeed, a couple of countries in the region maintain extensive social protection systems protected by legal frameworks and policies, and with high levels of national coverage of programmes that target the most vulnerable areas and populations. The next section covers the social protection landscape in Central and Eastern Africa, as well as selected national efforts at nutrition-sensitive social protection and/or improving outcomes across the first 1,000 days.

3.2 SOCIAL PROTECTION IN CENTRAL AND EASTERN AFRICA

Although Central and Eastern African may produce worse nutrition outcomes than other African regions, the region has made significant progress on the continent in furthering social protection systems and its coverage. Two countries in particular, Kenya and Ethiopia, feature some of the largest social protection programmes on the continent, with Kenya's accomplishment of a digitised, biometrically-linked single registry for beneficiaries serving as an international best practice in how to harmonise social protection systems. Every country in the region has at least one social protection programme in place, often school feeding, and almost all countries distribute social transfers, either in-cash or in-kind. Although social protection systems have yet to achieve full national ownership, international agencies, such as WFP, and non-governmental organisations (NGOs) contribute valuable technical, operational, financial, and analytical assistance, supporting efforts towards more national ownership. Furthermore, this assistance will remain essential to South Sudan and Somalia, given the ongoing conflicts and food crises in both countries. An overview of the existing programmes and mechanisms related to nutrition, health, and/or social protection in each country is provided in Annex C.

As a whole, the region is actively pursuing and expanding its social protection programming through a variety of measures. Social protection also enjoys strong support from national governments, as demonstrated through the many policies, frameworks, and strategic plans adopted, all of which solidify the sustainability of and continued political will for social protection. The scope of social protection programmes in Kenya and Ethiopia go beyond pilot level, and programmes in Rwanda and Uganda currently target a range of vulnerable and marginalised groups. In general, though, coverage of social protection interventions has yet to reach national levels in any country in

the region, with current programmes targeting specific groups and/or geographic regions. But, given this healthy social protection environment, the Central and Eastern Africa region offers viable entry points for more nutrition-sensitive social protection focused on the first 1,000 days, either through using social protection programmes as platforms for nutrition-specific interventions, the 'cash plus' model, BCC, and/or other interventions. Indeed, a few countries in the region have already implemented programmes that have the potential to more concretely further a first-1,000 days approach and to stand as examples of nutrition-sensitive social protection, and these are featured as three brief case studies below. The three case studies represent a different design model for nutrition-sensitive social protection programming, such as 'cash plus', linking nutrition-related objectives to cash transfers, as well as integrating programmes in a wider context of shock-responsive social protection.

Box 10. Cross-cutting issues: displacement in Central and Eastern Africa

The Central and Eastern Africa region hosts nearly 7 million refugees, asylum-seekers, IDPs, stateless persons, and other displaced persons (United Nations High Commissioner for Refugees, 2016). Nearly the entire region is affected by displacement due to conflict or natural disasters, and hosts refugees and asylum-seekers from two of the most protracted conflicts in Africa (Somalia and the Democratic Republic of the Congo), as well as those displaced due to the ongoing civil war in South Sudan. These high levels of movement exert stress on host governments and international partners in terms of housing, feeding, protecting, and caring for displaced populations, which often are some of the poorest and most vulnerable. Moreover, refugees and displaced persons may be entirely dependent on food aid or unable to access or purchase enough nutritious food to meet their needs. This, coupled with barriers to income-generating activities and access healthcare and/or education, and living in stressful situations, can all lead to poor outcomes within the first 1,000 days. As such, it is important that humanitarian responses are designed to ensure that displaced persons, especially those who are part of protracted refugee situations, do not become lost human capital.

Recognising the special considerations necessary to expand humanitarian aid beyond simply meeting basic needs to ensuring affected populations' wellbeing, there is a growing body of research on the overlaps between humanitarian aid and social protection. Furthermore, the humanitarian aid sector has witnessed the uptake of delivering CTs, traditionally a social protection instrument, to refugees and asylum-seekers. In Rwanda, for instance, a new initiative called the Nutrition and Education Counseling (NEC) is being offered in selected refugee camps as part of more holistic efforts to improve beneficiaries' nutritional, economic, and health status. Under the NEC, over 73,000 refugees have been trained and sensitised to adopt good feeding practices through applying practical skills such as how to prepare a balanced meal, construction of kitchen gardens, how to grow vegetables, breastfeeding, and good hygiene habits (Sesonga, Feeding the Future: How WFP is improving Nutrition Amongst Refugees in Rwanda, 2017). Additionally, nutrition animators in the camp encourage women to attend sessions on nutrition and use sports events, in which large numbers of refugees gather, as opportunities to disseminate key messaging related to good child and maternal health, and nutrition.

While CTs as part of humanitarian efforts differ from CTs as part of social protection programming, primarily due to the fact that humanitarian CTs are not part of national development or poverty reduction plans (Oxford Policy Management, 2016), they can both address similar issues. For example, both can be used for protective and preventive objectives. Furthermore, both are useful in helping households to invest in future livelihoods and in overcoming demand-side barriers to markets; these objectives are particularly relevant within protracted emergencies. Humanitarian CTs contain great potential to better respond to beneficiaries' needs, contribute to their empowerment, and maintain their nutritional, health, economic, and education statuses. Nutrition and health amongst displaced persons, refugees, and asylum-seekers, including during the first 1,000 days, is an under-researched topic, and more information is needed to further understand how to best minimise risks and ensure that displaced persons are not inhibited from reaching their full potential.

3.3 DJIBOUTI: SOCIAL SAFETY NETS PROGRAMME

Unstable food and fuel prices, frequent droughts, and other shocks contribute to food insecurity, poverty, and chronic malnutrition in Djibouti. In 2012, following the global financial crisis and an extreme drought, 75 per cent of rural households were moderately or severely food insecure.[48] In response, the Djiboutian government, led by the Djibouti Agency for Social Development (ADDS) with support from the Ministry of Health and local organisations, launched a series of initiatives including a nutrition-sensitive SSN pilot, targeting pregnant women, lactating mothers, and children under the age of two in poor areas. The geographical areas are selected based on data on poverty and nutrition.

In order to effectuate positive change within the crucial window of development during the first 1,000 days, the SSN pilot offers a comprehensive package of interventions including BCC through group and individual outreach sessions in communities; nutrition-specific interventions, such as micronutrient powders and food supplements; and free health visits for pregnant women for testing of hemoglobin levels, and for children between 6-24 months of age to receive immunisations and growth monitoring. The BCC and other services rely on existing community structures to the extent possible, with trained volunteer health workers and community facilitators giving BCC. These nutrition-focused services are complemented by the opportunity for beneficiaries to apply for cash-for-work, including community service and light labor. Each beneficiary, provided that she has participated in the nutrition-focused elements, can apply for up to 50 days of work to receive a small wage; the beneficiary may decide if she wants to perform the work or delegate a household member to do so.[49] Giving the beneficiary the freedom to choose who engages in labor helps ensure that pregnant women and lactating mothers are not overburdened or overworked, as stress during pregnancy or lactation can affect child health and nutrition outcomes.

Since programme inception in 2012, coverage has gradually scaled up, reaching over 5,400 beneficiaries, 4,400 of whom had enrolled in the cash-for-work scheme, by May 2014. However, the programme is still at pilot stage, therewith limiting an increase in coverage levels. But despite its pilot status, some initial results include dietary diversification, iron supplementation, regular use of soap, and increased household spending on food.[50] The reported success of the pilot led to the development of a Social Safety Nets Strategy in Djibouti that emphasises the importance of a long-term, development-oriented approach integrating different forms of social assistance through a national, nutrition-based programme.[51]

48 World Bank, 2014.

49 Ibid.

50 Food and Agriculture Organisation, 2015.

51 World Bank, 2014.

3.4 ETHIOPIA: NATIONAL NUTRITION PROGRAMME

Ethiopia's National Nutrition Programme (NNP) was first adopted in 2009, with Phase II (NNP II) launched in 2016. The NNP and NNP II seeks to address chronic malnutrition in Ethiopia, with a renewed focus on the first 1,000 days, by improving the nutritional status of adolescents, pregnant women, lactating mothers, women and girls of reproductive age, and children under the age of five; the NNP II largely targets the same groups[52] with the explicit target to end chronic malnutrition in Ethiopia by 2030. The programme includes high impact, nutrition-specific interventions, such as vitamin A supplementation and de-worming; and comprehensive nutrition-sensitive interventions administered as a preventive, community-based nutrition intervention package that links humanitarian food security interventions with the Productive Safety Net Programme (PSNP),[53,54] implemented by the Ministry of Agriculture. The linkage with the PSNP, as well as with the Health Extension Programme (HEP),[55] underscores the multi-sectoral nature of the NNP, with various ministries, departments, and agencies (MDAs) involved in the implementation of specific components of the NNP, under the leadership of the Ministry of Health and with involvement from community structures. Going further into the linkage with the PSNP, the PSNP's design specifically mentions a partnership with the NNP, identifying the following areas in which the PSNP can contribute to the NNP:[56]

- Ensuring that vulnerable households with a malnourished child are adequately targeted in safety net initiatives.
- Improving the nutritional value of the food basket with the addition of pulses or the equivalent cash value.
- Enhancing the implementation of nutrition-sensitive public works.
- Introducing soft conditionalities related to attendance at BCC events or uptake of other services, in order to increase health-seeking behaviour.
- Using the single registry to identify and refer households for health fee waivers.

The above points highlight how cross-sectoral linkages can strengthen targeting, service provision, and demand- and supply-side interventions, all with a focus on reducing chronic malnutrition and on addressing some of the causes thereof. Specifically, a stronger partnership between the NNP and PSNP can deepen the already-positive effects on expenditure on healthcare, improved household hygiene and sanitation, and higher feelings of empowerment amongst female beneficiaries that PSNP evaluations have reported.[57]

Considering that the NNP and NNP II were only adopted in 2009 and 2016, respectively, more time will be needed to fully measure and assess their success in eliminating chronic malnutrition in Ethiopia and in sustainably altering individuals' health, nutrition education, and economic outcomes over their life cycle. The NNP's integrated package of nutrition-specific and nutrition-sensitive interventions exhibits a preventive strategy to malnutrition, which works to solve malnutrition's underlying and basic causes, rather than react to them; furthermore, the provision of high impact, nutrition-specific interventions addresses some of the immediate causes of malnutrition. This strategy presents the potential to achieve more sustainable progress over the long run, especially given the multi-sectoral participation – nine national ministries are part of the National Nutrition Technical Committee – and explicit NNP objective to strengthen implementation of nutrition-sensitive interventions across sectors (Strategic Objective 4). Furthermore, even stronger linkages between the NNP and other social protection programmes, like the PSNP and other SSN, offer promising opportunities to broaden gains in reducing malnutrition and in furthering nutrition-sensitive social protection in Ethiopia.

52 Children up to the age of 10 are targeted under the NNP II.

53 Gavrilovic & Jones, 2012.

54 The PSNP, established in 2005, provides regular cash and/or food transfers to chronically food insecure households to enable them to strengthen resilience to shocks and grow their livelihoods. The provision of predictable social transfers over several years is tended to help beneficiary households better avoid negative coping strategies, such as sale of productive assets, and to meet basic food intake requirements during food deficit periods.

55 The HEP provides free services on a range of basic health interventions (immunisation; impregnated bed nets; and treatment for malaria, severe malnutrition and pneumonia in young children) as well as BCC through health extension workers and a "health development army." (Ministry of Agriculture, 2014).

56 Ministry of Agriculture, 2014.

57 Gavrilovic & Jones, 2012.

3.5 KENYA: HUNGER SAFETY NET PROGRAMME

The Hunger Safety Net Programme (HSNP) is one of four CTs under the National Safety Net Programme (NSNP) in Kenya. For its part, the HSNP targets poor households in the food insecure districts of the Arid and Semi-arid lands (ASAL) region in northern Kenya: Marsabit, Mandera, Turkana, and Wajir. The first phase of the HSNP ran from 2009 and 2012, reaching 69,000 households with a bi-monthly UCT, and the second phase of the HSNP, HSNP 2, began in 2013 and will scale up coverage to 100,000 households. The targeting process for HSNP beneficiary households relies on community-based targeting and proxy-means testing to select households from the poorest 10 per cent of each county. An additional 470,000 households in the four ASAL districts are eligible to receive emergency CTs in times of drought. Both the regular UCT and emergency funds are transferred electronically and deposited into households' bank accounts, in order to ensure fast delivery thereof. The addition of the emergency CTs reflects HSNP 2's expanded set of objectives to reduce extreme hunger and vulnerability amongst the poorest households, which build upon HSNP's initial objectives to reduce poverty, food insecurity, malnutrition, and to produce wider impacts of indicators of wellbeing and health.[58] Moreover, the HSNP's emergency CT classifies it as one of the region's unique examples of shock-responsive social protection, given the programme's ability to quickly scale up and scale back coverage in times of need.

An independent evaluation of HSNP 2 showed that the receipt of regular UCTs reduced reliance on negative coping strategies, such as reduced food consumption (one of the most common coping strategies in the region per the CSFVA mappings), and increased household resilience to deal with shocks;[59] households receiving the emergency CTs used the extra money on covering basic needs, such as food. A few wealthier households invested the UCT in purchasing a water tank to use in times of drought.[60] Beyond effects on household behaviour to shocks, inclusion in the HSNP 2 is linked with increased school attendance for children in beneficiary households, more diversification of livelihoods, and more purchasing of productive assets.

While the HSNP 2 does not contain explicitly nutrition-linked objectives, in comparison to the first phase, nor does it specifically target nutritionally vulnerable groups vis-à-vis the first 1,000 days, some of the above outcomes suggest that a more nutrition-sensitive model with designated nutrition actions could promote impacts on nutrition even further. For example, nutrition-specific interventions, like micronutrient fortification or vitamin supplements, could be disbursed to nutritionally vulnerable populations as a means of further safeguarding their nutritional status, particularly in times of climatic shocks. Or, trainings and/or BCC on improving food baskets and WASH behaviours for the regular UCT beneficiaries can empower them to enact lasting change to their consumption of nutritious diets and health status. While these additional actions may not be linked to programme objectives on nutrition, they can contribute to beneficiaries' overall nutritional status and resilience, which is a key objective of many social protection policies and programmes. And the building of more resilience in the face of shocks – be they environmental, economic, or related to health or family – is an important consideration given that ruptures to nutrient intake for pregnant and lactating women and children under the age of two can have adverse consequences during the first 1,000 days.

58 Hunger Safety Net Programme, 2017.

59 Oxford Policy Management, 2016.

60 Ibid.

3.6 CONCLUDING THOUGHTS ON NUTRITION-SENSITIVE SOCIAL PROTECTION IN CENTRAL AND EASTERN AFRICA

The Central and Eastern Africa region presents great diversity of political structures, environments, demographics, and cultures, containing countries engaged in devastating civil wars (Somalia, South Sudan) alongside four of the top ten fastest growing economies in Africa[61] (Djibouti, Rwanda, Uganda, Kenya). In spite of these vast differences, a fair generalisation of the region is that national governments, with varying levels of support from international partners, recognise the importance of reducing chronic malnutrition, either through the expansion of access to health services, existing safety nets, and multi-sectoral response mechanisms, including social protection programming. The extensive array of policies, strategies, programmes, and frameworks that address social protection, nutrition, health, and livelihoods confirms this recognition, and some countries have taken their efforts at reducing chronic malnutrition a step further towards preventive measures and a first-1,000 days approach. The three case studies on Djibouti, Ethiopia, and Kenya demonstrate avenues through which countries can achieve more nutrition-sensitive social protection, thus effectuating positive results over the first 1,000 days.

Still, there remains room for improvement, particularly in how social protection programmes in the region contribute to a first-1,000 days approach. First, although the case studies of Djibouti and Ethiopia are two examples of countries taking action towards improving outcomes during this period, the SSN in Djibouti is still at pilot stage while the cross-sectoral linkages and cooperation called for by the NNP in Ethiopia are still being strengthened.[62] And the HSNP in Kenya, while a strong example of a shock-responsive social protection programme, features no objectives, actions, or goals related to nutrition, diminishing its ability to address the underlying causes of malnutrition in the ASAL region and thus falling below the standard for truly nutrition-sensitive social protection. Moreover, WFP assessments of social protection interventions across the region found that the main beneficiaries of social protection programmes are children; heads of households, irrespective of sex; and older persons, with only little or no support targeted at pregnant women, lactating mothers, and/or children under the age of two years. This represents a gap in programming, particularly considering the region's high rates of chronic and acute malnutrition. However, numerous actors working in the region, such as WFP, have proven expertise in nutrition and social protection programming, and strengthening linkages between these actors can contribute to a more nutrition-sensitive approach to social protection, in addition to strengthening a first-1,000 days approach.

In the final section, the study concludes with programme recommendations and guiding principles for more nutrition-sensitive social protection programming in the Central and Eastern Africa region, targeted at WFP and other stakeholders.

61 Myers, 2016.

62 Rajkumar, Gaukler, & Tilahun, 2012.

4. Recommendations for Nutrition-Sensitive Social Protection in Central and Eastern Africa

Thus far, this study has presented key concepts and terms related to malnutrition and nutrition interventions; international evidence on effective responses to a first-1,000 days approach; social protection and selected approaches (e.g. the 'cash plus' model, nutrition-sensitive agriculture); and an overview of the state of malnutrition and social protection in the Central and Eastern Africa region. The study now concludes with recommendations for pursuing more nutrition-sensitive social protection in the Central and Eastern Africa region, tailored towards WFP offices and other stakeholders. The below recommendations are not intended as exhaustive and are designed to respond to the principal themes highlighted by the theoretical framework vis-à-vis the interactions between social protection interventions and factors influencing nutrition during the first 1,000 days, whilst maintaining regional relevance. The ability to retain regional relevance means that the recommendations are not country-specific, though the recommendations offer insights for how WFP country offices could operationalise them. Additionally, the recommendations are selected in line with WFP's existing expertise and experience in the region, and sensitised to WFP strategic documents, guidance, and thought papers. With these recommendations, viable entry points through which the WFP-RBN and country offices can expand their involvement in nutrition-sensitive social protection programming are identified.

The recommendations are as follows and are explained in further detail below:

1. Advocate for the inclusion of nutrition-related objectives, actions, and/or goals into national social protection programmes.
2. Orient transfer programme targeting towards identifying the most nutritionally insecure populations.
3. Design and implement transfer programmes to pursue a 'cash plus' model.
4. Set transfer values that are sufficient to achieve nutrition and health-related objectives.
5. Support other sectoral interventions' designs to become more nutrition-sensitive.
6. Enhance cross-sectoral cooperation as part of the implementation of more nutrition-sensitive social protection programmes.
7. Incorporate nutrition-sensitive social protection interventions into humanitarian responses.

Before delving into each recommendation, it is important to set some overarching principles. First, this report affirms the primacy of national policies, frameworks, strategies, and programming around social protection and nutrition in guiding WFP's role in and contributions to nutrition-sensitive social protection. As such, this report emphasises the positioning of WFP efforts to strengthen and contribute to national priorities, and not the setting up of parallel and/or conflicting programming. Second, the recommendations operate from an understanding of the WFP-RBN's existing expertise in providing technical assistance, such as policy advice; collecting data on poverty, food insecurity, and vulnerability profiles through the CSFVA mappings; supporting research on the costs of malnutrition, such as through providing funding to the *Cost of Hunger in Africa* (COHA) reports; implementing school feeding programmes; strengthening the capacities of smallholder farmers; and directly delivering cash and in-kind transfers, and leading logistics in humanitarian operations. Therefore, the recommendations speak to how to capitalise on this existing expertise, rather than how to shift WFP-RBN's focus to other areas. Finally, acknowledging international best practices for nutrition-sensitive social protection programmes and the importance of integrating gender in all nutrition-sensitive programming, it is vital to design such programmes that suit the context (cultural, gender, demographic, environmental, political), needs, and structures present within targeted areas and beneficiary populations.

4.1 ADVOCATE FOR THE INCLUSION OF NUTRITION-RELATED OBJECTIVES, ACTIONS, AND/OR GOALS INTO NATIONAL SOCIAL PROTECTION PROGRAMMES

Finding pathways through which social protection programmes can serve as entry points for more nutrition-sensitive interventions, even in the absence of explicit nutrition elements, can certainly contribute to the fight against malnutrition and to safeguarding the first 1,000 days. And advocating for the inclusion of nutrition-related objectives, actions, and/or goals for national social protection programming can more profoundly ensure that the nutritional status of beneficiaries, especially the most nutritionally vulnerable, is improved alongside and in concert with their socioeconomic status, resilience, and overall wellbeing. International stakeholders recognise the importance of including nutrition objectives into social protection programmes, with the Second International Conference on Nutrition (ICN2)[63] calling for states to "incorporate nutrition objectives into social protection programmes and into humanitarian assistance safety net programmes".[64] The inclusion of explicit nutrition objectives into national social protection policies and frameworks also has implications for making programme designs more nutrition-sensitive. For example, targeting of beneficiaries for social protection programmes with nutrition objectives would need to take nutritional status and performance on nutrition-related indicators into account, thus ensuring that social protection programmes are more nutrition-sensitive from the outset. And, national social protection policies and programmes that operate from a life cycle approach could include special nutrition objectives, actions, and goals for the first 1,000 days, given that this period of development is connected to longer-term effects on education, health, economic status, and human capital development.

The call for more definite nutrition elements to national social protection efforts has relevance for the Central and Eastern Africa region, where, in general, social protection programmes can work further towards the inclusion of nutrition objectives, actions, and goals into programme designs. The same is generally true for WFP programming, as in only one country – Burundi – does WFP social protection programming have a nutrition component.[65]

Although this represents a gap, there are various entry points for ensuring that nutrition components factor into national social protection programmes, policies, and priorities. First, school feeding programmes, in which WFP is a key implementer in the Central and Eastern Africa region, already provide platforms for nutrition-specific interventions and nutrition-related activities, such as nutritional education. As most countries within the region include school feeding as part of national policies,[66] this constitutes as viable entry point for WFP to advocate for stronger emphasis on adding more nutrition-sensitive interventions to national school feeding programmes. Furthermore, with WFP's dual mandate of nutrition and food security, it can advocate that humanitarian responses from various partners have a nutrition focus from the outset, so that beneficiary populations, especially those from nutritionally vulnerable groups, are not at risk of adverse impacts to their nutritional status during the first 1,000 days. With WFP's expanding foray into social protection and its existing expertise vis-à-vis technical assistance and implementation, it is in a unique position to advance robust nutrition-related objectives, actions, and goals as a hallmark of national social protection programming in the Central and Eastern Africa region.

4.2 ORIENT TRANSFER PROGRAMME TARGETING TOWARDS IDENTIFYING THE MOST NUTRITIONALLY INSECURE POPULATIONS

As discussed earlier in the study, it is important to distinguish between food insecurity and nutrition insecurity, given that an area can be technically food secure but still experience acute malnutrition. This dichotomy is particularly relevant to urban areas in developing countries, as many urban-dwellers consume energy-dense diets that are characterised by high levels of refined sugars, salt, and other additives, increased saturated fat intake, and reduced intakes of complex carbohydrates, fibre, fruits, and vegetables.[67] Poor urban households also typically spend up to 70 per cent of household income on food,[68] thereby reducing resources that could be spent on healthcare, education, and expanding income-generating activities. As such, targeting strategies for transfer programmes that weigh other factors such as urbanisation, consumption of nutrients,

63 The ICN2 took place in November 2014 in Rome and featured participants from national governments, United Nations' agencies, civil society, the private sector, and NGOs. Its main outputs were the Rome Declaration on Nutrition and the Framework for Action.

64 Food and Agriculture Organisation, 2015.

65 Based on information present in WFP's overview document of social protection programming in the Central and Eastern Africa region.

66 Eritrea, Rwanda, and Uganda do not yet include school feeding as part of national policies.

67 World Health Organisation, 2017.

68 Ibid.

percentage of household resources spent on food, obesity rates, prevalence of NCDs, and/or the availability and prices of nutrient-rich commodities on local markets may provide a more comprehensive landscape on nutritional insecurity; this landscape could then inform a more nutrition-sensitive targeting approach.

Furthermore, incorporating performance on nutrition indicators into targeting approaches and mechanisms, even for programmes that do not explicitly have nutrition-related objectives, can orient transfer programmes towards identifying the most nutritionally insecure populations and setting a more multi-faceted poverty floor for inclusion. As mentioned earlier in the study, malnutrition and poor performance on nutrition indicators are linked to poverty and deprivation, with malnutrition serving as a key determinant of educational, health, and economic performance over an individual's lifetime. Moreover, childhood malnutrition is often a consequence of and contributor to transgenerational poverty. As such, transfer programmes that target beneficiaries based on poverty data could go beyond using income levels – the most commonly used measure for poverty – and include performance on nutrition indicators as part of setting a more multi-dimensional poverty floor, even for transfer programmes that do not have explicit nutrition objectives. Furthermore, incorporating childhood malnutrition levels, as measured through prevalence of stunting, wasting, and underweight, would not only sensitise the transfer programme to a first-1,000 days approach, but would reflect a more preventative attitude towards poverty reduction, given the significant long-term effects of childhood malnutrition on productivity and human capital development.

A variety of data and information sources already capture performance on childhood malnutrition, health, and other indicators, and innovatively combining this data can yield more comprehensive transfer programmes that tackle the complex causes of malnutrition and poverty. The CSFVA mappings compiled by WFP capture a range of data on, *inter alia*, nutritional status, markets, vulnerability to shocks, and health, while national governments and other data collection exercises (e.g. Demographic Health Surveys) collect data on indicators related to health, education, social status, and other areas. Additionally, the methodology behind a Multi-Dimensional Poverty Index (MPI) considers indicators within the dimensions of education, health, and living standards to construct a wider-ranging vulnerability profile of assessed populations, resulting in an estimation of what per cent of a population are MPI poor. Within the MPI, though, there is room for context-specific innovations: for example, the indicators under the health dimension[69] can be adapted to include childhood stunting and wasting, as opposed to underweight in the global MPI.[70] Much of the data captured by CSFVA mappings, DHS, and MPI relate more to the underlying causes of malnutrition, rather than to the immediate causes, which may be more helpful in identifying nutritional insecurity versus food insecurity, and for universally targeting the most nutritionally vulnerable populations like pregnant women, lactating mothers, children under the age of two, and women and girls of reproductive age for transfer programmes that seek to address the first 1,000 days. For example, indicators relating to prevalence of anaemia in pregnant women and children under the age of two, as well as on stunting, wasting, and undernutrition[71] are linked to indicators of general malnutrition, which may be a result of nutritional insecurity and which are all relevant to the aforementioned nutritionally vulnerable groups. Moreover, climate-smart targeting, which makes a distinction between the chronically poor and those likely to suffer transitory poverty as a result of climate shocks,[72] could contribute additional information and perspectives on areas/populations at risk of nutritional insecurity linked to temporary periods of poverty.

With these data as a foundation, WFP offices and other policymakers can engage in knowledge sharing and thus target transfers – even in universal transfer schemes – to nutritionally vulnerable groups, particularly pregnant women, lactating mothers, children under the age of two, and women and girls of reproductive age, for comprehensive impacts on nutrition, thus exerting lasting effects on improving outcomes across the first 1,000 days.

69 Health indicators are nutrition for child and adults, and child mortality.

70 Santos & Alkire, 2011.

71 United Nations Economic and Social Council, 2015.

72 Kuriakose, Heltberg, Wiseman, Costella, Cipryk, & Cornelius, 2012.

4.3 DESIGN AND IMPLEMENT TRANSFER PROGRAMMES TO PURSUE A 'CASH PLUS' MODEL.

This study has already examined international evidence supporting the 'cash plus' model's ability to achieve sustainable and long-term impacts on beneficiaries' resilience, earnings, and uptake of nutritious diets and nutrition, education, and health behaviours. Within the Central and Eastern Africa region, however, the 'cash plus' model is still gaining traction and many CTs are given in absence of complementary activities. There are a few promising examples of 'cash plus' in action in the region – the cash-for-work component of Djibouti's SSN, linking Ethiopia's PSNP to the NNP – and any positive results from these programmes should be used to advocate for the expansion of the 'cash plus' model, particularly one that is consistent with nutrition-sensitive social protection and that targets the most nutritionally insecure vis-à-vis the first 1,000 days. Furthermore, the different contexts in Djibouti and Ethiopia demonstrate the flexibility of a 'cash plus' model, further strengthened by the ability to apply this model to different transfer modes, and highlighting this flexibility has importance for the Central and Eastern Africa region, given its environmental, political, cultural, and economic diversity.

Expansion of the 'cash plus' model does not only imply the introduction and scaling-up of 'cash plus' programmes; rather, it implies better linkages between existing CTs or other in-kind transfers, and nutrition-sensitive interventions. The example of growing linkages between the PSNP – in which WFP has involvement – and the NNP in Ethiopia signifies one such expansion, which neither required the introduction of a new programme nor the considerable scaling up of an existing one. But through these closer linkages, the package of services available to PSNP beneficiaries, such as better referral systems for health fee waivers and improved nutritional quality of food baskets, stands to be increased.

Maximising linkages through a more nutrition-sensitive 'cash plus' model[73] can provide beneficiaries with a broader package of services that is able to touch upon the immediate, underlying, and basic causes of malnutrition. Moreover, WFP can advocate that policymakers consider formulating such linkages to directly target the most nutritionally vulnerable groups, as a way to expand their package of services and further improve outcomes within the first 1,000 days. For example, beneficiaries who fall into nutritionally vulnerable groups could be further served by complementary activities like BCC on exclusive breastfeeding and IYCF, health-seeking behaviours, micronutrient fortification, and the provision of free health services for regular weighing and measuring of children under the age of two; or by adjustments to their benefit amount to cover additional food and nutrient needs for pregnant women, lactating mothers, and children up to the age of 24 months.

In this regard, WFP can either seek out the introduction of 'cash plus' transfer programmes or leverage its existing interventions and seek out closer partnerships with other social protection or sectoral programmes. For example, WFP could use its involvement in the HSNP 2 in Kenya or the Northern Uganda Social Action Fund (NUSAF), which only provides CTs, grants, and/or cash-for-work, to link beneficiaries to complementary services on livelihoods, nutrition, health, agriculture, and other areas within other programmes. Or, the provision of more nutrition efforts and goals to the HSNP 2 that are specifically tailored to nutritionally vulnerable groups could further positive outcomes already measured in the programme, thereby advancing efforts to reduce malnutrition in northern Kenya, and, ultimately, contributing to a first-1,000 days approach. As WFP already participates in various social protection programmes and activities in the region, it can use this participation as an entry point for advocating for the 'cash plus' model as part of nutrition-sensitive social protection.

4.4 SET TRANSFER VALUES THAT ARE SUFFICIENT TO ACHIEVE NUTRITION- AND HEALTH-RELATED OBJECTIVES

Thus far, the recommendations on transfer programmes have advocated for incorporating more nutrition-sensitive design features, such as nutrition-related objectives, more nutrition-sensitive targeting approaches, and uptake of the 'cash plus' model. The fourth recommendation focuses on another important design element of transfer programmes: the transfer value. As discussed earlier in the study, programme implementers should consider diverse data and information sources in constructing a comprehensive needs assessment of intended beneficiaries and the costs of enabling beneficiaries to meet programme objectives. A sufficient transfer value, supported by well-functioning institutional instruments and delivery mechanisms, is essential to the success of transfer programmes. For CTs, implementers should use the programme objectives as a guide in choosing which data sources to consult. For example, the delivery of CTs to Congolese refugees residing in Gihembe refugee camp in Rwanda replaced in-kind food assistance, and WFP based the CT's value on local market prices of the previously distributed

73 Please see section 5 on a 'cash plus' model for WFP-RBN.

food items; the most vulnerable refugees also receive supplementary rations, based on their specific needs, to maintain and improve their nutritional status.[74] Following a successful CT pilot in Gihembe, WFP Rwanda then conducted a market assessment to determine the feasibility of expanding CTs to other refugee camps in Rwanda, an exercise that highlights the importance of evaluating conditions even before a transfer programme is introduced.

In addition to WFP's regional experience in market and needs assessments, WFP has expertise globally in setting Minimum Expenditure Baskets (MEBs), such as in Egypt,[75] and is piloting the FNG tool in several countries. MEBs are primarily used in humanitarian situations, and their popularity is growing in concert with an increasing usage of cash-based assistance in humanitarian contexts. The information captured by a Multi-Sector Market Assessment (MSMA), which is then used to set the value of a MEB, is easily translatable to non-emergency situations, however, as it quantifies costs for recurrent and one-off expenditures across several sectors, which can then be disaggregated. Additionally, the MEB could be sensitised to the needs of nutritionally vulnerable groups, in recognition of their unique nutrition needs. Basing transfer values on a MEB has potential value for CTs and for 'cash plus' programmes, as 'cash plus' programmes may need to consult a wider range of sources in setting a transfer value, depending on the complementary services offered to beneficiaries. For instance, a 'cash plus' programme with objectives to improve outcomes over the first 1,000 days, such as reducing childhood malnutrition and increasing uptake of MNCH care and IYCF, may refer to quantified costs under the sectors of food security, e.g. the average costs for more nutritious and fortified foods; health, e.g., for essential MNCH care; and transport, e.g. transport to healthcare appointments and local markets. Moreover, maintaining a MEB for nutritionally insecure areas and nutritionally vulnerable populations not only provides a good reference point for setting transfer values, it can allow for faster adjustments to transfer values in times of shock or crisis.

Within the Central and Eastern Africa region and beyond, WFP has already conducted complex assessments related to establishing baseline costs for accessing adequate food and sustaining basic needs. As such, WFP can capitalise on this experience to both set sufficient transfer values for its own programmes, as well as contribute to knowledge sharing on setting transfer values that promote strong nutritional outcomes, particularly across the first 1,000 days, with partners implementing similar transfer programmes in the same area. Increased interaction with partners vis-à-vis transfer programmes can also foster more harmonious relationships, as both parties can discuss whether there are large discrepancies between the monetary value of similar programmes, which could lead to feelings of confusion amongst beneficiaries; and to identify where transfer programmes could potentially work together to provide a broader package of services.

4.5 SUPPORT OTHER SECTORAL INTERVENTIONS' DESIGNS TO BECOME MORE NUTRITION-SENSITIVE

Thus far, this study has advocated the importance of targeting transfer programmes to the most nutritionally insecure populations as they pertain to the first 1,000 days. However, as many social protection programmes do not target these groups, the opportunity to support these programmes to become more nutrition-sensitive through fitting design elements should not be neglected. Although nutrition-sensitive social protection programmes that target smallholder farmers and primary and secondary schoolchildren may not fit into an explicit first-1,000 days approach, such programmes can still contribute to positive results during this critical period of development. For example, agricultural strengthening programmes should become more nutrition-sensitive through undertaking comprehensive nutritional context assessments, and then focus production efforts on responding to the assessments' findings on gaps and shortcomings in nutrient levels, producer knowledge on how to safeguard the nutritional content of harvested crops, and availability of nutritious goods on local markets, among other areas. Or, agriculture initiatives can be designed to include BCC for smallholder farmers on better food baskets, the importance of eating nutritious diets, WASH, and hygienic food preparation techniques. Gearing the agricultural sector towards enhancing local populations' nutritional status, thereby achieving more nutrition-sensitive agriculture, can contribute to a first-1,000 days approach through improving local populations' diets and food baskets and enriching smallholder farmers' – who include women and men with children – knowledge on nutrition.

74 Sesonga, Rwanda: WFP Introduces Cash Transfers for Refugees in Gihembe Camp, 2014.

75 WFP Egypt, UNHCR Egypt, and Save the Children jointly determined the MEB for combined cash and voucher assistance to Syrian refugees in Cairo through focus group discussions with refugees and market assessments.

The principal idea behind supporting sectoral interventions, including social protection interventions, to become more nutrition-sensitive in their design, even if they do not have defined goals, actions, beneficiaries, and/or objectives linked to the first 1,000 days, is that the fight against malnutrition requires multi-level and multi-generational support; and interventions should garner such support through the introduction of more nutrition-sensitive components. Within the Central and Eastern Africa region, WFP maintains involvement in social protection interventions like school feeding programmes and in agriculture-linked social protection interventions, like Purchase for Progress (P4P), both of which have room to become more nutrition-sensitive. For example, P4P could include the abovementioned and other design elements for more nutrition-sensitive agriculture, while WFP-supported school feeding programmes can incorporate nutrition and health education, WASH trainings, and school gardens growing nutritious foods for school meals. And although the effects of more nutrition-sensitive sectoral interventions on the first 1,000 days may not be immediately revealed or quantifiable, the establishment of communities with nutrient-rich and high quality commodities available in local markets, schoolgoing children who are eating nutritious meals, and changed attitudes towards good nutrition and health across different groups within society (men, women, children) all add to longer term, transgenerational impacts on malnutrition and, ultimately, on the first 1,000 days.

4.6 ENCOURAGE CROSS-SECTORAL COORDINATION AND IMPLEMENTATION ARRANGEMENTS WITHIN NUTRITION-SENSITIVE SOCIAL PROTECTION PROGRAMMES

The above recommendations have all included an element advocating for more coordination across sectors and actors for nutrition-sensitive social protection, and this recommendation looks at pathways through which closer cross-sectoral coordination in implementation can be fostered. As mentioned earlier in this document, effective nutrition-sensitive interventions and social protection programming must be multi-sectoral, which follows that the implementation of nutrition-sensitive social protection should likewise be multi-sectoral in character. Cross-sectoral coordination should be present at all levels, from national to local levels, so as to improve nutrition outcomes in a harmonised and comprehensive manner. Greater levels of cross-sectoral coordination can also reveal inhibitors to fully maximising nutrition outcomes within the first 1,000 days, thereby promoting efforts and strategies to tackle any identified gaps. For example, the public health, public works, and agriculture sectors can provide integral supply-side responses to deficiencies in healthcare facilities, infrastructure linking communities to markets, poor WASH conditions, and availability of nutrient-rich and nutritious foods on local markets, all of which affect outcomes over the first 1,000 days. While such responses may not be linked to explicit nutrition objectives, the interdependence between public health, agriculture, and good nutrition necessitates attention to the ways in which other sectors can interact with each other to optimise nutrition outcomes.

Within the Central and Eastern Africa region, WFP already participates on several multi-sectoral coordination mechanisms related to nutrition and social protection, such as technical working groups and committees, and this presence can be used for policy advocacy towards more cross-sectoral coordination in the implementation of programming. Moreover, nearly every country in the region is a member of the Scaling Up Nutrition (SUN) Movement,[76,77] which calls for multi-sectoral efforts to end malnutrition; as such, the guiding principle of multi-sectoral engagement promoted by SUN can be utilised as an advocacy tool for more cross-sectoral coordination in nutrition-sensitive social protection. For example, there exist various opportunities for cross-sectoral coordination in the implementation of school feeding programmes. As mentioned before, school feeding already serves as a platform for nutrition-specific interventions; and home-grown school feeding programmes (HGSF), through the purchase of commodities from local farmers, are a platform for more interaction with the agricultural sector. Within implementation arrangements, nutritionists or health sector personnel can consult on school meal composition, to ensure high nutritional content. Concurrently, the promulgation of agricultural strengthening programmes, such as P4P, can enhance local capacities to produce more commodities while also sensitising programme designs to become more nutrition-sensitive through the production of nutrient-rich foods that fill nutrient gaps.

76 The SUN Movement promotes collaborative engagement between national governments, civil society, NGOs, and international organisations to end malnutrition (Scaling Up Nutrition), in particular advancing efforts at safeguarding the first 1,000 days.
77 Djibouti and Eritrea are the only two countries in the region that are not SUN members.

In this regard, school feeding programmes and agricultural strengthening initiatives represent strong examples of the coming together of various sectors – education, health, agriculture, social protection – in the implementation of stronger, more comprehensive interventions that can broaden their impacts vis-à-vis reducing malnutrition through addressing its various causes. And although school feeding and programmes like P4P may not directly target the first 1,000 days, through its potential to strengthen education, health, and nutritional outcomes and attitudes, particularly for girls; to increase the resilience and economic position of smallholder farmers, including women; and to increase the supply of nutritious foods on local markets, both can contribute to longer-term impacts on the first 1,000 days. WFP, with its established relationships with MDAs and other partners throughout the Central and Eastern Africa region, can leverage and develop strategic partnerships for cross-sectoral coordination, as well as advocate, provide technical assistance, and build capacity[78] in the implementation of more nutrition-sensitive social protection programmes.

4.7 INCORPORATE NUTRITION-SENSITIVE SOCIAL PROTECTION INTERVENTIONS INTO HUMANITARIAN RESPONSES

While the scale, reach, and scope of social protection interventions in Central and Eastern Africa are generally on the rise, access to social protection interventions in times of crisis or humanitarian emergencies may be constrained or limited. Globally, though, there is a growing recognition of the effectiveness of availing SSN and other social protection tools to populations undergoing acute and prolonged humanitarian crises, and of implementing shock-responsive social protection systems. The integration of social protection elements into long-term humanitarian responses can help displaced populations affected by structural food and nutrition insecurity caused by recurrent natural disasters, conflict, protracted refugee situations, and other shocks invest in their futures[79] and meet essential needs. The receipt of predictable social transfers, such as CTs, allows displaced populations to smooth consumption and ensure that access to education, health, food, and other services is not interrupted. Protecting this access is essential to safeguarding the human capital development of these populations, which includes positive outcomes over the first 1,000 days.

As a region, Central and Eastern Africa is affected by high levels of migration and displacement, as well as protracted refugee situations in several countries. The uptake of more shock-responsive social protection programmes, and even systems, and of delivering CTs to displaced populations present advantages to both acute migration patterns and to protracted situations, and are relevant to the regional context. For example, CTs enable recently displaced populations to meet their immediate, material needs, and to avoid negative coping strategies such as the sale of productive assets and reducing food consumption, both of which are common in Central and Eastern Africa. Moreover, CTs offer operational advantages, as they have the potential to improve the speed and efficiency of response relative to in-kind aid, and may promote a move away from silo, cluster-based response approaches.[80] Speed, efficiency, and scalability are hallmarks of truly shock-responsive social protection systems, as shocks to vulnerable households arrive suddenly and without warning, thereby necessitating that humanitarian actors move quickly to ensure minimal damage to a household's health, economic, and nutritional statuses.

Within the region, WFP is already implementing cash and in-kind transfers and nutrition-focused activities as part of humanitarian responses, such as CTs coupled with the NEC in refugee camps in Rwanda. Given WFP's long-standing expertise in providing aid in times of emergencies and displacement, as well as its strong logistics capacity, deep field presence, and ability to link nutrition response to food security,[81] it is well positioned to take a lead on how social protection tools, such as CTs and the 'cash plus' model, can be implemented to promote integrated, nutrition-sensitive humanitarian actions. Additionally, WFP has experience in both emergency and protracted refugee situations, experience that enables WFP to share valuable insights on the different needs and options for both. Furthermore, WFP's background in deploying assistance in emergency situations augments its position to support more shock-responsive social protection programmes that can deliver social transfers quickly and in large numbers to affected populations. While SSN and other traditional social protection interventions for humanitarian response systems may not form components of national social protection strategies, capitalising on WFP's experience in delivering CTs, in-kind transfers, and nutrition education to refugees, as well as on existing shock-responsive social protection programmes (e.g. the HSNP 2), all stand as entry points for more nutrition-related actions, delivered via social protection tools or other activities, within humanitarian response systems that address outcomes over the first 1,000 days.

78 World Food Programme, 2017.

79 The Cash Learning Partnership.

80 Oxford Policy Management, 2016.

81 World Food Programme, 2017.

5. A 'Cash Plus' Model for the WFP-RBN

Thus far, this report has highlighted the relevance and potential effectiveness of the 'cash plus' model for nutrition-sensitive social protection interventions, and within the Central and Eastern Africa region. Going forward, though, should the WFP-RBN pursue greater uptake of 'cash plus' in the region, it is necessary to think through how to operationalise the related recommendation (recommendation 3) in a way that is feasible and reflective of the WFP-RBN's and WFP country offices' existing expertise and interventions.

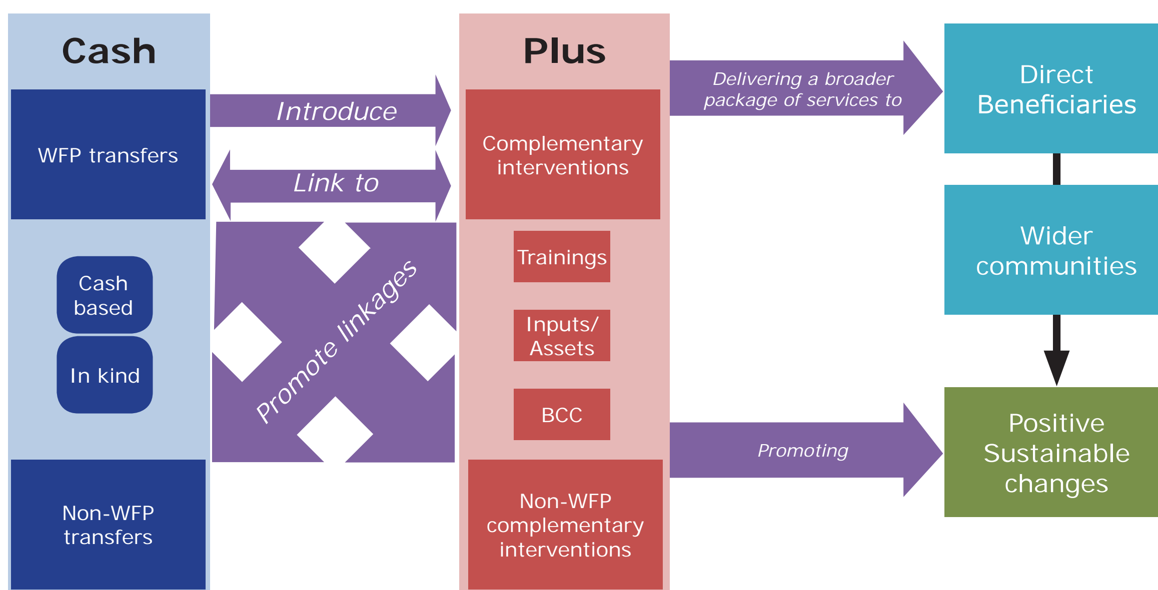
First, it is important to define what 'cash plus' means in the context of WFP's work in the Central and Eastern Africa region. At face value, 'cash plus' is a broad term that simply refers to the idea of complementing cash assistance with other services. Given that WFP has expertise in delivering both cash and in-kind assistance, either through food aid or vouchers, the conceptualisation of 'cash' within 'cash plus' should extend, as indicated before, beyond physical money to encompass the different forms of transfers that WFP country offices offer to beneficiaries. Moreover, 'cash' functions as an umbrella for the various transfer modalities available, such as mobile money, electronic transfers to beneficiary bank accounts, (electronic) vouchers pre-loaded with a set monetary value and/or locked to expenditure on certain items, and the physical distribution of cash or general food assistance (GFA). As such, the relevance of the 'cash plus' model for WFP's work in the region lies in the recognition that linking social protection programmes to complementary services further optimises the development outcomes of joint efforts.

Moving beyond 'cash', reflecting on how WFP can integrate the 'plus' is essential to constructing a 'cash plus' model. In the context of nutrition-sensitive social protection for the first 1,000 days, 'plus' can encompass a variety of interventions, such as BCC on exclusive breastfeeding, IYCF, complementary feeding, and improving nutrition and health; provision of fortified foods to nutritionally vulnerable populations; and/or free MNCH services or referral to healthcare. Beyond targeting outcomes across the first 1,000 days, provision of agricultural inputs and extension services; trainings on livelihoods development, agriculture, and managing household resources; and providing loans, grants, or linkages to micro-finance institutions constitute examples of 'plus' activities. Although WFP in the Central and Eastern Africa region does provide some of the aforementioned 'plus' elements, the greatest value that WFP can offer in promoting 'plus' is in linking with other, non-WFP programmes to offer a broader package of services to a diverse array of beneficiaries. For example, linking P4P with school feeding, as is already being done, signifies 'cash plus' in the sense that schoolchildren benefit from a nutritious school meal (i.e. the 'cash'), composed of locally grown foods; while smallholder farmers in P4P benefit from improved cultivation practices and more structured demand (i.e. the 'plus'). Furthermore, the beneficiary in this 'cash plus' model is not only the students or smallholder farmers, but entire communities, as they benefit from stronger markets with more availability of nutritious foods through increased agricultural production.

Therefore, at a conceptual level, the meaning of 'cash plus' for the WFP-RBN is two-fold, in that it refers to 1) WFP's role in enabling more beneficiaries to access a broader package of services either through incorporating complementary interventions into its own transfer programmes, linking its transfer programmes to other WFP programmes, or linking WFP programmes to non-WFP, complementary programmes; and 2) increasing the range of persons who positively and sustainably benefit from the 'cash plus' model, even if not directly targeted by an intervention. In order to visualise how the WFP-RBN can operationalise its efforts to enlarge 'cash plus' for nutrition-sensitive social protection within the region, ***Figure 3*** below is offered.

The figure itself is divided into 'cash' and 'plus' columns. Under 'cash' are listed **WFP transfers** and **non-WFP transfers**, both of which comprise cash-based transfers, like vouchers or CTs; and in-kind, like school meals or GFA. Within non-WFP transfers, these transfers can be delivered by national governments and/or other technical and development partners, such as UN agencies, international organisations, and NGOs. In the 'plus' column, **WFP** and **non-WFP complementary interventions** are displayed, which encompass relevant trainings, the provision of inputs and/or assets, and BCC; as with non-WFP transfers, non-WFP complementary interventions are programmes implemented by national government and other partners. The inclusion of both WFP-led and non-WFP programmes underscores that 'cash plus' models to which WFP participates should contribute to national social protection systems as a whole, and that WFP need not own the 'cash plus' space. For the WFP transfers, the figure shows three pathways for achieving the 'plus': 1) the introduction of complementary interventions to a WFP transfer programme (e.g. the NEC in Rwanda); 2) linking a WFP transfer programme to another WFP programme that would provide complementary interventions (e.g. linking WFP-supported school feeding to P4P); or 3) promoting linkages between a WFP transfer programme and a non-WFP programme that would provide complementary interventions. For non-WFP transfer programmes, WFP can still pursue the 'plus' through promoting linkages with a WFP-supported complementary intervention; an example of this scenario could be WFP's support in linking P4P beneficiaries to a non-WFP CT. Finally, the model indicates the output from 'cash plus', being the delivery of a broader package of services to both direct beneficiaries and communities at large, as well as the outcome of promoting positive, sustainable changes within targeted beneficiaries and areas.

Figure 3. A 'cash plus' model for the WFP-RBN



Overall, this 'cash plus' model posits that 'cash plus' need not be confined to the design of a single programme nor to the purview of a single actor. Moreover, simply advocating that all transfer programmes introduce complementary interventions is unrealistic, as it overlooks constraints in resources and expertise that programme implementers may face, and is potentially detrimental to the advancement of more multi-sectoral coordination and cooperation in service delivery to beneficiaries. Rather, 'cash plus' – and WFP – should capitalise on linking existing programmes that operate in the same areas and whose objectives can strengthen each other, as part of expanding the package of services delivered to beneficiaries and their communities; enabling the achievement of long-term, sustainable changes that benefit as many individuals; and ultimately contributing to national development agendas and priorities.

6. Concluding Thoughts

While the past few decades have seen global progress in reducing malnutrition, significant work remains to end malnutrition, particularly on the African continent. Malnutrition exerts a range of negative impacts on affected populations and countries, with malnourished or undernourished children in their first 1,000 days experiencing substantial damage to their future cognitive, physical, and socioeconomic development. A country's ability to truly safeguard the first 1,000 days has ramifications for national and human capital development, and as such, many countries are undertaking serious efforts to improve outcomes across this crucial window of development. Some of the more successful efforts have included community-led trainings and BCC with key messages for target groups on the uptake of exclusive breastfeeding for the first six months, IYCF and complementary feeding, more nutritious food baskets and diets, and health-seeking behaviours. For these efforts to achieve long-term and transgenerational effects, though, they must go beyond a silo approach and realise cross-sectoral coordination amongst, *inter alia*, the public health, agriculture, gender, education, and economic development sectors. The involvement of social protection within a cross-sectoral approach to optimising outcomes over the first 1,000 days has shown strong potential, especially in the case of nutrition-sensitive social protection.

Nutrition-sensitive social protection can take various forms, such as targeting approaches that target the most nutritionally vulnerable populations (e.g. pregnant women, lactating mothers, children under the age of two) and/or nutritionally insecure areas; a 'cash plus' model that offers complementary components promoting good nutrition during the first 1,000 days; nutrition-sensitive agriculture aimed at simultaneously enhancing smallholder farmers' production capacities and the production of nutrient-rich foods; and the setting of transfer values that enable beneficiaries to improve the nutritional quality of their diets. For more nutrition-sensitive social protection to really flourish, though, a healthy and receptive political and operational environment is needed so as to support the sustainability of such interventions and their potential integration into national social protection systems. The Central and Eastern Africa region, for instance, features expanding and large-scale social protection programmes in nearly every country, in addition to high levels of malnutrition and undernutrition. Considering these two features, more nutrition-sensitive social protection programming constitutes a viable option for capitalising on a strong social protection environment to address serious issues facing the region vis-à-vis nutrition.

However, for nutrition-sensitive social protection for the Central and Eastern Africa region to maximise results – especially across the first 1,000 days – this study offered several recommendations that specifically pinpointed 1) the advocacy of nutrition-related objectives, actions, and goals into national social protection priorities, 2) the targeting of nutritionally vulnerable groups for transfer programmes, 3) greater uptake of the 'cash plus' model, as well as a specialised 'cash plus' model for the WFP-RBN, 4) setting sufficient transfer values that can achieve nutrition- and health-related impacts, 5) the rendering of sectoral interventions as more nutrition-sensitive, 6) the enhancement of cross-sectoral coordination in the implementation of nutrition-sensitive social protection programmes, and 7) the incorporation of nutrition-sensitive social protection interventions into humanitarian responses. These recommendations are crafted for the WFP-RBN and WFP country offices in the region, though they can be accessible to a variety of stakeholders working on nutrition and social protection. Within Central and Eastern Africa, WFP has maintained a long-standing presence in the coordination and implementation of emergency relief and humanitarian assistance operations, agricultural strengthening initiatives, school feeding programmes, and other social protection programmes, all of which can serve as viable entry points for the pursuit of more nutrition-sensitive social protection that functions from a first-1,000 days approach. Moreover, WFP's existing mandate of food and nutrition security, as well as its growing involvement in social protection in the region, place the agency in a unique position to positively contribute to more nutrition-sensitive social protection that achieves lasting impacts on reducing malnutrition and to improving outcomes within the first 1,000 days.

The continuing fight against malnutrition and its three levels of causality – immediate, underlying, and basic – necessitates creative, sustained, and comprehensive responses from national governments and the international community that are both context-specific and flexible enough to meet beneficiary populations' changing needs. The Central and Eastern Africa region is one of incredible diversity and dynamism, in which forces like urbanisation, migration and displacement, conflict, and economic growth co-exist and present distinct challenges to overcoming issues like poverty, gender inequality, and malnutrition. However, the commitment that governments and international partners, including WFP, in the region have shown to employing social protection to enhance the most vulnerable populations' resilience and socioeconomic status, as well as to improving nutrition outcomes, are critical steps in setting targeted groups and areas on the path to success during the first 1,000 days; and for setting countries on the path to implement more nutrition-sensitive social protection programming.

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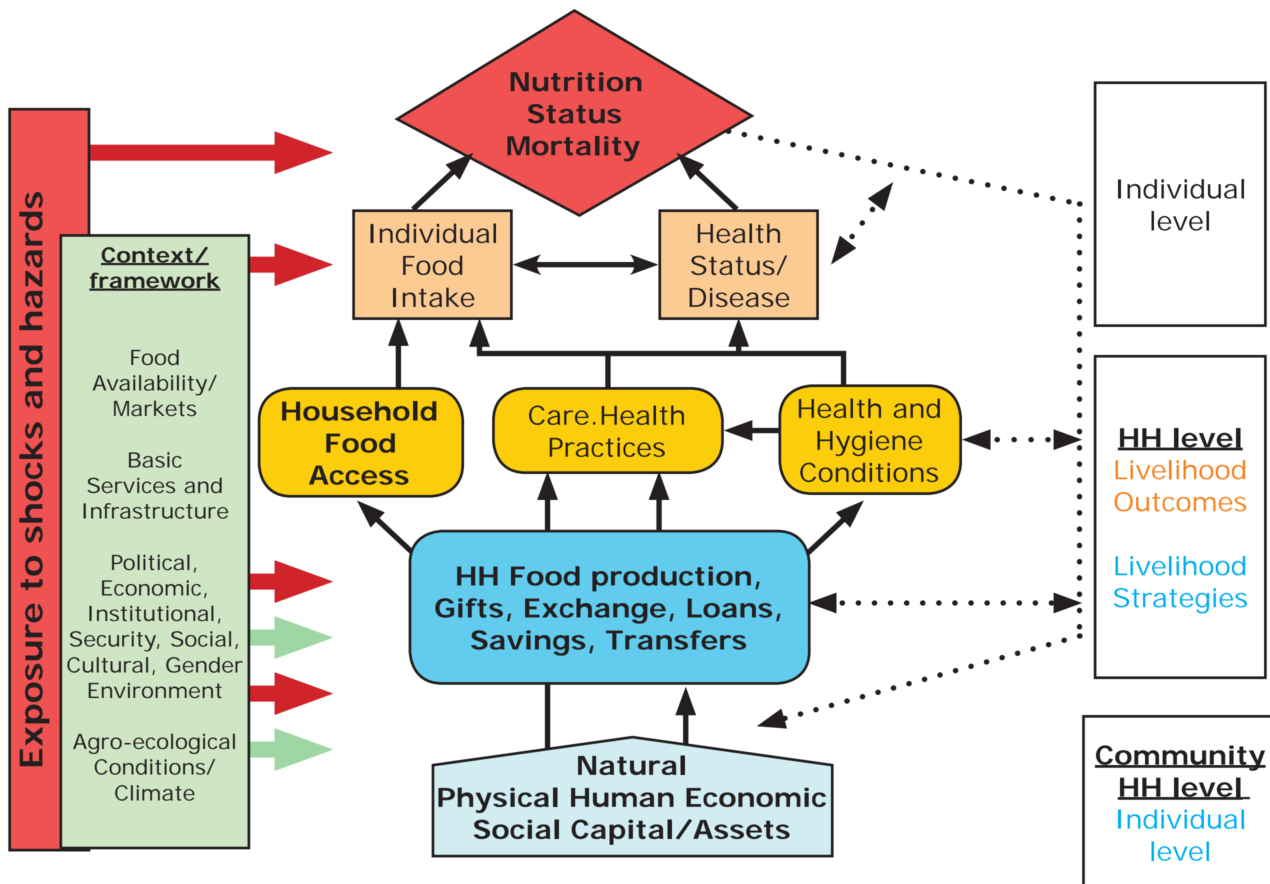
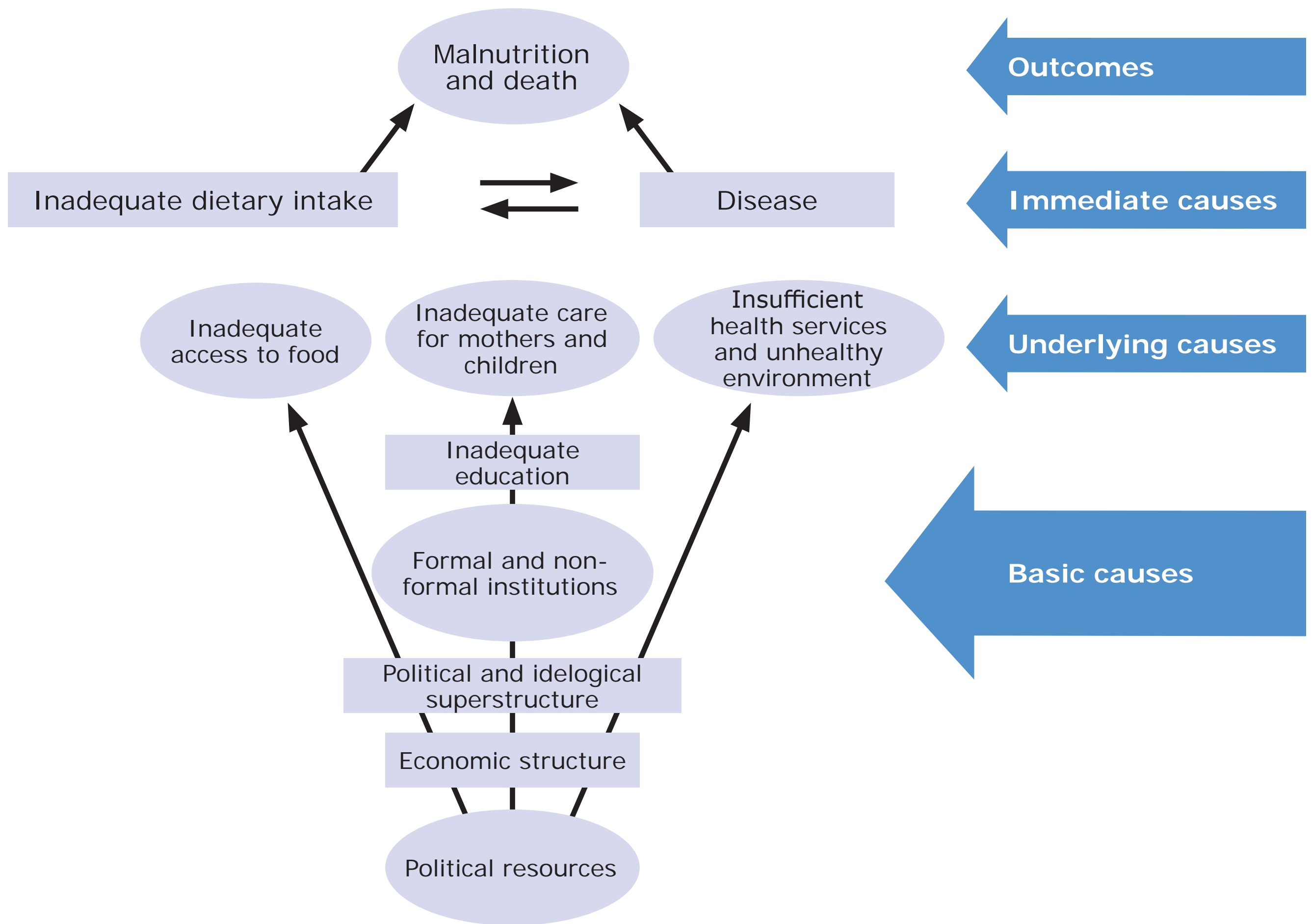
Annex A

Figure 4. WFP food and nutrition security conceptual framework



Annex B

Figure 5. UNICEF Nutrition Causal Framework



Annex C

Selected Results on the First 1,000 Days

Table 4. Selected results on the first 1,000 days from BCC programmes delivered through community structures

COUNTRY	REPORTED RESULTS
Nepal	Impact evaluations, conducted in 2015, on a nutrition-sensitive intervention that used a household-based approach and integrated services within the first 1,000 days found that mothers in implementation areas were more likely to consume a more nutritious diet during pregnancy, feed colostrum at birth, exclusively breastfeed, and feed their children a more nutritious diet including eggs and dairy than in comparison areas. Female community health volunteers, working through governmental structures, primarily delivered services and messages to households.[82]
Malawi	A programme working through a care group model and supported by community health workers, found that 69 per cent of participating women exclusively breastfed their newborns for six months following delivery, and that 75 per cent of newborns were breastfed within 30 minutes of birth; these statistics were markedly higher than the national averages for exclusive breastfeeding (58 per cent) and putting a newborn to the breast within 30 minutes of delivery (57 per cent).[83]
Madagascar	In 1999, Madagascar's Ministry of Health introduced a campaign to increase exclusive breastfeeding through interpersonal communications, community mobilisation events, and local mass media on the benefits of breastfeeding. These efforts through BCC have seen exclusive breastfeeding rates rise from 41 per cent to 51 per cent, with over 70 per cent of newborn babies put to the breast within one hour of birth.[84]
Senegal	A community-based service delivery model adapts to local contexts as part of national efforts to improve results over the first 1,000 days. These services include health education, breastfeeding promotion, IYCF counseling, monthly weighing sessions, micronutrient supplementation, CCTs, and targeted food security support, among others. Anecdotal evidence from programme beneficiaries indicated changed attitudes towards maternal and child health and nutrition, such as increased uptake of exclusive breastfeeding during the first six months and complementary feeding thereafter, and improved cognitive abilities observed in children who received the package of services.
India	In Bihar state, thousands of community health centres and child development centres are the sites of efforts to improve children's intake of vitamin A, in line with information indicating this nutrient deficiency. Frontline health workers and community volunteers administered preventive vitamin A syrup to children and counsel mothers on the importance of improving vitamin A intake for their children. In 2009, Bihar's vitamin A supplementation programme reached 13.4 million children under 5, protecting 95 per cent of children in this age group against the devastating consequences of vitamin A deficiency.[85]
Pakistan	Starting in 1994, Pakistan has been training and deploying "Lady Health Workers" who sensitise communities on maternal nutrition, iron and folate use, rest during pregnancy, and the uptake of breastfeeding. Each Lady Health Worker is responsible for about 1,000 women, with whom they hold group meetings to discuss the aforementioned topics; additionally, Lady Health Workers undertake household visits to monitor vitamin A status in children and emphasise improved MNCH behaviours for women. Over the course of the Lady Health Worker programme, exclusive breastfeeding rates have risen from in targeted areas, while women who were beneficiaries of the programme were more likely to rest during pregnancy, among other outcomes.[86]
Brazil	Community health workers throughout the country cover over 80 million people and the Family Health Programme (FHP), in which community health workers work within Family Health Teams to improve household health-seeking behaviours has been in place since 1994. While the Family Health Teams link households to holistic health services throughout the life cycle, the programme has been credited with improving antenatal care for pregnant women and health-seeking behaviours. To date, 27,000 Family Health Teams active in all of Brazil's 5,000+ municipalities.[87]

82 U.S. Agency for International Development, 2017.

83 World Vision International, 2015.

84 Save the Children, 2012.

85 United Nation's Childrens Fund, 2009.

86 Global Health Workforce Alliance, 2010.

87 World Health Organisation, 2008.

Annex D:

Social Protection and Nutrition in Central and Eastern Africa

Table 5. Overview of social protection and nutrition in Central and Eastern Africa

COUNTRY	NATIONAL SP POLICY? (Y/N/ PLANNED)	SCHOOL FEEDING? (Y/N)	CASH AND/ OR IN-KIND TRANSFERS (Y/N)	OTHER MECHANISMS DEALING WITH WITH NUTRITION, FOOD SECURITY, AND/OR SP
Burundi	Y	Y	Y	• National Social Protection Policy (PNPS) & National Social Protection Commission (CNPS) • Multi-sectoral Food and Nutritional Security Platform (PMSAN) • Multi-sectoral Strategic Plan for Food Security & Nutrition (MSPFSN) • 2012-2017 National Agricultural Sector Investment Plan (PNIA)
Djibouti	Y	Y	Y	• International Code of Marketing for Breastmilk Substitutes • National Initiative for Social Development (INDS) • Social Safety Nets Strategy
Eritrea	N	Y	Y	• Community-led total sanitation (CLTS) strategy • Pension Fund • Saving & micro-credit facilities
Ethiopia	Y	Y	Y	• National Social Protection Policy (NSPP) • Productive Safety Net Programme (PSNP) • Managing Environmental Resources To Enable Transitions (MERET) • Health Extension Programme (HEP) • Social and Community-based Health Insurance (CBHI) schemes • Urban Productive Safety Net Programme (UPSNP) • Integrated Nutrition and Social Cash Transfer (IN-SCT) • Social Cash Transfer Pilot Programme (SCTPP) • Urban Food Security and Job Creation Strategy and Programme • Urban Productive Safety Net Programmeme (UPSNP) • National Nutrition Programme (NNP)
Kenya	Y	Y	Y	• Single registry • NSPP • National Safety Nets Programme (NSNP): Hunger Safety Net Programme (HSNP), Orphans & Vulnerable Children Cash Transfer Programme (CT-OVC), Older Persons Cash Transfer Programme (OPCT), People living with Severe Disabilities Cash Transfer Programme (PWSD-CT) • Urban Food Subsidy Cash Transfer Programme (UFSCT)
Rwanda	Y	Y	Y	• Rwanda Economic Development & Poverty Reduction Strategy: the Vision 2020 Umurenge Programme (VUP) • CBHI & Formal sector insurance schemes • Old age pension fund • Ubudehe Household Registry & MIS • NSPP & National Social Protection Strategy (NSPS) • One cow per poor family (Girinka programme) • Assistance to OVC, genocide survivors, persons with disabilities & other vulnerable groups
Somalia	N	Y	Y	• Joint Resilience Strategy (UNICEF, FAO, WFP)
South Sudan	Planned[88]	Y	Y	• South Sudan Development Plan (SSDP) • Social Protection Core Team
Uganda	Y	Y	Y	• Social Protection Strategy, under the Uganda National Development Plan • Northern Uganda Social Action Fund (NUSAF) • Senior citizens' grant (SAGE) • Uganda Resilience Strategy

88 World Bank, 2015.

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