

Field reports**Integrated psychosocial and food security approach in an emergency context: Central African Republic****Elisabetta Dozio, Lisa Peyre, Sophie Oliveau Morel & Cécile Bizouerne**

In the Central African Republic, a political crisis started in 2013 that greatly affected the population. They were exposed to traumatogenic factors causing the emergence of symptoms of posttraumatic stress disorder in large segments of the population. The situation of high food insecurity, combined with high levels of psychological distress, have significantly limited the population's coping strategies. Within this context, the nongovernmental organisation, Action Contre la Faim, implemented a programme aimed at addressing both immediate and underlying causes of malnutrition, integrating psychosocial and food security approaches. In order to improve the access to food, 900 pregnant and lactating women received monthly food coupons that were exchangeable in the local market. Of these, 199 women who had been identified as the most psychologically vulnerable benefited from specific support: individual counselling or therapeutic groups. Through this multi-sectoral approach, the women's average individual dietary diversity score increased and households improved their food consumption score. Further, these women improved their psychological wellbeing and were able to regain some degree of hope and to develop coping skills. They regained confidence and felt stronger and more prepared to face the future, showing that this multi-sectoral approach strengthened family resilience.

Keywords: integrated approach, mother and child bonding, trauma

Introduction

The Central African Republic (CAR) is a vast, sparsely populated country landlocked within a sub region where both political and security situations are particularly

volatile. A resurgence of violence in 2013 has led to massive destruction of property, human rights violations and mass displacement of people in the intervening years.

In socio-economic terms, economic growth is too weak to actively reduce poverty or generate new employment. As a result, CAR remains fragile and vulnerable to the slightest economic shock. Indicators for the education and health sectors are currently among the lowest in the sub region and state investment in these sectors is very limited.

Nutritional crisis

The nongovernmental organisation (NGO) Action Contre la Faim (ACF, Action Against Hunger) began in the Central African Republic in 2006, carrying out activities related to responding to a nutritional crisis. Since this period, ACF has continued its initial commitments in CAR to reinforce undernutrition detection and treatment capacities, while at the same time developing solutions within ACF's areas of expertise to manage the underlying causes of undernutrition.

The recent crisis that began in 2013 has greatly affected the population in Bangui, where food insecurity remains high and coping strategies are limited. According to the April 2015 *Integrated Food Security Phase Classification (IPC) report* (IPC, 2015), 25% of the population in Bangui, the capital, was considered to be in a humanitarian needs phase (severe lack of food access combined with excess mortality, very high and increasing undernutrition, and irreversible livelihood asset stripping).

According to the UNICEF SMART (Standardized Monitoring and Assessment of Relief and Transitions) survey (UNICEF, 2015) done in 2014 (the latest figures available for the country), the global acute malnutrition rate is estimated between 4.9% and 8.9% (with an estimate of severe malnutrition rates of 0.7% to 3.5%). The nutrition situation in CAR is worrying according to the World Health Organization (WHO) Crisis Classification (WHO, 2000) with the rate of chronic undernutrition (stunting) very high at between 17.4% and 53%.

Causes of undernutrition in CAR are complex and linked to a variety of factors; issues related to food insecurity and child care practices play a role, alongside other underlying causes, such as limited access to health care services, water and sanitation.

According to the SMART survey, feeding practices and care of young children are also inadequate; only half of women breastfeed their child at birth and 75% of women introduce complementary foods before the age of 6 months (porridge, sugar, etc.). For the majority of children aged from 6 to 23 months, dietary diversity is insufficient. Eighty-three percent of children eat one or two meals a day, and only one meal is eaten by 38%, with only 21% of mothers preparing special meals for children since the beginning of the crisis in 2013. Several psychosocial and child care practices assessments conducted by ACF teams since 2007 (ACF, 2007; 2009; 2010; 2011; 2013) showed a strong tendency of mothers to stop breastfeeding for a variety of reasons ranging from poor diet to cultural practices. Weaning is often brutal, and in case of new pregnancies, mothers may wean the existing baby very suddenly. Since December 2013, ACF has assisted in several cases where there has been a temporary reduction of breast milk due to posttraumatic stress. The impact of psychosocial aspects adds additional risk factors for undernutrition.

Traumatogenic factors

During the violent events in 2013, the population was exposed to traumatogenic factors (assault, rape, separation, confrontation with death, loss of one or more family members and their belongings) causing the emergence of posttraumatic symptoms in much of the population (ACF, 2013). Presently, the level of psychological distress is still very high with a corresponding sense of hopelessness and loss of will to live remaining frequent.

A large number of households lost their breadwinner (murdered, fugitive, disappeared or expatriated) who acts as a guarantor in the Central African culture. As a result, families do not have the resources to meet their basic needs. The severity of psychological symptoms correlated to a situation of extreme socio-economic vulnerability results in the inability of adults to take charge and ensure their parenting role. Sometimes, this vulnerability can lead to physical and psychological maltreatment of children. An increase of physical and psychological abuse of children was confirmed in all focus groups with 454 adults in the internally displaced people (IDPs) camps in Bangui, for 70% of parents (ACF, 2012).

Mothers can be very irritable in the face of their children's attitudes; often they are alone and unsupported by their husbands in looking after the children and the house. They are unable to find enough resources to face the difficulties of everyday life. According to a study conducted in 2015 by the NGO Save the Children (de Fouchier, 2015), adults in CAR are often in great pain and their perceived stress reaches a pathological level with feelings of being out of control.

Mainstreaming psychosocial aspects into food security approaches

According to this study, parents who attribute a link between the intensity of their

economic difficulties and the psychological wellbeing of their children are even more stressed than others.

All of these psychosocial factors, when linked to poor child care practices and the availability of a parental system able to care for the child in a proper way, combined with lack of food availability and knowledge of a balanced diet can have an important impact on child undernutrition.

The correlation between food security and mental health has been largely demonstrated (Carter, Kruse, Blakely, & Collings, 2011). This relationship has also been established in many developing countries (Hadley, et al., 2008; Hadley & Patil, 2006; Roberts, Ocaka, Browne, Oyok, & Sondorp, 2009).

Women and mothers seem to be more involved in this association between food security and mental health difficulties, with previous studies suggest that an important risk factor for families' inadequate food access is the mother's experience of mental health problems (Corcoran, Heflin, & Siefert, 1999; Wehler et al., 2004). These mental health problems frequently affect a woman's availability for (further) childbearing, above all during the child's first years and child rearing years (Melchior et al., 2009). In particular maternal depression has been associated with food insecurity (Casey et al., 2004; Stuff et al., 2004). Results of previous studies have also suggested that stressful life conditions and coping behaviours may be as important as income in determining an individual's risk for food insecurity. *'Low income pregnant women may be in need of psychological counselling in addition to increased access to optimal nutrition'* (Laraia, Siega-Riz, Gunderson, & Dole, 2006).

All these studies show the interest and the need for interventions and studies to test whether supporting mothers' mental health may reduce the impact of food insecurity above all in households with young children. In this context, ACF implemented a programme aimed at addressing both

immediate and underlying causes of undernutrition, integrating psychosocial with food security approaches. This project was financed by the Comité Interministériel d'Aide Alimentaire (CIAA) of the French Embassy. The project design was elaborated in accord with the *'ACF Nutrition Security Conceptual Approach'* (ACF, 2014).

Nutrition security recognises that nutritional status is dependent on a wide array of factors. As such, it constitutes a conceptual way to deal with undernutrition in a comprehensive way, while exploring and using all possible avenues to prevent undernutrition and mitigate its consequences (ACF, 2014).

In other, words, nutrition security is an outcome of good health, a healthy environment and good practice, as well as household food security. It is achieved when all household members have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences, combined with a sanitary environment, access to clean water, adequate health services, psychological wellbeing and appropriate child care and feeding practices to ensure an active and healthy life (WHO, 2013).

ACF's nutrition security approach builds on the UNICEF nutrition conceptual framework (Engle, Lhotská & Armstrong 1997), which calls for adopting a multi-sectoral approach.

Multi-sectoral actions can strengthen nutritional outcomes (better child nutrition and psychomotor development) by acting simultaneously on determinants of undernutrition and by increasing coherence amongst intervention strategies and programme.

Even the 2013 *Lancet Maternal and Child Nutrition* series (Black et al., 2013) developed an intervention framework (Figure 1) that shows the means to optimum foetal and child growth and development and highlights the overall multi-sectoral and multi-level approach required to tackle undernutrition. These considerations motivated the adoption of a nutrition security approach through

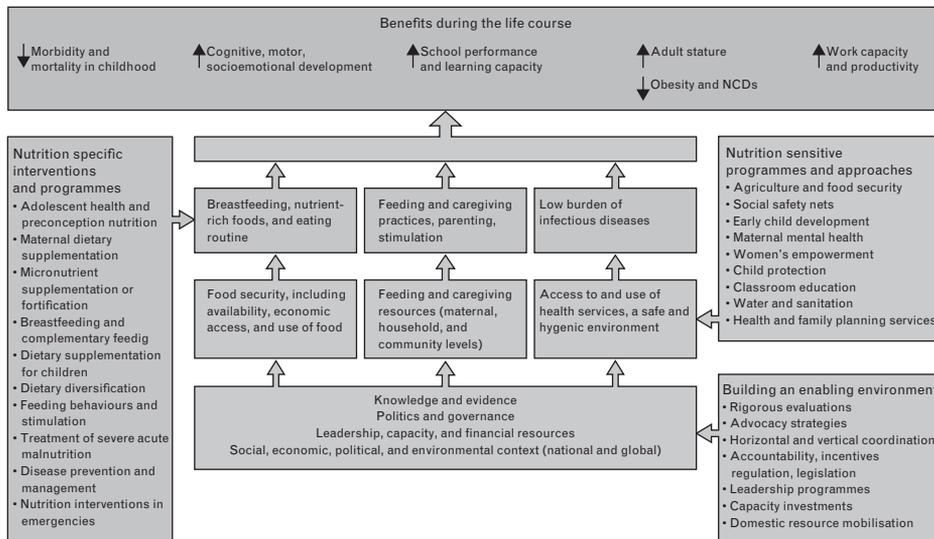


Figure 1: Framework for actions to achieve optimum foetal and child nutrition and development (Black et al., 2013).

a multi-sectorial intervention in CAR in order to address the underlying causes of undernutrition utilising psychosocial support coupled with food security activities. The programme implemented in CAR aimed to promote empowerment and resilience in the population, with a specific target of pregnant, lactating women and their babies as they represent the most at risk population for undernutrition according to the ‘1000 days’ initiative¹. Developed as part of the initiative ‘Scaling Up Nutrition’ (SUN)², the concept of the ‘1000 days’ identified the period of pregnancy up to 24 months after birth as space/time where child and mother are most at risk of undernutrition.

Project description

Objectives

The project addressed multi-sectorial issues with the objective to prevent severe and moderate acute malnutrition among pregnant and lactating women and their babies under 2 years in Bangui. It addressed two

main underlying causes: the access to food and the psychosocial aspect of child care practices (women/mother mental health, child development, infant and young child feeding practices linked to cultural beliefs, and the caretaker emotional availability). In particular, the project aimed to improve both qualitatively and quantitatively the access to sufficient food and to improve the child care practices of the targeted population. Furthermore, by supporting adults particularly affected by the traumatogenic context in alleviating their psychological suffering, the project aimed to improve the parental availability in responding adequately to children needs by reducing the risk of vulnerability to undernutrition. The project took place in the 7th arrondissement in Bangui, where ACF has been working with the nutritional treatment centres (St. Joseph Center) since 2009. The project was planned for a period of five months, with three months of psychosocial support to the most vulnerable pregnant and lactating women identified during the project.

Table 1. Distribution rate according marital status

Marital status	Rate
Unmarried	30%
Divorced	50%
Married	6%
Widow	14%

Forty-six percent of women are heads of household. Among those who are not heads of households, 84% live with their parents and 14% in foster families. The average size of households is 6.7 people.

Population

With the objective of preventing undernutrition, the inclusion criteria were: the most at risk of undernutrition populations, i.e. pregnant and lactating women and children under 2 years. Women were selected through a community based committee that was established with a representative from each district. The committee selected 900 pregnant and lactating women economically vulnerable, i.e. having no or very limited income source, and being isolated without a partner or family to provide financial support. The distribution of target population, from the marital status perspective, prioritised single women (Table 1).

Project team

The team was composed of food security animators with a background in either sociology or agronomy. The psychosocial component was carried out by psychosocial workers with previous experience in ACF psychosocial programmes. They were trained by an expert clinical psychologist at the beginning of the project and are continuously trained and supervised during project implementation.

Activities implementation

The project was organised around four main activities: distribution of food vouchers, cooking demonstration, sensitisation on child care practices and psychological support (Table 2).

Food security activities

Distribution of food vouchers In order to improve access to food for selected households, the food security department organised a monthly distribution of food coupons that were exchangeable in the local market for each women/household, for three months. The coupons provided a nutritious food basket of approximately 135,900 kilocalories per month, per household. For a household of five people, this provides the equivalent of approximately 900 kilocalories per person, per day.

Table 2. Project activities

Activity	Type of beneficiary	Target
Distribution of food voucher	Pregnant and lactating women (PLW) and their babies	900
Cooking demonstration	Pregnant and lactating women	900
Child care practices sensitisation	Pregnant and lactating women and their babies	75% of PLW and babies, receiving food vouchers
Psychological support	Pregnant and lactating women and their babies	PLW and babies identified as <i>distressed</i>

Cooking demonstration During the weeks between distributions, cooking demonstrations were carried out showing how to prepare a balanced porridge for complementary feeding. A training course on household economics has been proposed as well, using an interactive methodology on decision making, balanced diets and the importance of savings.

Psychosocial activities

Alongside the food security approach, a psychosocial intervention has been implemented for the same population. The psychosocial component of the project was structured on activities focused on two main objectives: the prevention of undernutrition through sensitisation on child care practices for pregnant and lactating women and their babies who had received the vouchers; and psychological support for women who had suffered loss and abandonment during the crisis and were showing high rates of distress, or for mother and baby dyads at risk (showing difficulties in relationship).

Sensitisation on child care practices

The sensitisation on appropriate child care practices were integrated into the cooking demonstration.

Sensitisations were organised around different topics direct linked to the *1000 days initiative*:

- Care practices for women during pregnancy (and family planning);
- Breastfeeding (including the emotional aspect) and infant care practices (including child development and stimulation);
- Young child nutrition (weaning and complementary feeding).

Sensitisations were participative and focused on the present preoccupations and difficulties expressed by mothers in caring for their babies.

Psychosocial support

A psychological intervention was defined for people presenting with psychological distress signs. During the cooking demonstration, the psychosocial team had the opportunity to identify the most vulnerable women showing distress symptoms and allowed them to propose further psychological follow-up. The identification was possible as the psychosocial workers implemented sensitisation sessions on two main subjects: child care practices with a particular focus on bonding between caregiver and baby, and on stress manifestations in behaviours during a conflict. At the end of the session, psychosocial workers were available to meet those willing to share their pain and to be included in the psychosocial project component.

The support has been proposed to women showing a high level of distress (at least 7 on a 0 to 10 score rate, measured through the self-administered suffering scale) and a low perceived social support (less than 5 on a self-administered scale scored from 0 to 10). The psychological support was organised for a short time, around four weeks, to reflect the constraints of the women and to also support them in their empowerment, avoiding the dependency to therapy.

The sessions were preferably held within a group in order to reach a larger number of vulnerable women, however, when they expressed a preference for an individual session, they received individual counselling.

Sessions were organised on a weekly basis. Each group session was also organised around a particular theme: life before the war, how war affects lives, loss, grief and bereavement. After digging into the psychosocial effects of war, the sessions were directed to the exploration of individual and collective resources to work on resilience and projection into the future. These sessions included alternating between role play, psycho-education and relaxation exercises or creative expression through drawing.

Project measures: for the food security component

In order to measure improvement on the adequate intake of essential nutrients at both the individual and household, level a random sample of 86 pregnant and lactating women were interviewed by the food security team at the start, and at the end of the intervention. Two different scores were measured.

The Individual Dietary Diversity Score (IDDS) relates to nutrient adequacy (coverage of basic needs in terms of macro and micro nutrients) and to diet variety/balance, which are two of the main components of diet quality. The value of this variable will range from 0 to 8.

The analysis of food consumption at household level was completed utilising the indicator Food Consumption Score (FCS). The FCS is a composite score based on dietary diversity, food frequency, and relative nutritional importance of different food groups. The score is calculated using the frequency of consumption of different food groups consumed by a household during the 7 days before the survey. The value of the FCS ranges from 1 to 112. The typical thresholds are: 0–21 poor, 21.5–35 borderline, > 35 acceptable.

Project measures: for the psychosocial component

In order to better understand the needs and the lack of knowledge of child care practices, and consequently define the main subjects of sensitisation, a pre and posttest survey on knowledge, attitude and practice (KAP) has been conducted.

For psychological support we used two main tools: the suffering scale and the perceived social support scale. For the suffering scale, women had to rate their suffering in a range score from 0 to 10, where 0 is 'no suffering' and 10 is 'very high suffering'. The same range was applied for the perceived social support scale where 0 is 'no social support' and 10 is 'very

high social support'. Both scales were represented with a pictogram in order to give a better understanding of the questions. The scales have been administered by psychosocial workers in charge of psychosocial interventions at the beginning and at the end of the given psychological support.

Results

Despite the project's short duration, results provided strong evidence for improvements in food security and psychological wellbeing among the project participants. The participants also responded overwhelmingly positively regarding the quality and usefulness of the different project components, with 97% stating that they had learned a lot from the project activities. While it is not possible to separate out the effects of the different components of this project on undernutrition indicators, the project evaluations do point to a number of positive impacts that are described below.

Food security results

The dietary diversity score of pregnant and lactating women has shown positive developments (Figure 2). While at the beginning of the project there were women who said they had not eaten the day before, at the final survey every woman had eaten at least four types of food the day before. The average IDDS score stood at 5.7 at the end of the project, against 4 at the beginning.

The food consumption score (FCS) had improved substantially (Figure 3) in the final survey, with none of the beneficiaries in the category 'poor', and the vast majority (over 80%) had reached an acceptable food consumption (Lewis, 2016).

Psychosocial support results

Seven hundred and fifty-eight of the 900 (84.2%) pregnant and lactating women participated in the sensitisation on child care practices during the cooking demonstration. The KAP survey results showed a good rise

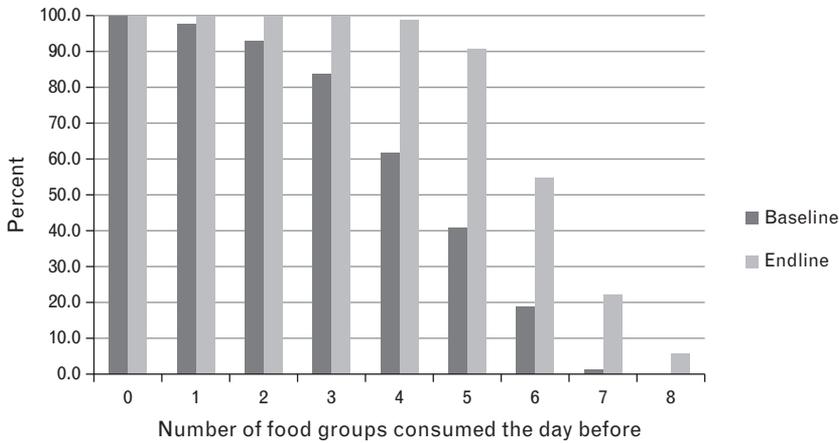


Figure 2: IDDS score improvement.

in knowledge across all of the key messages discussed during sensitisation sessions (in particular, exclusive breastfeeding, complementary feeding practices, maternal nutrition, etc.). Additionally, the psychosocial team were able to follow-up on 90% of people spontaneously requesting psychological support. Needs for this kind of support

to CAR populations still remains very high and are considered as a priority according to last OCHA (Office for the Coordination of Humanitarian Affairs) report on humanitarian need in CAR (OCHA, 2016). In terms of the psychosocial approach, 199 women benefited from psychosocial support, of which 169 participated in individual

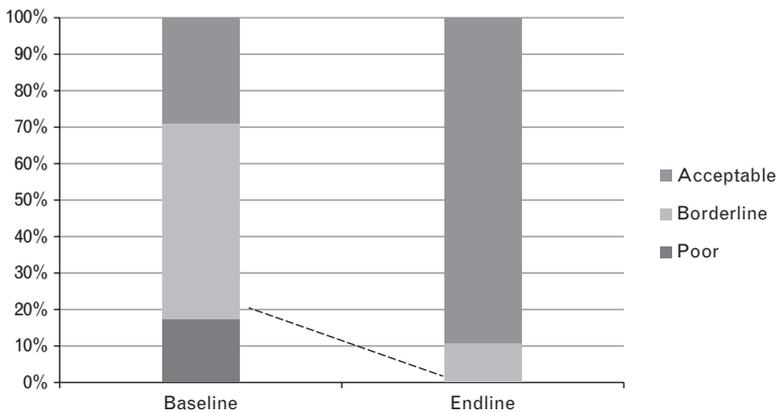


Figure 3: FCS score improvement.

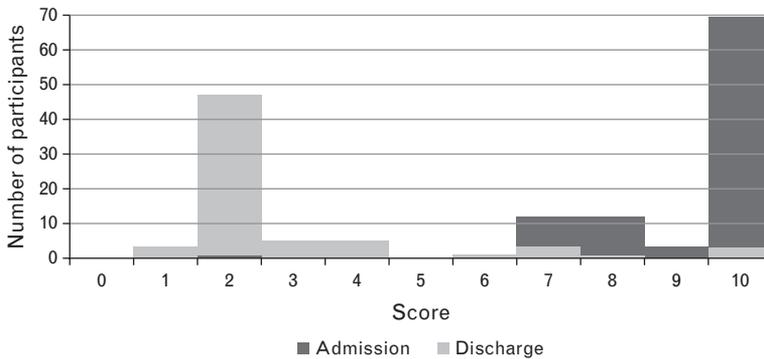


Figure 4: *Distribution of participants' psychological suffering at the admission and at the end of the project.*

counselling and 30 in therapeutic groups. This number reflects the short time available (three months) for psychological follow-up. Data on the population were collected with a sample of 125 women. Women were aged between 15 and 60, with an average of 28 years old and 50% are between 22 and 29 years old.

The reasons given for suffering were various: very poor living conditions; a new family composition in which the mother is often left alone to assume responsibility for the whole family; the traumatic experience of violent events; the violence suffered by the husband or other family members; situations of exclusion and isolation; the almost nonexistent financial resources, disagreements between the couple or family; and overwork. The narratives in the consultations were diverse, but all evoked extremely vulnerable situations. The team observed symptoms of posttraumatic stress or other symptoms suggesting depressive disorders, up to the loss of will to live or at risk behaviours among adolescents. Over 60% of beneficiaries are concerned with two main issue: psychological distress and anxiety. The improvement of wellbeing had been measured at the admission and

at the end of the project, but it was only possible to get a final score for 85 women, for the suffering scale and the perceived social support scale.

Regarding psychological suffering, the discharge scores are significantly lower at the end than at the beginning, which highlights the significant reduction of suffering. At admission, at least 50% of recipients had a maximum score (10/10). At the end, 50% of beneficiaries had a score of 2/10 or less (Figure 4).

At admission, women had an average score of 3.8 for social support. Half of them were 2 out of 10, or less. At the end of the project, the average score for social support was 8.6 out of 10, with half the women having 9 or more (Figure 5).

In conclusion, at the end of the project there was a sharp drop in the suffering scale and a sharp increase in social support scale (Figures 6 and 7).

On average, women who participated in the psychological support activity decreased their pain score to 6.4 points. Half of them were decreased by at least 7 points out of 10. Half of women had an increase of 5 or more points on the score of the social support scale. Only one woman had a degradation of 3

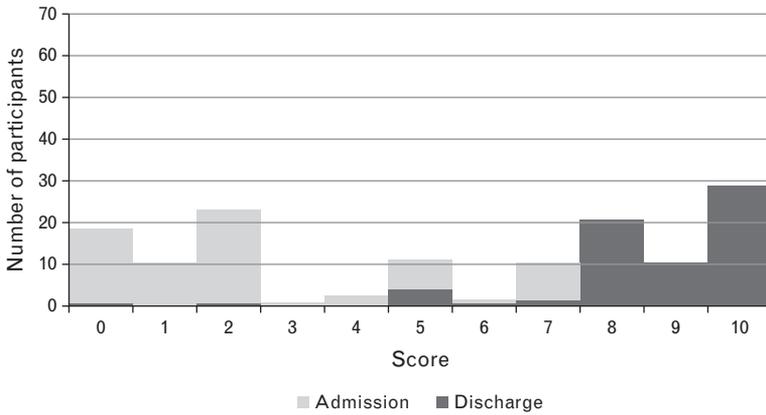


Figure 5: Distribution of beneficiaries according to their degree of social support on admission and at the end of the project.

points (she had a high level of 10 points of perceived social support at admission). The group sessions, built on creating a safe environment and a confidential and supportive setting, allowed women to express and share extremely painful life stories. Psychosocial workers were able to contain and avoid an overflow of emotions in order to

accommodate and transform difficult emotions and to allow women to bypass certain situations. Women were able to express their pain, their suffering, to evoke certain life events that they have never previously expressed. Some have managed to overcome the psychological blockages situations of bewilderment,

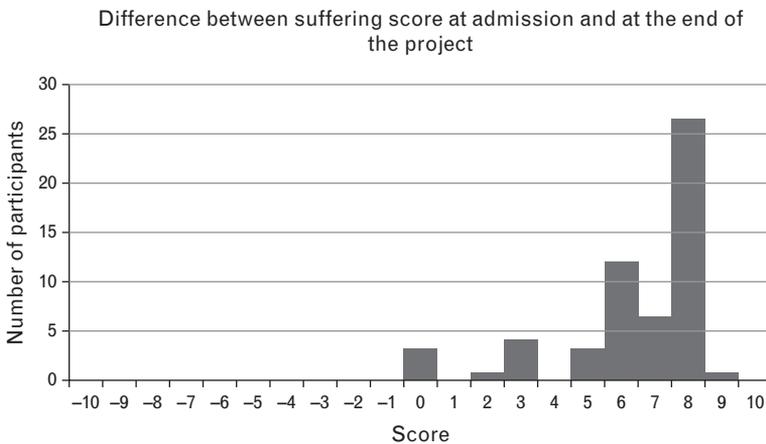


Figure 6: Points of decreased perceived suffering between the admission and the end of the project.

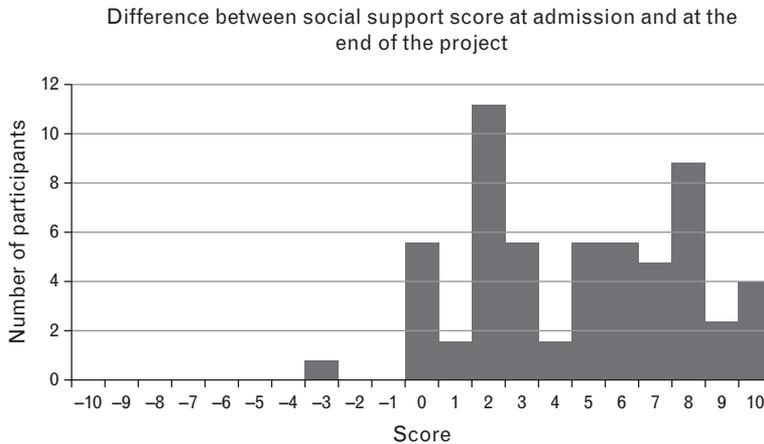


Figure 7: Increased perceived social support.

and in the majority of the situations, women found a way to challenge the link between traumatic events before and their present life now and this has led them to be able to project themselves into the future.

Women could find mutual support in the group through sharing similar situations and difficulties, they felt part of a group with a common past and it allowed them to strengthen their social links. As a result, the therapeutic groups have proven their efficacy and seemed to be well adapted to the context and well received by the population. Good results have been noticed even on individual psychological counselling, the tailored support and the therapeutic work on traumatic symptoms for very affected and vulnerable women helped them, not to forget, but to coexist and to move on with this despite while the context continues to be insecure, frightening and very unstable.

Limitations

The most important limitation of the programme is linked to the short duration of funding making the programme an ad hoc intervention. This element brings up the question of the sustainability of the effect of

the action, and especially the impact on psychological wellbeing once the distribution of vouchers has ended. A perspective for the future should consider extending the project with a post crisis phase where households could be supported for a longer period to become economically autonomous. Additionally, a programme phase including income generating activities could be incorporated.

In order to better understand the impact of each component and to strengthen the positive evidences of the integrated approach, some other research orientations can be considered, including different groups: a group of women receiving just vouchers or exclusively psychological support, and a group combining both kind of support. The monitoring system needs to be improved as well, through a common data base and more rigorous measures of impact in order to allow both correlational and causal analysis, which were not possible for this project.

Conclusions

The programme showed encouraging positive results on women and their family

life. Even if it is not yet possible to observe results in the long term, we can attribute part of the success of the intervention to the specific integrated approach that considers household resilience through a holistic vision of wellbeing, taking in account both material and emotional needs. Numerous studies show the association between food insecurity and mental health, and how an increase in food insecurity is associated with increased symptoms of anxiety and depression. In particular, women's anxiety and depression symptomology is associated with their food security situation, which also has implications for children's health and nutritional status (Hadley & Patil, 2008; Tsai, Tomlinson, Comulada, & Rotheram-Borus, 2016).

The direct material support can answer the immediate basic need of vulnerable people, but is not sustainable and the effect can seem to last but a short time. This is especially true if people are not psychologically ready and available to make an effort and to continue to find a way to be economically autonomous. The same situation exists with standalone psychological support projects, where people may not be in condition to work on their inner emotional status as their mind is completely overwhelmed by extremely poor life conditions. More detailed research will be required to better understand the different aspects that impact improvement in wellbeing.

The vouchers permitted this population group to have better access to food and, consequently, to improve the nutritional status of household members. This answering of a basic need helped them to be less stressed by food scarcity and to alleviate the preoccupation of how to provide for the family needs, especially children.

Moreover, we cannot forget the psychological impact of inappropriate nutrition, hunger leads to psychological changes and behaviours that limit people's ability to adapt to their day-to-day life and can have negative impacts on social relationships. It

can also seriously affect relations with communities and neighbours, already impoverished by the external situation, limiting the resilience mechanisms that can come from the collective support.

One key factor of success was the technical approach used, which was adapted to the cultural context. Both individual and group settings were focused on narration, with the possibility for people to share and to put into words their feelings and emotions about traumatic events experienced. Often, a traumatic event is something incomprehensible for those who have experienced it and because it is incomprehensible, it cannot be integrated into their personal history, and thereby remains incomplete, unfinished. A traumatic experience is a profound alteration of temporality, a loss of the ability to assign meaning to things. The narrative can be used to restore meaning where it is so difficult to find sense (Crocq, 1999).

In this way, suffering and traumatic experiences can potentially be attributed to a real dimension through sharing inner feelings and thoughts about something that is incomprehensible. The narrative becomes a possibility to put into words the feeling of hate and anger and the desire for revenge in a secure and protective setting. It is a way to give meaning to the present, to life and to restore confidence to others. This process supports people who have experienced a traumatic event to feel part of the continuity between past and present, and supporting the restoration of hope for the future (Robjant & Fazel, 2010).

By improving access to nutritious food as well as promoting positive and psychosocial support, the project aimed to improve the capacity of the population to face a complex situation and hard life conditions. While the voucher distribution covered the household's basic needs, it was necessary to support this action with a more sustainable, longer lasting intervention in order to strengthen the family resilience, and the psychosocial component did add to

sustainability through the psychological follow-up for those more affected by the traumatic events.

Women were able to regain some degree of hope and to develop coping skills thanks to the individual and group psychological support. They created strong links with other participants, and regained confidence, feeling stronger and more prepared to face the future. The improved psychological well-being of women also contributed to a major impact on improved baby care practices as well. Indeed, the link between psychic availability of the mother, or the effects of maternal depression on risk of undernutrition and infant mortality, is well known (Ruel & Alderman, 2013).

This confirmed the importance of reinforcing wellbeing in women, as they can be considered to be a pillar of the family due to their role of providing family and children's needs.

Finally, while this project took place within an emergency setting, it is possible to imagine a similar approach in other contexts, where food security interventions are paired with actions to improve the psychological wellbeing to promote resilience and economic empowerment, so that this, in turn, can have a positive impact on nutrition security.

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¹ <http://thousanddays.org/the-issue/why-1000-days/>.

² <http://scalingupnutrition.org>.

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