

Learning from the integration of social protection and nutrition in Eastern and Southern Africa

# Addressing Child Poverty, Nutrition, and Protection

through the Nutrition Improvements  
through Cash and Health Education  
(NICHE) programme in Kenya





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# Executive summary

This is one of a series of case studies that aim to provide internal learning for UNICEF on the linkages between social protection and maternal and child nutrition programming. This case study explores how Kenya's Nutrition Improvements through Cash and Health Education (NICHE) programme targets vulnerable households with cash, nutrition counselling and child protection services to address multiple determinants of child undernutrition and vulnerability.

## Kenya's poverty, nutrition and child protection situation

Poverty is highly prevalent in Kenya with 42% of children living in monetary poverty and 53% living in multidimensional poverty. By February 2022, 3.5 million people in the Arid and Semi-Arid Lands (ASAL) were severely food insecure, following dry spells from five consecutive poor seasonal rainfall performances. While levels of stunting and wasting have fallen in recent years, both remain a problem at 26% and 7% respectively. Rates of stunting are very high in counties such as Kitui and West Pokot (46%) and child wasting levels regularly reach 20% in the ASAL counties.

Underlying determinants of child undernutrition in Kenya are poor child diets, inadequate infant and young child feeding practices, lack of responsive care for children, and low access to health and nutrition services. Poverty and gender inequalities are key enabling determinants of child undernutrition that must be addressed together with underlying determinants, including child protection, to ensure holistic child wellbeing.

## Integrated social protection, nutrition and child protection programming in Kenya

In 2016, UNICEF partnered with county governments with funding from the European Union (EU) Supporting Horn of Africa Resilience (SHARE) in Kenya programme, to implement the two-year Nutrition Improvements through Cash and Health Education (NICHE) pilot. NICHE brought together relevant government departments and stakeholders to address multiple vulnerabilities in extremely poor households in Kitui County and parts of Machakos County. Cash top-ups were provided to recipients of the Government's Cash Transfers for Orphans and Vulnerable Children (CT-OVC) programme, alongside nutrition and positive parenting counselling.

A Randomised Control Trial (RCT) showed minimal positive changes in stunting reduction in recipient households, likely due to the short duration of the project and multiple drivers of stunting. However, the programme had a significant positive impact on immediate and underlying determinants of undernutrition, including minimal acceptable diet (+44%), treatment of drinking water (+40%), use of household handwashing facility (+29%), optimal complementary feeding (+11%); early initiation of breastfeeding (+8%); and exclusive breastfeeding (+7%).

Based on these findings, NICHE is being scaled up in five stunting 'hot spot' counties (Kitui, Marsabit, West Pokot, Turkana and Kilifi), led and funded by the Government of Kenya (GoK) with support for the first five years from the World Bank and UK Foreign and Commonwealth Development Office (FCDO) under the Kenya Social and Economic Inclusion Project (KSEIP). In this phase, households registered to receive any government cash transfers with a child under two years or pregnant woman receive a bi-monthly cash top-up alongside routine payments, plus nutrition counselling. Nutrition counselling is delivered by Community Health Volunteers (CHVs) through the Baby Friendly Community Initiative (BFCl) approach – a government initiative that aims to strengthen routine community nutrition services. In Kilifi, NICHE households also receive counselling in positive parenting practices to support child protection outcomes.

By the end of 2021, over 12,000 households had been enrolled in the NICHE programme in fifteen sub-counties, with cash top-up payments starting in July 2021 to cover the period March to April 2021. Training was rolled out to all relevant government staff cadres to support the nutrition and

parenting counselling element, including training for CHVs in wasting screening in response to the current food insecurity crisis.

## Challenges and opportunities

Challenges identified in the first pilot study included difficulties managing programme entry and exit, false reporting of behaviours, CHVs not visiting all households, and false reporting by CHVs. To overcome these in phase two, a stronger system for identifying and enrolling recipients was rolled out, as well as a digital information management system, staff training and operations manuals. A formative evaluation of phase two showed high programme performance on the cash transfer but revealed that the cash transfer value may be too small to significantly impact household behaviours. Evidence also suggested the need for further integration between social protection, health, and nutrition staff at sub-national levels to fully link cash transfers with nutrition counselling and other sectoral services. This is now being acted on.

The first pilot had a strong evaluation component set up as an RCT that provided detailed operational insights, as well as a clear indication of programme impact. A similarly strong evaluation and learning component is included in phase two and regular monitoring has been integrated into the routine management information system.

## Lessons learned

**Strategies to address poverty, undernutrition and child protection can be integrated** and targeted to the same audience to support more effectively holistic child growth, and wellbeing.

**Providing cash alongside nutrition counselling** can ‘nudge’ vulnerable populations towards the adoption of positive nutrition practices and improve access to food and nutrition services.

**Multi-sectoral coordination bodies** at national and devolved levels can help facilitate coordination and integration between health and social protection systems. UNICEF has an important role to play in establishing and facilitating such coordination bodies where they are not already functional.

Aligning integrated social protection and nutrition programmes with the strategies of each sector and ensuring **complementarity between sector policies and strategies** are key enablers of joint programming.

Joint targeting of social protection and nutrition services depends on **strong system linkages at programme-level**. This is greatly facilitated by common digital registration and management information systems.

Programme-level integration between health and social protection can be supported through **comprehensive training of different staff cadres and operational guidance** that details specific roles and responsibilities.

Nutrition-sensitive social assistance programmes are more likely to achieve desired nutrition impact when **cash transfers are of sufficient value and paid on time**. The social protection system may need strengthening to achieve this, including strategies to secure sustainable financing.

**Robust evaluation of pilot projects** will enable the generation of quality evidence that can be used to advocate for support for scale up. Programme design should take donor priorities into account at an early stage.

While the social protection system in Kenya has provision to scale up in response to shocks, the scale of the current food insecurity crisis in the ASAL regions suggests that **further system strengthening is urgently needed to avert future nutrition emergencies**.

# Introduction

This is one of a series of case studies that aim to provide internal learning for UNICEF on the linkages between social protection and maternal and child nutrition programming. This case study explores how Kenya's Nutrition Improvements through Cash and Health Education (NICHE) programme, led and funded by the GoK with support from the World Bank and UK Foreign Commonwealth Development Office (FCDO), targets vulnerable households with cash, nutrition counselling and child protection services to address multiple determinants of child undernutrition and vulnerability.

## 1 Kenya situation

### Development situation



Kenya is one of the fastest growing economies in Sub-Saharan Africa, with an average growth rate of 5.7%.<sup>1</sup> While 2020 saw a sharp drop in growth due to the COVID-19 pandemic and a locust infestation in the north-east, there was significant economic recovery in 2021. Increased spending on health and education in recent years in Kenya has led to reduced child mortality and near universal primary school enrolment. However, poverty remains high with 36% of Kenyans (15.9 million) and 42% of children (8.7 million) living in monetary poverty, and an estimated 53% of children (11.1 million) living in multidimensional poverty (KNBS, 2020). Overall, Kenya ranks 143 out of 189 countries on the Human Development Index (UNDP, 2020).

Populations residing in the Arid and Semi-Arid Lands (ASAL) are particularly vulnerable to poverty and food insecurity following dry spells from four consecutive poor seasonal rainfall performances, below average crop and livestock production, localised conflict, and the secondary impacts of the COVID-19 pandemic and Ukraine conflict. In February 2022, it was estimated that 3.5 million people in the ASAL were in Integrated Phase Classification (IPC) phase 3 (food security crisis) with further deterioration expected (IPC, 2022). Counties in the ASAL also have the lowest rates of Gross Domestic Product (GDP) per capita and highest rates of poverty (KIPPRA, 2020).

<sup>1</sup> <https://data.worldbank.org/country/kenya>

## Nutrition situation

Child undernutrition in Kenya has decreased in recent years. Levels of child stunting fell from 35.2% in 2009 to 26% in 2014 and wasting from 7% in 2009 to 4% in 2015 (KNBS et al, 2015). However, there are regional disparities; 46% of children in Kitui and West Pokot counties are stunted and wasting regularly reaches 20% in the ASAL counties (KNBS et al, 2015). Urban food insecurity and undernutrition are also growing problems due to increasing urban migration, food price spikes and poor living conditions (Lokuruka, 2020).

Underlying determinants of child undernutrition in Kenya are poor child diets, inadequate infant and young child feeding practices, and lack of access to health and nutrition services. Although 99% of children had ever been breastfed in 2014, only 61% of those less than six months were exclusively breastfed, and only 22% of children aged between 6 and 23 months received a minimum acceptable diet (falling to 3% in the highly food insecure North-eastern region) (KNBS et al, 2015).

## Relationship between poverty, gender, child protection and undernutrition

Poverty is an enabling determinant of child undernutrition in Kenya, demonstrated by the fact that 36% of children in the lowest wealth quartiles are stunted compared to 14% in the highest quartiles (KNBS et al, 2015). Poverty is also a result of undernutrition, as child stunting negatively affects cognition, school attainment and later economic productivity (World Bank, 2014). This in turn drives risk of undernutrition in the next generation. Child undernutrition is also linked to maternal attributes, for example 34% of children of mothers who did not complete primary school are stunted compared to 17% of mothers with a secondary or higher education (KNBS et al, 2015).

Violence against children is common in Kenya – a problem with lifelong negative consequences. A 2010 Kenya survey found that 79% of boys and 76% of girls experienced physical, sexual and/or emotional violence before age 18 (UNICEF, 2018). Poverty, gender inequality and gender-based violence are mutually reinforcing and the highest rates of child marriage exist in the most insecure, marginalized, and economically poor counties (UNICEF, 2018). Infants born to mothers under the age of 20 years in Kenya face increased risk of low birth weight and poor growth and nutritional outcomes later in childhood. Responsive caregiving is also linked to improved child growth and development, as highlighted in the Nurturing Care Framework.<sup>2</sup>

Integrated strategies are needed that address the multiple determinants of child undernutrition and vulnerability among Kenya's most vulnerable households to ensure optimal growth, development, and wellbeing.

# 2 Policy, governance, and financing

The second Kenya National Nutrition Action Plan (KNNAP) 2018-2022 (MoH, 2018) operationalizes the National Food and Nutrition Security Policy 2012 and its implementation framework (2017-2022) and provides an umbrella framework for County Nutrition Action Plans (CNAPs). The KNNAP includes social protection as a key strategy for addressing the underlying and enabling determinants of undernutrition. Implementation is overseen by multi-sectoral coordination structures at national and county levels, including the National Food and Nutrition Security Council, Food and Nutrition Security Steering Committees and Secretariats and Food and Nutrition Security Stakeholder Technical Committees.

<sup>2</sup> <https://nurturing-care.org/>

Social protection is guided by the Kenya Social Protection Investment Plan 2018 to 2030 and National Social Protection Policy (2011). The updated policy (2019), currently in draft, emphasizes the potential for social protection to address multiple child vulnerabilities. The Department for Social Protection under the Ministry of Public Service, Gender, Senior Citizens, Affairs and Special Programmes provides the institutional home for social protection, and the National Drought Management Authority (NDMA). The National Social Protection Secretariat (NSPS) currently coordinates social protection, although the 2019 draft policy lays out plans to strengthen coordination structures to improve system coherence.



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The social protection system has shifted in recent years from being primarily donor funded to being owned and almost entirely funded by government. Although actual government spending on social assistance remains low at 0.3% of Gross Domestic Product (GDP), further investments are planned, and a case has recently been made to increase investments to 2% of GDP by 2030 (GoK, 2019). Sustainable financing options will need to be explored to support this ambition (World Bank, 2021).

## 3 Social protection system

Social protection in Kenya is organised under four pillars: income security, social health protection, shock-responsiveness, and complementary programmes.

### Income security

The National Safety Net Programme (NSNP) is the main social assistance programme in Kenya, managed by the Social Assistance Unit of the Ministry of Public Service (Table 1). The NSNP includes an Older Person Cash Transfer (OP-CT) for persons aged 65 to 69 (with planned transition to a universal cash transfer for persons aged 70 and above under Inua Jamii); the Cash Transfer for Orphans and Vulnerable Children (CT-OVC); and the Persons with Severe Disabilities Cash Transfer (PWSD-CT). A Hunger Safety Net Programme (HSNP), implemented by the NDMA is targeted to households in ASAL counties most vulnerable to shock-related food insecurity.

All cash transfer programmes are currently being consolidated under 'Inua Jamii' – a common operational platform and payment mechanism. To support this, a single digital registry – the Enhanced Single Registry (ESR) – is being rolled to provide a single point of registration for all cash transfer programmes. These initiatives signify a great step forward in the integration and strengthening of social assistance in Kenya.

**Table 1: Cash transfers under the Social Assistance Unit**

Name of cash transfer	Recipient criteria	Benefit level	People reached <sup>3</sup>
Older persons cash transfer (OPCT)	Any Kenyan citizen aged 65 to 69	KES 2,000 (USD 18) per month	203, 011 individuals
Inua Jamii Pension scheme	Any Kenyan citizen aged 70 and above	KES 2,000 (USD 18) per month	523,000 individuals
Cash transfers for orphans and vulnerable children (CT-OVC)	Poor households caring for orphans or other vulnerable children	KES 2,000 (USD 18) per month	246,000 households
Persons with severe disability cash transfer (PWSD-CT)	Poor households caring for a child or adult living with a severe disability	KES 2,000 (USD 18) per month	45,505 individuals
Hunger safety net program (HSNP)	Poor households living in areas with high poverty rates and vulnerable to drought (currently targeted to four counties of Northern Kenya with planned expansion into four more counties)	KES 5,400 (USD 48) every two months	100,000 households regular support, scaled up to over 270,000 households in response to shocks (with planned expansion to more households)

<sup>3</sup> <http://www.socialprotection.or.ke>



For formal workers, income security is provided by the National Social Security Fund (NSSF). This is now being extended to informal workers, although overall coverage remains low at around 10% of the working population in 2016 (2.4 million employees) (GoK, 2019).

### **Social health protection**

The National Hospital Insurance Fund (NHIF) is Kenya's main public health insurance scheme. Membership is compulsory for formal workers and is now also being extended to informal workers, Inua Jamii recipients, and pregnant women through delivery of free maternity services. By 2017, 36% of the population (17 million people) were covered by the NHIF (GoK, 2019).

### **Shock responsive social protection**

The HSNP scales up horizontally in response to climatic and covariate shocks across several counties under the KSEIP. A national Drought Emergency Fund with a Catastrophe Deferred Drawdown Option under the NDMA supports the rapid dispersal of funds when emergencies are triggered (GoK 2019; Doyle and Ikutwa, 2021). Given the extent of the current food crisis in ASAL regions, questions need to be asked about the sufficiency of the HSNP as a mechanism for responding to climate-related shocks.

The multi-stakeholder Cash Working Group in Kenya is conducting research to identify the Minimum Expenditure Basket (MEB), i.e., the minimum household transfer value required to cover the shortfall of survival costs according to each phase classification of the IPC.<sup>4</sup> Results will inform advocacy for vertical scale up of cash transfers in food insecure counties according to shock severity. Another consideration is the suitability of cash transfers in situations where markets have failed. In these situations, food transfers, or a blend of cash and food, may be more suitable. Regular market assessments could be used to determine this.

### **Complementary programmes**

The fourth 'complementary programmes' pillar of the Kenyan National Social Protection policy promotes human development and productive capacity through increased access to social services (such as health care, nutrition, and education), strengthened social welfare structures, livelihoods support, and the building of population resilience, mostly at present through externally funded pilot programmes. The main nutrition intervention under this pillar is the NICHE programme (the focus of this document), as well as additional cash transfers for pregnant and lactating women (PLW) in exchange for attendance at health clinics; supplementary feeding for wasted children; expansion of the national school meals programme and home-grown school feeding programmes; and linking households to sustainable livelihoods programming to increase productive capacity and diverse diets. Linkages with other sectors are still in the development stage.

Although excellent progress has been made in expanding social protection programmes in Kenya, still over 90% of children are currently unable to access social assistance (GoK, 2019). As non-contributory social assistance is targeted to those in extreme poverty and contributory social assistance is accessible only by the rich and middle classes, there is a large 'missing middle' unable to access social protection (GoK, 2017). More also needs to be done to use social assistance to build the resilience of populations in Kenya vulnerable to ever increasing climatic shocks.

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4 Integrated Phase Classification. [www.ipcinfo.org](http://www.ipcinfo.org)

## 4 Design of integrated social protection and nutrition programmes

### Nutrition Improvements through Cash and Health Education (NICHE) pilot (2016-2018) – Phase 1

In 2016, UNICEF partnered with county governments with funding from the European Union (EU) Supporting Horn of Africa Resilience (SHARE) in Kenya programme, to implement the Nutrition Improvements through Cash and Health Education (NICHE) pilot. NICHE aimed to bring together relevant government departments and stakeholders to address multiple vulnerabilities in extremely poor households in Kitui County and parts of Machakos County (two counties with very high levels of stunting). By simultaneously providing cash transfers alongside nutrition and parenting counselling, the project aimed to address lack of access to food, services and suboptimal care and feeding practices as key underlying causes of child undernutrition.

The NICHE pilot targeted all households receiving the CT-OVC cash transfer that had either a pregnant woman and/or child under two years of age (3,800 households). In addition to the regular CT-OVC cash transfer, recipients received nutrition counselling, positive parenting counselling (for certain households) and a bi-monthly cash top-up of 500 Ksh per child and/or pregnant woman up to two household members, therefore to a maximum of 1,000 Ksh per household. The cash top up aimed to boost the impact of the CT-OVC in improving access to a diverse diet, while the nutrition and parenting counselling aimed to improve care practices. Nutrition counselling was delivered by trained Ministry of Health (MoH) Community Health Volunteers (CHVs) in all areas through weekly household visits and, in select areas, child protection group sessions were also delivered by Child Protection Volunteers (CPVs).

**Figure 1: Households’ most frequently mentioned words when describing Community Health Volunteer (CHV) visits**



Source: Guyatt et al, 2018

An evaluation set up as a Randomised Control Trial (RCT) measured the impact of the programme compared to control households receiving standard CT-OVC cash transfers only. Results showed minimal positive changes in stunting reduction, likely due to the short duration of the project and the multiple drivers of stunting. However, the programme had a significant positive impact on some immediate and underlying determinants of undernutrition, including minimal acceptable diet (+44%), treatment of drinking water (+40%), use of household handwashing facility (+29%), optimal complementary feeding (+11%); early initiation of breastfeeding (+8%); and exclusive breastfeeding (+7%) (Guyatt et al, 2018).

Qualitative data revealed that counselling sessions were relevant to participants, and that learning translated into changes in IYCF and livelihoods behaviours, especially the planting of kitchen gardens and purchasing of small livestock. Reported problems included difficulties accessing cash through banks, cash transfer values being too low to make desired changes, and communication difficulties with programme implementers and CHVs when problems arose (Guyatt et al, 2018).

### **Expanded NICHE (2019 – 2024) - Phase 2**

Based on findings from the initial pilot, the GoK has now scaled up NICHE in five stunting 'hot spot' counties (Kitui, Marsabit, West Pokot, Turkana and Kilifi). This phase is being implemented and funded by the GoK, with support from the World Bank and FCDO under the KSEIP for the first five years. UNICEF and partners are providing technical support for the first three years, with a view to full government ownership and implementation from year four onwards.

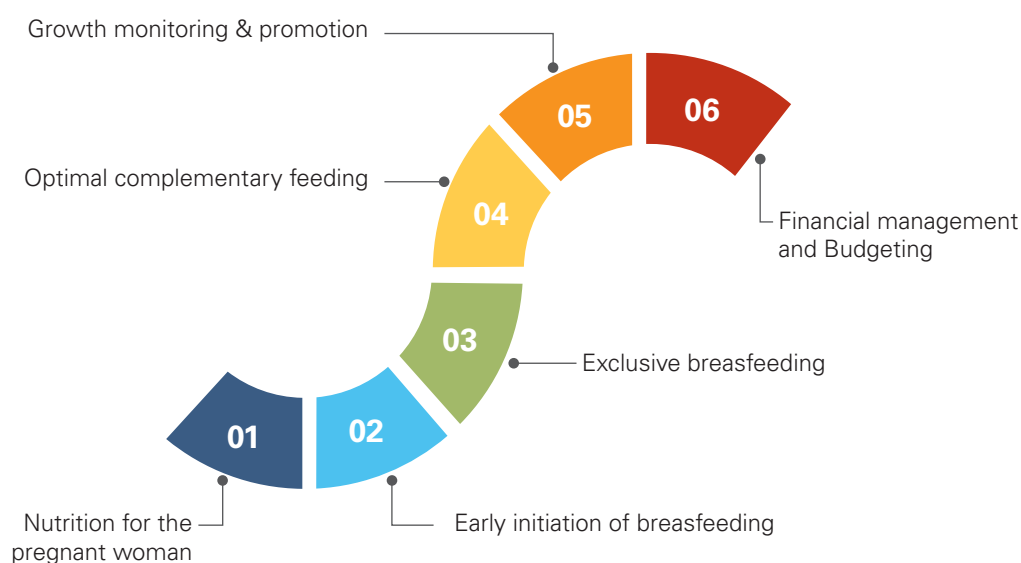
In this phase, households registered to receive any government cash transfer (NSNP and HSNP) that have either a child under two years of age and/or a pregnant woman are targeted with a bi-monthly cash top-up of up to 500Ksh per beneficiary up to two beneficiaries (maximum 1,000 Ksh). Cash top ups are provided alongside routine payments, plus nutrition counselling (Figure 2). Eligible households are identified using NSNP and HSNP recipient lists and validated through a process of community identification with continuous/ on-demand registration. A digital management information system (MIS) was developed within the existing information system for the NSNP and HSNP (CCTP MIS) to support registration, results tracking and reporting on performance indicators. The NICHE MIS is also interoperable with the Kenya Health Information System (KHIS).

Nutrition counselling is delivered through the Baby Friendly Community Initiative (BFCl) approach – an MoH initiative that aims to strengthen routine community nutrition services. CHVs deliver counselling during home visits every two weeks supported by Community Health Extension Workers (CHEWs), and mothers also participate in community mother support groups. A Social Behaviour Change Communication (SBCC) strategy and materials have been developed to support these activities.

In Kilifi, NICHE households are also receiving counselling in positive parenting practices to support child protection outcomes to pilot this approach, with a view to expanding to all other participating counties. Here, Child Protection Volunteers (CPVs) and Lay Volunteer Counsellors (LVCs) facilitate group parenting sessions for vulnerable households and households providing alternative family-based care. CHVs are also oriented on positive parenting and other child protection components, so that these elements are integrated with nutrition counselling messages. A national parenting manual is currently under development to support these sessions.

By the end of 2021, over 12,000 households had been enrolled in the NICHE programme in fifteen sub-counties, with cash top-up payments starting in July 2021 to cover the period March to April 2021. Training has been rolled out to CHEWs and CHVs who are now implementing the counselling component. In response to the current food insecurity crisis in programme areas, CHVs have also been trained to provide Minimum Upper Arm Circumference (MUAC) screening for the early detection and referral of wasted children. Although this was not in the original design of the programme, this has been a necessary adaptation in response to the current crisis.

**Figure 2: Nutrition counselling topics in NICHE**



## 5 Implementation, workforce, and delivery mechanisms to support nutrition-sensitive social protection

Several implementation challenges were identified in the evaluation of the NICHE pilot (2016-2018). These included difficulties managing programme entry and exit for recipients given the transient nature of the target period (pregnancy up to the child’s second birthday); false reporting of behaviours; CHVs not initially visiting all households (improved through closer management); falsification of household reports by CHVs; and out of date government information leading to difficulties identifying eligible households.

Design changes were made to the second phase to overcome these challenges. An improved system for identifying and enrolling recipients is being used (Figure 2), supported by the new digital information management system, to enable swift programme entry and exit. An operations manual has been developed for programme staff to support standardised as well as enhanced implementation. This also builds the capacity of government field personnel to sustain implementation in the absence of UNICEF’s technical assistance. The capacity of the Government’s health workforce has also been built by training CHEWs as trainers who then cascade training to all CHVs in the area. To support implementation of the child protection element, Child Protection Volunteers (under the Directorate of Children’s Services) and Lay Volunteer Counsellors (under the Directorate of Social Development) are being trained to provide group parenting sessions.

A formative evaluation of phase two showed high programme performance on the cash transfer side with funds being transferred regularly and on time. However, there is evidence that the cash transfer value is too small to impact household behaviours. Evidence also suggested the need for further integration between social protection, health, and nutrition staff at sub-national levels to fully link cash transfers with nutrition counselling and other sectoral services. This is now being actioned.

Through NICHE, stakeholders from multiple sectors have been brought together around a common programme, coordinated at national and county levels by the Department of Children Services in liaison with the Ministry of Health. Political will for joint working was secured through the alignment

of NICHE with the strategic plans of both the social protection and nutrition sectors. A Memorandum of Understanding (MoU) between the Ministry of Public Services and MoH was instrumental in articulating joint responsibilities and enabling the flow of inter-ministerial funding.

## 6 Monitoring, evaluation, and learning of nutrition-sensitive social protection

The first pilot had a strong evaluation component set up as an RCT. This provided detailed operational insights, as well as a clear indication of programme impact. This evidence was critical in advocating for Government endorsement and partner funding for further scale up. Regular monitoring of phase two has been integrated into the MIS and Health Information Management System. A strong evaluation and learning component will generate evidence to inform full integration of NICHE into the routine system following this phase. This includes an endline impact evaluation currently being planned to measure impact along the theory of change, including changes in nutrition practices, health seeking behaviour and household spending on food. A cost-effectiveness study will also be carried out to assess the cost-benefit of the NICHE programme, as well as of the technical assistance provided by UNICEF. Integration into the national NSPS and scale up by government will depend on these results.

## 7 Overall lessons learned

**Strategies to address poverty, undernutrition and child protection can be integrated** and targeted to the same audience to support more effectively holistic child growth, and wellbeing.

**Providing cash alongside nutrition counselling** can 'nudge' vulnerable populations towards the adoption of positive nutrition practices and improve access to food and nutrition services.

**Multi-sectoral coordination bodies** at national and devolved levels can help facilitate coordination and integration between health and social protection systems. UNICEF has an important role to play in establishing and facilitating such coordination bodies where they are not already functional.

Aligning integrated social protection and nutrition programmes with the strategies of each sector and ensuring **complementarity between sector policies and strategies** are key enablers of joint programming.

Joint targeting of social protection and nutrition services depends on **strong system linkages at programme-level**. This is greatly facilitated by common digital registration and management information systems.

Programme-level integration between health and social protection can be supported through **comprehensive training of different staff cadres and operational guidance** that details specific roles and responsibilities.

Nutrition-sensitive social assistance programmes are more likely to achieve desired nutrition impact when **cash transfers are of sufficient value and paid on time**. The social protection system may need strengthening to achieve this, including strategies to secure sustainable financing.

**Robust evaluation of pilot projects** will enable the generation of quality evidence that can be used to advocate for support for scale up. Programme design should take donor priorities into account at an early stage.

While the social protection system in Kenya has provision to scale up in response to shocks, the scale of the current food insecurity crisis in the ASAL regions suggests that **further system strengthening is urgently needed to avert future nutrition emergencies.**

## 8 Future opportunities

Opportunities that could be explored for future action are:

- The social protection and nutrition sectors coming together with aligned objectives to advocate for increased coverage and adequacy of social protection.
- Streamlining the coordination and oversight of social protection programmes in Kenya and securing engagement from multiple sectors to ensure that the multiple needs of households are considered.
- Integration of NICHE model into all social protection programming.
- Evaluation of current shock responsive mechanisms within the social protection system in the light of the current food insecurity crisis in the ASAL regions to inform system strengthening.
- Integration of a nutrition component within the HSNP to maximize impact during the lean season and in response to shocks.
- Learning from the current food insecurity crisis to permanently build shock response mechanisms within the NICHE programme, such as MUAC screening and referral by CHVs and scale up vertical and horizontal support in response to crises.
- Further advocacy to increase cash transfer values within the NSNP for example by making the CT-OVC and PWSD-CT individual entitlements so that those with multiple children receive a greater benefit and tying cash transfer values to inflation.
- Further advocacy to scale the HSNP vertically as well as horizontally, by increasing the cash transfer value according to the level of crisis and/or using food assistance when markets are unavailable, to provide more comprehensive shock response.
- Exploring further linkages between the NSNP and HSNP with livelihoods programmes to support diet diversity.
- Further roll out of the child protection element of NICHE based on evaluation findings to support holistic child wellbeing.

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