Using cash and voucher assistance for nutrition outcomes

Webinar

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Global NUTRITION CLUSTER

NORCAP NORWEGIAN CAPACITY | CASHCAP

CVA for nutrition outcomes

- Objectives
- CVA terminology
- Frameworks
- CVA components in a nutrition response
- Additional considerations
- GNC’s engagement and next steps

CVA terminology

Ways to transfer humanitarian assistance

In-kind

Cash

Vouchers

Services

Choice of one or a combination

CVA terminology

SECTOR SPECIFIC

BASIC NEEDS

MULTIPURPOSE CASH TRANSFER

DESIGN

What the interventions aim to achieve (objectives), and/or how they are designed

UNCONDITIONAL

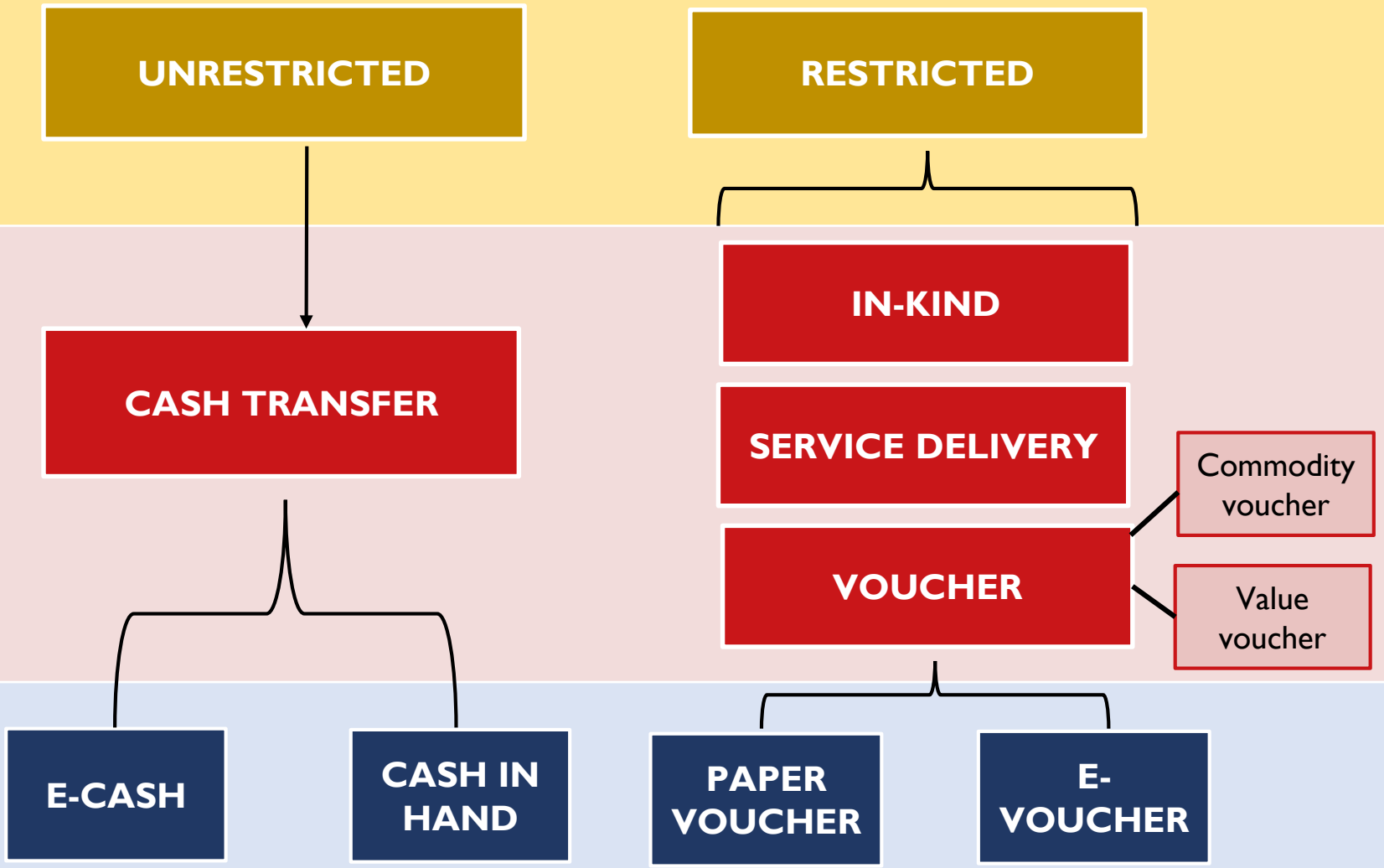
CONDITIONAL

E.g. Cash for Work, conditional tranches

QUALIFYING

Activities or obligations that must be fulfilled ***in order to receive*** assistance

CVA terminology



UTILIZATION

Limitations, if any, on use of assistance received. What a transfer can be spent on ***after*** the recipient receives it

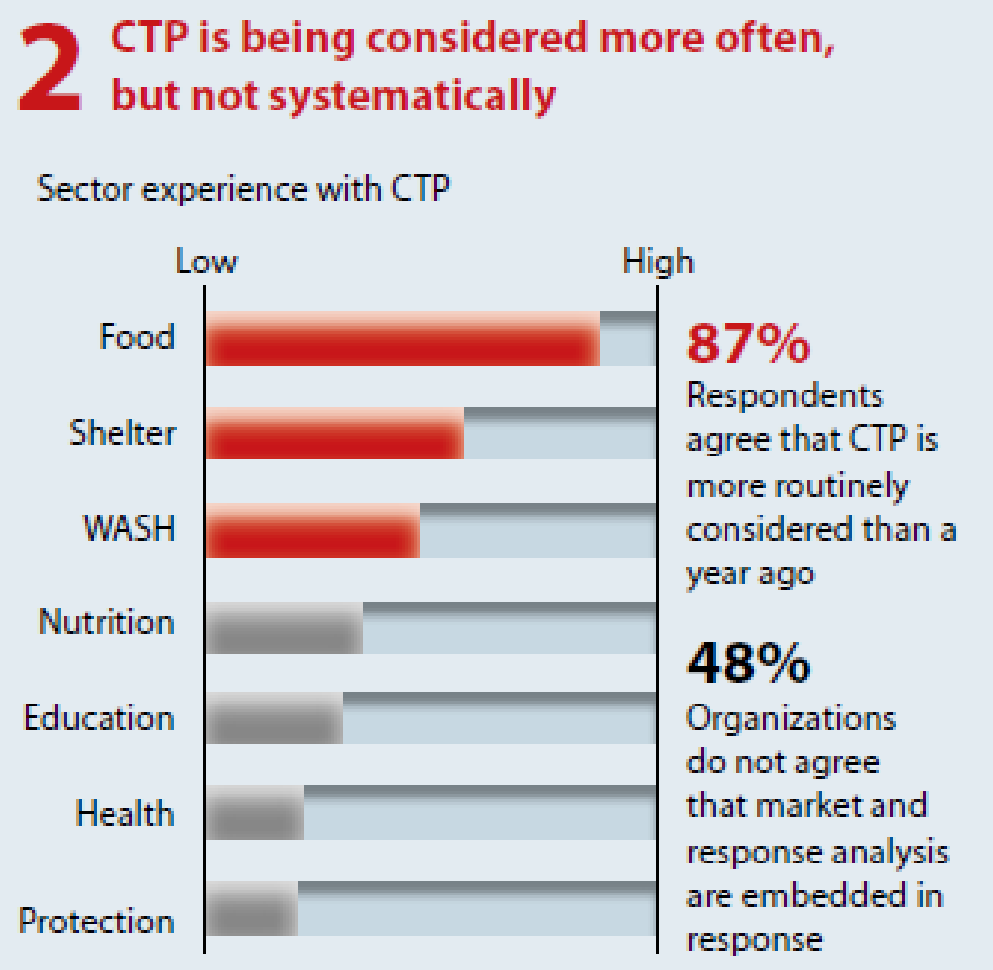
MODALITY

The form of assistance provided to recipients

DELIVERY MECHANISM

The means of delivering a transfer

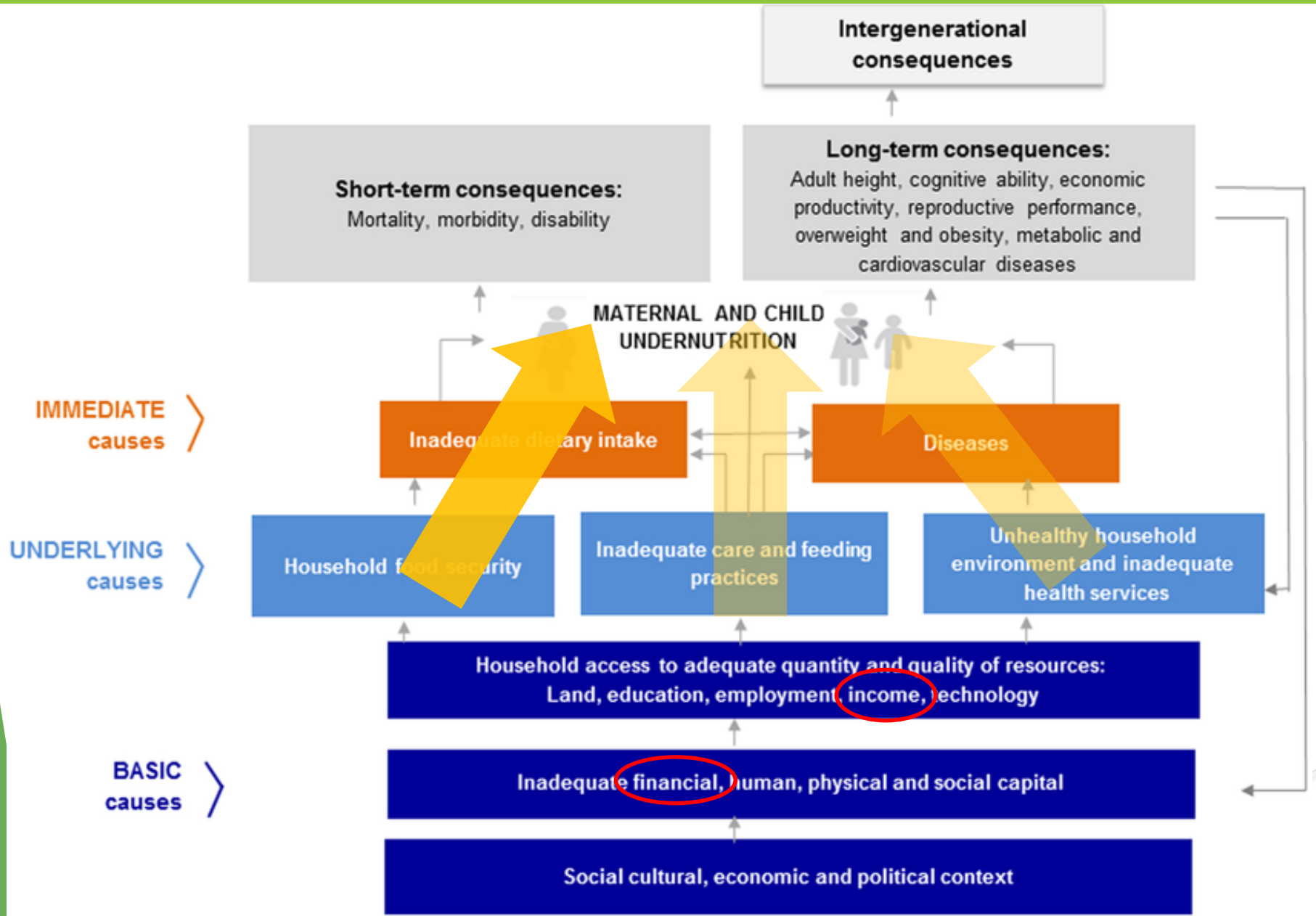
Barriers to using CVA in nutrition



- Lack of knowledge on CVA and experience with CVA
- Limited evidence base for CVA in nut in emergency
- Limited learning from practice
- Feeling of cash as threat
- Result: relatively few practical experiences

State of the World Cash Report (2018)

CVA and nutrition outcomes



Cash temporarily addresses lack of income / lack of financial capital

Demand and supply side barriers to nutrition security

- Nutritious food not affordable
- Markets physically not accessible (cost of transport)
- Insufficient awareness regarding the importance and preparation of nutritious diet
- Inadequate storage and preparation
- Food inadequately shared within HH, not child centered

- Inadequate care and feeding pract.
- Lack of time for care taking (economic pressure)
- Inadequate physical and mental well-being of care taker

- Inadequate health seeking behavior
- malnutrition not perceived as disease
- Health services not affordable (incl staying with sick child)
- Health services physically not accessible (incl cost of transport)

- Inadequate hygiene practices
- Safe water not affordable

Food security barriers

- Insufficient food production and importation
- Insufficient availability of nutritious food in local markets
- Insufficient quality of food
- Food prices instability
- Inadequate storage of fresh foods

Barriers to adequate care

- Lack of services and support for adequate care (IYCF)

Health related barriers

- Health services not available
- Health service not of sufficient quality
- Unavailability of therapeutic foods, medication or vaccination
- Unfavorable disease environment

WASH related barriers

- Inadequate availability and quality of water
- Inadequate water and sanitation infrastructure

Economic barriers to nutrition security

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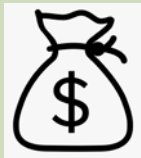
CVA components in a nutrition response

Prevention

Prevention of micro-nut. deficiencies

Blanked suppl. feeding

HH basic needs assistance: cash, voucher, in-kind



IYCF
SBCC
Nut education

Nut sensitive cash

Other health services: vacc., deworming, pre-post-natal care

Treatment

Targeted suppl. feeding

Therapeutic care

Treatment of micro-nut def. disease

Health services

CVA basic needs assistance

- UCT (MPC) and/or vouchers (based on food needs)
- Can contribute to nut outcomes or improve effectiveness of other nut-specific interventions for prevention & treatment
- Cash usually not enough to improve nut status
- Examples: Niger (Fenn et al.), Somalia (Jelle et al.)
- Make basic needs cash (MPC) more nutrition sensitive
  - When?
  - Pair with SBC / nutrition education
  - Include 'nutrition' in targeting criteria (1000 days)
  - MEB and amount calculation
  - Objectives: FS indicators, access to health services, WDDS, MDDS (children 6-23 m), etc.

Prevention: Cash combined with SBC for nutrition

- Cash and SBC can reinforce each other:
  - Cash allows people to act upon what they learn
  - SBC can nudge people towards improved nutrition and child-centred decision making (IYCF, HH nutrition, WASH practices, etc.)
- But people know best what they need, no?
- Provide incentive for participation in education activities (if conditional)
- How best to design SBC (methods, scope) in emergency setting?
- Evidence and examples: Bangladesh (Ahmed et al.), Yemen (IFPRI), Nigeria (OPM), Pakistan (Fenn et al.), Niger (Bliss et al.)

Prevention of malnutrition

- CVA can complement preventative in-kind interventions
- Can CVA replace BSF or micro-nutrient def prevention in some contexts?
- CVA can remove access barriers to health services
- Conditional CVA can provide incentive to seek health service / participate in activity
- Need to understand food markets and health systems: market assessment, Cost of the Diet, HeRAMS
- CVA objectives: access, opportunity costs, locally available fresh and fortified foods, dietary diversity (PLW, child)
- Evidence and examples: Niger (Sibson et al.), Niger (Langendorf et al.)

Treatment of malnutrition

- Involves interaction with health facility
- HH CVA can complement treatment response
- CVA can compensate for transport and other cost
- CVA objective of cash: access, opportunity cost, in-patient costs, attendance (if cond.), faster recovery, reduced relapse, reduced non-response to treatment, etc.
- Targeting and perverse incentives
- Evidence and examples: DRC (Grellety et al.), Somalia (ICRC)

Additional considerations

- Role of conditionality (soft vs hard)
- Amount – size matters
- Timing and duration matters
- Positive effect of cash does not extend beyond intervention
- Who receives the transfer matters
- Cost-efficiency and cost-effectiveness considerations
- Linkages to social protection
- Role of supply-side interventions

GNC's involvement

- Review evidence and practice ongoing
- Interview with key informants ongoing
- Reference Group formed
- Next steps (until Aug 2020):
  - Guidance outline and drafting
  - Case study documentation (case studies to be selected)
  - Finalize and launching of guidance note
  - Some technical support (if feasible)
  - Capacity building (to be determined)

Challenges

- What is the current practice? Exapmles of nutrition projects with a CVA component → please share!!!

country	Org	Timeframe	Objective	Target group	HH assistance	Component A	Component B	Cond	Documentation obtained
Somalia	WFP		diatary diversity of PLW: improve access to vegetables and fresh food	PLW	In-kind food ration	vouchers or cash		Conditional on mother child health nutrition session attendance	
Somalia	WVI								
Somalia	ICRC		payments connected to SAM treatment						
Syria	WFP	2015, ongoing	Dietary diversity of PLW: improve access to vegetables and fresh food	PLW	In-kind food ration	e value voucher		none	implementation guidelines
Nigeria	WFP		multi-sector malnutrition prevention project (MSP)						
Nigeria	ACF		Cash top up for fresh foods plus fire wood plus BCC						
Nigeria	WFP								
Nigeria	ACF								
Kenya	UNHCR		cash for nutrition project for scurvy in Kakuma						
Ethiopia	UNHCR / WFP		small cash response in Gambella that uses e-vouchers for beneficiaries to access fresh food						
South Sudan	WVI								Documented case study
Bangladesh	WVI								Documented case study
Bangladesh	WFP, Unicef,		nutrition cash, CfW						
Egypt	WFP		Loyality system: reduces price on nutritious foods						
Several	several		Cash provided at health centres to cover transportation and other costs						

Key resources

- Innocenti paper (2015)
- REFANI literature review (2015)
- REFANI synthesis report (2017)
- ODI – what does the evidence say (2016)
- R4ACT – full final report (2018)