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**Case study: Documentation of experiences using cash and voucher assistance (CVA) for nutrition outcomes in Somali**

July 2020

Prepared by: Andre Duerr, Cash Advisor to the Global Nutrition Cluster (CashCap)

With the support of: Noanne Laida, Cash Advisor to UNICEF-led cluster in Somalia,

and Naema Hirad, Deputy Nutrition Cluster Coordinator Somalia

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# Introduction

*Background*

The Global Nutrition Cluster is in the process of developing an evidence and guidance note on the use of cash and voucher assistance (CVA) for nutrition outcomes. As part of this guidance note, the operational experience and learning of humanitarian actors on this topic should be reflected and included. For this reason, the GNC plans to conduct up to three case studies. The findings of the case studies will be directly integrated into the guidance note on the use of CVA for nutrition outcomes.

Food security and nutrition needs in Somalia remain high. According to the 2019 Gu results, GAM is 13.8 per cent with some areas having GAM rates over 20 per cent (over the WHO emergency threshold of 15 per cent). It is estimated that 1.3 million boys and girls and pregnant and lactating women (1.008 million boys and girls) will suffer from acute malnutrition in 2020, with 178,000 children under 5 affected by life-threatening severe malnutrition, with 830,000 moderately malnourished and 270,000 pregnant and lactating women also requiring emergency nutrition services (HRP Somalia, 2020) . GAM is higher than the 15 per cent emergency threshold in 10 out of 33 areas, with the majority (51.7 per cent) of malnourished children concentrated in six regions, as well as in areas hosting IDPs. The ongoing COVID-19 pandemic as well as flooding across regions and desert locust will further aggravate malnutrition in Somalia. At the same time, lack of access to clean water in many areas has heightened the risk of outbreaks of water-borne diseases, augmenting existing vulnerabilities.

According to the 2020 HRP, the Nutrition Cluster will focus the response on the prevention of malnutrition through the provision of specialized nutrient-dense supplementary feeding programs (BSFP and MCHN) and the promotion of optimal infant and young child feeding. Partners are providing childcare counselling for mothers, especially regarding micronutrient deficiency control for both themselves and their children. Through preventive supplementary feeding programmes the nutrition cluster is targeting 617,482 people, 334,911 children under two and 282,571 PLWs are planned to be reached in areas with GAM rate higher than 15 per cent accounting for 58 out of 74 districts.

The Nutrition Cluster Coordination Team and partners in Somalia has expressed interest to accommodate one of the case studies on the use of CVA for nutrition outcomes[[1]](#footnote-1). There is a strong interest to better explore the potential of CVA modalities in preventative and curative strategies in the context of Somalia.

The *objectives* of the case study include the following:

* Review existing and planned nutrition interventions which have a CVA component, including response analysis / decision-making, objectives, design, risk management, MEAL, etc.
* Review tools used as part of these interventions
* Review the nutrition-sensitivity of the MEB and existing multi-purpose cash interventions
* Document how CVA is being integrated into nutrition responses
* Document and review the role of the Nutrition Cluster Coordination team in CVA
* If possible, identify opportunities to improve and/or expand the use of CVA for nutrition outcomes
* Facilitate exchange of experiences between partners
* Generate lessons learned and best practice

*Methodology*

The case study is based on key informant interviews with partners (Nutrition Cluster, UNICEF, WFP, FAO, ICRC, BRCiS, WVI) and a desk-based project documentation review. The GNC cash advisor was meant to visit Somalia/Kenya, in April to conduct interviews with partners, review projects and facilitate a learning workshop. Unfortunately, the visit had to be cancelled due to travel restrictions related to the ongoing pandemic. Consequently, key informant interviews with key partners were conducted remotely.

Table 1 provides an overview on ‘nutrition projects’ with a CVA component that were reviewed as part of this case study.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Org.** | **Duration** | **Location** | **Project** | **Documents reviewed** |
| BRCiS consortium | 2019-2021 | 16 districts | Shock-responsive safety net pilot, | Concept note, Minimum package for health and nutrition, nutrition lens guide |
| FAO | 2019-2020 | Several regions | Improving and sustaining food security in rural Somalia | FFP project proposal |
| ICRC | 2015-2018 | Baidao and Kismayo | Cash transfers to caregivers of SAM children | Study design |
| ICRC | 2017-2018 | Kismayo | Commodity vouchers plus SC to prevent MN | ICRC learning document |
| UNICEF | 2019-2020 | *Bakool region* | Safety net cash programme | Concept note |
| WFP | 2016-ongoing | Several regions | e-vegetable programme (with fresh food vouchers) | Concept note |

Table 1. Overview on reviewed projects and documentation

In addition, three peer-reviewed studies on CVA and nutrition Somalia were identified Somalia and are included in this case study (see table 2 below).

|  |  |  |
| --- | --- | --- |
| **Research inst. and publication year** | **Humanitarian partner** | **Study name** |
| University College London, 2018 (Grijalva-Eternod et al.) | Concern International | A cash-based intervention and the risk of acute malnutrition in children aged 6–59 months living in internally displaced persons camps in Mogadishu, Somalia: A non-randomised cluster trial |
| John Hopkins, 2020 (Doocy et al.) | World Vision International | Cash and voucher assistance and children's nutrition status in Somalia |
| University College London, 2020 | Concern International | Cash for improved nutrition in Somalia (CINS) –unpublished |

Table 2. Peer reviewed studies on CVA and nutrition in Somalia

*Structure*

Chapter 2 of the case study looks at the role of CVA in nutrition programming. It draws heavily from the draft ‘evidence and guidance note on the use of CVA for nutrition outcomes’. Chapter 3 reviews past and ongoing nutrition interventions with a CVA component in Somalia with a particular focus on design, results and learning. It further incorporates results and learning from peer-reviewed studies conducted in Somalia. Chapter 4 looks at the broader CVA response in Somalia and reviews the nutrition sensitivity of household cash transfers. Chapter 5 looks at the recently Cost of the Diet analysis and discusses measures to make a nutritious diet[[2]](#footnote-2) more affordable. Chapters 6 and 7 conclude the case study and provides some recommendations for actions next steps.

# The role of CVA in nutrition programming

In principle, CVA programmes can impact the *underlying determinants* of maternal and child nutrition in three different ways:

1. It allows households or individuals to purchase goods and access services that can have a positive impact on maternal and child nutrition. These include nutritious foods, items to prepare food, hygiene and sanitation, safe water, health services and medication, transportation, and productive inputs.
2. If provided conditionality, CVA can promote participation in nutrition social and behavioural change communication (SBC) activities[[3]](#footnote-3) and attendance to priority health services[[4]](#footnote-4).
3. The temporary increase in household purchasing power can have additional positive and sometimes negative consequences which can impact child and maternal nutrition: Reduced or increased household tensions, reduced economic pressure within households which can increase time available for caregiving, improved decision-making power of women, improved psychological well-being of caregivers, etc.

CVA can by no means address all barriers to adequate food, feeding and healthy environment. CVA is suited to address economic demand side barriers to adequate nutrition and relies upon functioning and accessible systems (e.g. food markets or health services) on the supply side to be effective (see Annex 1 for an overview on demand and supply side barriers to adequate nutrition).

The evidence base for CVA to address the underlying and immediate determinants for adequate nutrition and to improve nutrition status of children and women is summarized in Annex 2. Based on the expanding evidence base, there is today a broad consensus within the nutrition sector that:

* CVA alone is in most circumstances not sufficient to impact nutrition outcomes
* CVA is most effective when complemented or integrated with other nutrition-specific and nutrition-sensitive interventions

Table 2 below provides and overview on the different components of a nutrition response at household or individual level, the traditional response modalities used and the potential for CVA to replace or complement the traditional response modality. It is important to note that the interventions described in the table and the respective modalities can be combined in multiple ways. SBC promoting maternal, infant and young child nutrition is a cross-cutting intervention that can be integrated with any of the above response options.

|  |  |  |  |
| --- | --- | --- | --- |
| **Components of nutrition response** | **Traditional response modality** | **Potential role of CVA** | **Primary objective of CVA**[[5]](#footnote-5) |
| ***Nutrition sensitive response options*** | | | |
| Household assistance  *Can complement any nutrition-specific response option* | In-kind general food distribution (GFD)  Non-food item distribution (NFI) | **Replace** in-kind assistance through household CVA | * Improve household food security and dietary diversity * Protect nutritional status * If paired with individual feeding: Reduce sharing of SNF * If paired with treatment: Reduce defaulting, non-response to treatment and relapse. |
| Livelihood support | Cash grants or  in-kind livelihood inputs (seeds, tools, etc.) | Cash grants and vouchers for productive inputs commonly used in livelihood support interventions | * Enhance food production and/or income generation at community or household level |
| ***Nutrition-specific response options aimed at preventing malnutrition*** | | | |
| IYCF through social and behavioural change interventions | Communication and counselling services | CVA can be provided **conditional** on participation in SBC activities  CVA can allow recipients to put learning from SBC regarding nutritious diets and complementary feeding into practice | * Incentivize participation in SBC activities * Allow for healthy food purchase and preparation * Stimulate demand for nutritious diet |
| Blanket supplementary feeding (BSF) | SNF: LNS-MQ; fortified blended foods | **Replace** in-kind SNF through:   * Cash top-up * Vouchers for locally available fresh and fortified foods   Amount/value based on the nutrient requirements of at-risk groups | * To prevent deterioration in the nutritional status of at-risk groups. * To reduce the prevalence of MAM in children under five thereby reducing the mortality and morbidity risk. * Support dietary diversification |
| Complementary feeding assistance | SNF targeting children 6-23 months:  fortified blended foods | **Replace** in-kind SNF through   * Cash top-up * Vouchers for locally available fresh and fortified foods   Amount/value based on the nutrient requirements of children 6-23 months | * children between 6-23 months receive sufficient macro and micro-nutrients for their growth and development |
| Prevention of micro-nutrient deficiencies | Variety of options, including SNF: micronut powder; LNS-LQ/MQ; FBF | **Complement** nutrition supplements through household CVA | * See household assistance |
| Provision of breast milk substitutes (BMS) | Provision of in-kind BMS | **Replace** in-kind BMS with commodity voucher to access code compliant BMS | * Ensure adequate nutrition for infant |
| Provision of priority health services | Health service provision: vaccination, deworming, pre- post-natal care, growth monitoring, etc. | **Complement**: CVA to cover direct and indirect costs of accessing priority health services  *CVA can be* ***conditional*** *on attendance to priority health services* | * Promote attendance to priority health services by covering direct and indict costs * Reduce opportunity costs |
| ***Nutrition-specific response options aimed at treating malnutrition*** | | | |
| Targeted supple-mentary feeding (MAM treatment) | * Health service (routine treatment) * SNF: FBF, RUSF | **Complement**:   * CVA to cover direct and indirect costs for health services * Household CVA | * Facilitate access to health services * Cover direct costs for health services * Cover transportation costs * In-patient care: cover food and accommodation costs of caregivers * Reduce opportunity costs |
| Therapeutic care (SAM treatment) | * Treatment of SAM * SNF: RUTF |
| Treatment of micro-nutrient deficiency disease | * Health service * Oral supplement tablet or capsule |

Table 2. The role of CVA in different nutrition response options (GNC, 2020)

# The use of CVA in the nutrition response in Somalia

Different partners have in the past years used cash and voucher assistance, as part of their nutrition response to prevent and treat malnutrition and the number of projects seems to be increasing. The projects reviewed as part of the case study (see project list in chapter 1) can be broadly categorized as follows: pairing CVA (at household or individual level) with nutrition social and behavioural change (SBC), pairing household assistance[[6]](#footnote-6) with individual feeding assistance[[7]](#footnote-7), and providing cash transfers in combination with SAM treatment.

## Pairing household cash transfer with SBC (and other measures)

There is relatively strong peer-reviewed and operational evidence from humanitarian and development settings that pairing household cash transfers with SBC can be an effective strategy to improve nutrition outcomes of children. The two components seem to mutually reinforce each other in the sense that the SBC component seems to promote nutrition-sensitive and child/women-centred spending decisions while the cash transfer allows caregivers to put some of the acquired knowledge and skills into practice.

Most reviewed projects in the context of Somalia included an SBC component. FAO in Somalia is implementing a programme that combines a monthly household cash transfer over 3-6 months with nutrition SBC activities. The programme further provides a livelihood support package tailored to livelihood group, technical training on different livelihood activity and technical training, aiming to restore the food production of shock-affected vulnerable communities. SBC activities aim to improve food choices and utilization and include nutrition and food safety messages and cooking demonstrations. They are implemented through community nutrition champions who were previously trained. The SBC trainings and activities focus on the different nutrition needs of people throughout the life cycle (i.e. from infancy to old age), with an emphasis on women and children.

The CINS research (UCL and Concern, 2020) piloted an SBC intervention that was delivered through weekly voice message (mHealth). These messages were sent directly to caregivers’ cell phones and covered the following topics: vaccinations, IYCF, WASH, health seeking, prevention, recognition and treatment of acute malnutrition, and maximizing health and nutrition for all household members. The mHealth intervention did not have any measurable impact on knowledge of health and nutrition topics among mothers/caregivers of children aged <5 years. It did however lead to an increase in household expenditure on food and an improvement in the child dietary diversity score, as well as significantly reducing the risk of mortality in children aged <5 years.

## Pairing household assistance with individual feeding assistance

A common preventative strategy utilized in various contexts is to combine household assistance (in-kind food, cash or voucher) with individual feeding assistance (usually provided through specialized nutritious foods) targeting at risk groups within households. CVA modalities can in principle be used for both components. Individual feeding assistance through CVA can be provided through cash top-ups or vouchers for fresh food or locally available fortified food corresponding to the macro- and micro-nutrient value of the supplementary food ration.

WFP started to use fresh food vouchers (FFV) to assist pregnant and lactating women in 2016. FFV (e-vegetables) are provided together with specialized nutrition products (Plumpy doz for children under two and super cereal plus for PLW) during pregnancy and until 6 months after the delivery. They aim to diversity diets and behaviour change. Voucher assistance is conditional on the attendance to Mother and Child Health and Nutrition centres, where women receive preventative health services (including ANC, PNC, growth monitoring and immunization) alongside SBC activities on health, nutrition and dietary diversity. Project monitoring from November 2019 shows that 23.7 percent of children 6-23 months consumed minimum acceptable diet compared to the national MAD rate of 9 percent. The results also revealed that 68% of women met the minimum dietary diversity (MDD-W) threshold of having consumed more than 5 food groups out of 10 in the past 24 hours.

To prevent further deterioration in the nutrition situation and reduce malnutrition prevalence (2017-2018), the ICRC designed a two-phase intervention using an unconditional cash transfers, food vouchers and SNF. Eligible households received an unconditional cash transfer plus BP5 in a first round and commodity food vouchers plus Supercereal (SC) in a second and third round. Monitoring results showed an important improvement of the GAM and particularly SAM rate among assisted households. The approach of combining commodity food vouchers with SC was later replicated in other regions, with similar positive results.

A study conducted by Doocy et al. (2020a/b) in close collaboration with World Vision International examined the impact of CVA on the prevention of child and maternal acute malnutrition in 2017/2018 in the context of the Somalia food crisis. Changes in diet and acute malnutrition were measured over a 4-month period among children age 6–59 months and pregnant and lactating women from households receiving monthly household assistance of approximately US$450 (cumulative value) delivered either as food vouchers or a mix of in-kind food, vouchers, and cash. Overall, the study found that household food security was similar for both intervention groups at endline and that the two interventions had similar preventative effects on child nutrition status. Considering the general preference of cash transfers among beneficiaries and the lower implementation costs of cash transfers, the authors argue that an expanded use of cash should be considered.

## Provide general household CVA to caregivers who access SAM treatment

Research from the DRC (Grellety et al., 2017) has demonstrated that household CVA provided as part of SAM treatment can improve treatment outcomes by improving weight gain and recovery and reducing the likelihood of defaulting. At the same time, providing household CVA to parents who bring their malnourished children for treatment at stabilization centres is a controversial approach among humanitarian practitioners and nutritionists, as cash transfers tied to the nutrition status of children can provide the perverse incentive to caregivers to make or keep their children (or at least one of them) undernourished.

From 2015 to 2018, the ICRC provided unconditional cash transfers to caregivers whose children were treated for SAM in stabilisation centres (in-patient) in Baidao and Kismayo. The objective of the cash transfer was to cover transportation costs, stabilize household food security following discharge and prevent relapse of children into SAM. Caregivers did not get assisted if they quit the stabilisation centre before the treatment was finalized or if they returned for treatment. They were eligible to three cash payments of USD 100 each commencing once the child has completed treatment and had been formerly discharged. To what extent the programme was able to achieve its objective is not clear. A planned study to review the outcomes and the concerns around perverse incentives was cancelled for security reasons and the cash transfer component was subsequently stopped in July 2018.

UNICEF adopted a similar approached in 2019 with the intention to provide caregivers of children with SAM monthly cash transfers of USD 20 over 9 months following their enrolment at the treatment centre. The aim of the cash transfer was to enhance the impact of therapeutic care and prevent children from relapsing into acute malnutrition. The programme also included SBC and counselling around optimal maternal and child feeding, and care practices targeted towards beneficiary households and the communities that host them. Due to operational and funding constraints, the programme was cut short and only provided three cash transfers. Regular monitoring activities had to be cancelled or postponed.

Partners that are considering this approach should explore the risk of the perverse incentive and possible mitigation measures during community consultations. Any project that targets cash transfers based on the nutritional status of children should incorporate the perverse incentive into its monitoring strategy and framework.

# CVA in Somalia

## Overview

The use of humanitarian cash and voucher assistance has been expanding rapidly in Somalia over the past years and constitutes a major component of the 2020 Humanitarian Response Plan. In fact, humanitarian and resilience cash transfers contribute to monthly transactions of about US$155 million, which represents 36 per cent of Somalia’s GDP (OCHA, 2020). Most cash transfers are today delivered through mobile money, which is considered a preferred method for transferring money in Somalia.

Out of the USD 1.03 billion requested for the Somalia HRP 2020, USD 332 million (32%) is planned for CVA (see figure 1 below). The majority of CVA is programmed within the food security sector (USD 209 million). An increasing amount of CVA is programmed as multi-purpose cash[[8]](#footnote-8) (MPC), i.e. the assistance intends to achieve results across several sectors. Until recently, in Somalia, the Food Security Cluster who uses CVA more frequently that the other clusters were tracking all MPC (by default) even if the cash amount supported other sectoral outcomes. This is due to beneficiaries spending the majority of cash assistance on food purchase.

Only roughly USD 100,000 is programmed under the nutrition sector. Nevertheless, the nutrition cluster recognizes the potential of CVA modalities to improve living standards and quality of diets, thus improving the nutrition status of women, children and the general population, and contributing to nutrition security for all in the context of Somalia (OCHA, 2020).



Figure 1. Planned CVA – budget and percentage against total requirements by cluster (OCHA, 2020)

MPC is seen by many organisations as an effective approach to aid displaced populations, supporting a dignified assistance and value for money. In the absence of an institutionalised social protection system, MPC can be used as shock-responsive assistance to ensure vulnerable IDPs do not fall into destitution while transitioning to recovery. In general, cash assistance is best used as an enabler to address basic needs, increase access to services and/or specialised assistance aiming at complementing each other on the delivery of sectoral outcomes. (OCHA, 2020)

## Applying a nutrition lens to household CVA

While household CVA (including MPC or food security CVA) can under specific circumstances lead to nutrition outcomes, evidence has shown that CVA alone is usually not sufficient. Several measures can however be taken to apply a nutrition lens to household CVA, thereby increasing the chances that cash or vouchers can contribute to nutrition outcomes. These measures include pairing household CVA with SBC, appropriately reflecting nutrition in the minimum food basket (MFB) / minimum expenditure basket (MEB) and transfer amount calculation and putting a stronger focus on targeting groups at risk of malnutrition.

*Paring household cash transfers with SBC*

SBC can promote nutrition-sensitive and child/women-centred spending decisions while the cash transfer allows caregivers to put some of the acquired knowledge and skills from SBC activities into practice. SBC should be considered the most important measure to make household cash transfers more nutrition sensitive and a must if household cash transfers are meant to contribute to nutrition outcomes.

While many of the ‘nutrition projects’ reviewed in chapter 3 included a nutrition SBC component, regular MPC or food security oriented CVA in Somalia usually does not. The implementation of an SBC component alongside household CVA does require resources and can be challenging in a context like Somalia where access to affected communities is often limited. SBC interventions delivered through mobile phone messages (such as the mHealth approach as part of the CINS research) could offer an interesting opportunity to integrate SBC into household CVA at relatively low cost in the context of Somalia.

*MEB and transfer amount*

The MEB is a tool that helps to identify and quantify basic needs items and services that are accessible in adequate quality through local markets and services (CaLP, 2019). Items and services included in an MEB are those that households in a given context are likely to prioritize, on a regular or seasonal basis. An MEB is inherently multisectoral and based on the average cost of the items composing the basket.

The minimum food basket (MFB) can be a standalone expenditure basket or considered as the food component of an MEB. Both MEB and MFB should be designed to meet the macro and micronutrient needs of households or individuals[[9]](#footnote-9). In addition to staple foods, the MFB should also contain locally appropriate fruits, vegetables and animal source products. The MEB can further contain transportation expenses and health related expenses (related to direct or indirect costs of accessing health services[[10]](#footnote-10)) that can facilitate access to health services.

The table to the right shows the content of the Somalia MEB. The MEB represents the minimum culturally adjusted set of basic food items (comprising 2,100 kilocalories per person per day of basic energy) and non-food items (NFIs) required to support an average Somalian household of 6-7 members for one month. Expenditure on transportation and health are not included in the MEB. A short analysis of the food component of the MEB using NutVal reveals that the food basket is able to cover the average requirements for macronutrients (calories, protein and fat) but falls short of a healthy diverse diet and average requirements for most micronutrients. For more details, please see the NutVal calculation[[11]](#footnote-11).



The transfer value used by the food security sector should correspond to 100% of the food MEB, while the multi-purpose transfer value should correspond to 80% of the full MEB (CWG, 2020).

As part of the Fill the Nutrient Gap exercise led by WFP, a Cost of the Diet (CotD) analysis was conducted for Somalia in 2019. The CotD finds that nutritious diet for an average household of five persons[[12]](#footnote-12) costs on average $ 6.96 per day (or $ 209 per month) (WFP, 2019). The cost of a nutritious diet is four times higher than the cost of a calorie-based diet ($ 1.85 per day or $ 56 per month) and significantly higher than the value of the MEB, which ranges between roughly $ 70 and $ 130 depending on the region (see table to the right). We can conclude that a cash transfer value based on 80% of MEB falls significantly short of ensuring a nutritious diet for targeted household.

*Targeting*

Targeting criteria for household CVA are in most cases based on economic vulnerability indicators, such as such as income or expenditure (if these can be reliably collected), food security (e.g. number of meals per day), households composition (e.g. dependency ratio), asset ownership (e.g. livestock, land), coping strategies, etc.

In Somalia, there is no homogenised approach to targeting beneficiaries for cash assistance. The majority of partners select a region and/or districts based on the following factors: high density of ‘drought affected people’, accessibility and security. The country is a clan-based society; with pressure often put to target those with clan affiliations as project beneficiaries. As a result, targeting is also often biased against ‘minority’ populations. In fact, there is evidence to suggest that minority groups are the most affected when a disaster, like drought strikes. As a result of both their marginalised status and their location (access issues), minority groups are not included in the provision of humanitarian assistance.

Targeting criteria for nutrition interventions are either based on at-risk groups for preventative strategies or individuals suffering from malnutrition for treatment strategies. Targeting strategies based on the nutrition status of children should be used with caution, as they might incentivizing some caregivers to make or keep one of their children malnourished. In contexts where malnutrition rates are high, targeting strategies for household CVA could pay specific attention to at risk groups, such as PLW, children below 5 years of age, adolescent girls, the elderly or people living with HIV. These groups could be explicitly categorically targeted to increase the nutrition impact of MPC.

Furthermore, evidence from the development literature indicates that targeting interventions to PLW and younger children during the first 1000 days[[13]](#footnote-13) has greater impact on child nutritional outcome (REFANI, 2015). As such, safety net programmes providing household CVA could be targeted towards household with pregnant women and children under the age of two.

# Affordability of a nutritious diet

The big difference between the cost of a nutritious diet and the cost of an energy-based diet can be explained by the relatively high costs of nutrient dense foods. Vegetables, fruits and animal-source foods are most expensive per calorie. On average, energy-dense foods such as grains, oil and sugar cost $ 0.04 (oil, sugar) and $ 0.08 (grains) per 100 calories; nutrient-dense foods cost $ 0.32 (eggs) and $ 0.52 (vegetables) per 100 calories (WFP, 2019). According to the CotD analysis, eight in ten households cannot afford to meet nutrient needs. Consequently, diets in Somalia are mainly based on staple foods (maize, sorghum, rice, wheat and pasta), oil and sugar, with limited consumption of nutritious foods. Furthermore, the availability of foods, particularly nutrient-dense foods such as green leafy vegetables and animal-source foods, is a major bottleneck for accessing a nutritious diet in many parts of Somalia. The COVID-19 crisis is likely to further aggravate the availability of (nutritious) food in local markets. Already before the pandemic, a nutritious diet could not be achieved with the locally available foods.

In order to address the challenge of non-affordability of a nutritious diet, the CotD analysis suggests different measures on the demand and supply side, one of them being cash transfers.



Figure 2. Measures to improve the affordability of a nutritious diet (WFP, 2019)

The CotD analysis reviewed the impact of different measures on the daily cost of a nutritious diet. The analysis estimated that the delivery of a package consisting of LNS-MQ for a child 12-23 months; school meals for a school-aged child and adolescent girl, MMT for the breastfeeding mother, homestead production of goat’s milk for the household and a cash transfer of $70 per month, can reduce the daily cost of the nutritious diet for the modelled household from $6.96 to $4.04. The interventions would reduce the cost by $2.92 per day and the cash transfer would provide $1.61 per day, leaving the household with a remaining cost of $2.43, which is affordable for most households (WFP, 2019).

# Conclusion

The context of Somalia is rich in experiences using CVA for nutrition outcomes. The projects reviewed as part of this case study are just a selection of broader experience that has been accumulated in the past years. The projects illustrate the varied ways CVA can be used in a nutrition response and illustrate some broader lessons that have been observed in other contexts as well:

* CVA modalities can be part of preventative and treatment strategies but are generally more suited for preventative approaches.
* CVA can be provided as household assistance (e.g. MPC) or individualized assistance by addressing the specific nutritional requirements of at-risk groups within households (e.g. fresh food vouchers).
* Cash transfers have a much better chance to impact nutrition outcomes of mothers and children if provided alongside context-specific nutrition SBC.
* CVA conditional on attendance to health services can increase uptake of priority health services and in turn improve nutrition outcomes.
* Targeting CVA based on the nutritional status of children in a treatment response should be used with caution as it can incentivize caregivers to keep or make their children malnourished.

We further saw that household CVA (as a food security intervention or MPC) have been rapidly expanding in the Somalia context, which offers the opportunity of better applying a nutrition lens to the design and implementation of household cash transfers. A short analysis of the food component of the MEB taking into account the findings of the Cost of the Diet analysis suggests that the MEB falls short of addressing the micronutrient needs of targeted households and individuals. Lastly, targeting could offer another way to improve the nutrition sensitivity of household CVA in the context of Somalia.

# Recommendations

Based on these conclusions, the case study **recommends the following actions**:

*To the Nutrition Cluster (NC):*

* Engage stronger on documentation of emerging experiences and learning from nutrition responses with CVA components.
* Set up a regular exchange forum with the Cash Working Group to discuss: Reporting, learning and dissemination, opportunities to integrate CVA modalities in the nutrition sector based on the upcoming evidence and guidance note, opportunities to improve nutrition sensitivity of household cash transfers, MEB and transfer amounts, etc.
* Based on the findings of the Cost of the Diet analysis and in close collaboration with the FSC, advise the Cash Working Group and partners on how to reflect a nutritious diet in the food component of the MEB.
* In close coordination with the FSC and other partners, consider promoting measures to improve the affordability of a nutritious diet in the context of Somalia (see recommendations from the Fill the Nutrient Gap report).
* In collaboration with the CINS team, the CWG and the FSC, explore the possibility to use and integrate mHealth messaging as part of household cash transfer programmes.

*To the Cash Working Group (CWG):*

* Set up a regular exchange forum with the Nutrition Cluster (see above)
* Consider reviewing the food component of the MEB to include nutritious food and better reflect micronutrient requirements; consequently, consider reviewing the transfer value of household cash transfers (food security sector interventions and MPC) in order to better contribute to nutrition outcomes.
* Consult the Nutrition Cluster on the food component of the MEB
* In collaboration with the CINS team and the NC, explore the possibility to use mHealth messaging as part of household cash transfer programmes
* Advise as required nutrition partners on technical aspects of CVA and market assessment

*To nutrition and CVA partners:*

* Consider paring household cash transfers with SNF, especially in areas with limited availability of nutritious foods and high rates of acute malnutrition.
* Invest in monitoring to better measure results and document lessons learned in using CVA for nutrition outcomes. Some suggestions on monitoring of CVA for nutrition outcomes can be found in Annex 4.
* Document and disseminate learning on CVA in nutrition responses

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# Annex 1: Demand and supply side barriers to adequate nutrition

*From: GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.*

|  |  |  |
| --- | --- | --- |
| **Demand-side barriers** |  | **Supply-side barriers** |
| **Underlying determinant: adequate food** | | |
| * Inadequate production of nutritious foods for HH consumption * Insufficient knowledge and skills on nutritious diet preparation * Nutritious diet not affordable * Transportation to markets not affordable * Markets not accessible due to distance, safety concerns, social and cultural factors, etc. * Cooking utensils and cooking fuel not affordable * Inadequate storage and preparation of food at household level * Household income not used to purchase nutritious foods * Inadequate sharing of food within households (not child or women centred) |  | * Insufficient availability and/or quality of productive inputs * Insufficient food production and/or importation * Insufficient availability and/or quality of nutritious food in local markets * Inadequate handling and storage of foods (especially fresh foods) along the supply chain * Insufficient availability of cooking utensils and fuel in local markets |
| **Underlying determinant: adequate feeding and care** | | |
| * preparation of adequate complementary food for children 6-24 months not affordable * Inadequate knowledge and skills on how to prepare nutritious complementary food * Lack of caregivers’ time for optimal feeding and care due to economic pressure (e.g. work) * inadequate caring practice due to lack of knowledge and skills * Traditional beliefs, practices and perceptions that negatively impact adequate feeding and care of infants, young children and women * Lack of caregivers’ control over resources contributing to spending decisions that are not child or women centred * Inadequate physical and mental well-being of caregivers |  | * Infant and young child feeding (IYCF) policies at central and local level not adequate * IYCF services and support for adequate care (e.g. health services, IYCF counselling services, women support groups) are not available or not functional * Insufficient availability of nutrition dense complementary foods * Inadequate social protection policies (e.g. paid parental leave; support of breast-feeing in the workplace or in society) |
| **Underlying determinants: healthy environment** | | |
| * Accessing and using health services is not affordable due to direct costs (e.g. consultation fees, diagnostic tests and/or medicines) and indirect costs (e.g. transport or accommodation costs) * Health services not accessible due to distance, safety concerns, acceptability by community, social and cultural factors, etc. * Opportunity costs of seeking health and nutrition services are considered too high * Lack of knowledge on existing (preventative) health services * Inadequate health seeking behaviour due to lack of knowledge of malnutrition and other disease, traditional beliefs, etc. * Hygiene items for general and specific needs (e.g. new-born hygiene, menstrual hygiene) not affordable * Lack of knowledge and skills on hygiene and sanitation practices * Safe water and water treatment not affordable |  | * Health services not sufficiently available * Health service of insufficient quality * Adequate drugs, supplies (e.g. therapeutic foods) and equipment for maternal and child health services are not available * Hygiene and sanitation items for general and specific needs not available in the local market * Inadequate availability and quality of water at household, community and health facilities level * Inadequate water and sanitation infrastructure * Inadequate and insufficient water storage at household and health facility level * Lack of hygiene items in the market |

Economic barriers

# Annex 2: Summary of evidence base

*From: GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.*

This chapter summarizes the overall evidence base for these pathways and for achieving nutrition outcomes at different levels, with a focus on humanitarian settings. It further looks at evidence of the impact of design on nutrition outcomes. The summary builds on comprehensive evidence reviews which have been conducted by [Fenn](https://www.actioncontrelafaim.org/wp-content/uploads/2018/06/R4ACT-Final-Report-230718.pdf) (2017), [Bastagli et al.](https://www.odi.org/publications/10505-cash-transfers-what-does-evidence-say-rigorous-review-impacts-and-role-design-and-implementation) (2016), [REFANI](https://www.actionagainsthunger.org/publication/2015/09/refani-literature-review) (2015), [De Groot et al.](https://www.unicef-irc.org/publications/782-cash-transfers-and-child-nutrition-what-we-know-and-what-we-need-to-know.html) (2015), and [Bailey et al.](https://www.odi.org/publications/6338-impact-cash-transfers-nutrition-emergency-and-transitional-contexts) (2012). An overview on studies on CVA and nutrition in humanitarian and development settings can be found in CaLP’s [CVA and nutrition programming tool](https://www.calpnetwork.org/publication/considering-incorporating-cva-into-nutrition-programming-a-3-step-programming-tool/) (Annex 4).

There is a sizable and growing body of evidence on the impact of CVA on nutrition outcomes. The bulk of evidence is in development settings, but an increasing number of studies are looking at humanitarian settings as well. According to Harvey et al. (2018), the evidence is a mixture of the positive impacts, where cash transfers contributes to nutrition outcomes, and the non-significant, where no clear contribution is identifiable. Table 2 below provides a summary of impacts on determinants of adequate nutrition and nutrition status.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Level of impact** | **Mostly positive** | **Mixed** | **None** | **Comment** |
| **Impact on nutrition status of children** | | | | |
| Child nutrition status |  | \*\* |  | Mostly positive evidence on stunting, mixed evidence on wasting, limited and inconsistent evidence on MN status |
| **Impact on immediate determinants** | | | | |
| Dietary diversity of children | \*\* |  |  | Growing positive evidence for children, limited evidence for women |
| Health status of children | \* |  |  | Positive impact on improving treatment results in one study |
| **Impact on underlying determinants** | | | | |
| Household food expenditure | \*\*\* |  |  |  |
| Household food consumption and dietary diversity | \*\*\* |  |  | Consistent positive impact of CVA |
| Uptake in preventative health services | \*\* |  |  | Evidence mostly from development settings |
| Water, sanitation and hygiene | \* |  |  | Limited positive evidence access to water, sanitation and hygiene items |
| Feeding behaviours and practices |  |  | \* | No evidence mainly due to the heterogeneity of indicators used |
| Psychosocial care for children |  |  | \* | No evidence mainly due to the heterogeneity of indicators used |
| Intra-household decision making | \*\* |  |  |  |
| Intimate partner violence | \*\* |  |  | Positive results are mainly due to a reduction in income-related tension, frustration, and fighting |
| Caregivers’ mental health |  |  | \* | Psychosocial wellbeing as positive spill-over from receiving CVA |

Strength of evidence: \* none or limited, \*\* growing, \*\*\* moderate, \*\*\*\* strong

Table: Summary of impacts of CVA on nutrition[[14]](#footnote-14)

***Nutrition status of children and women***

Bastagli et al. (2016) found statistically significant positive changes in anthropometric outcomes for *wasting* in one out of five studies. More recent studies in humanitarian settings also documented statistically significant impacts of CVA on wasting (Kurdi et al., 2019a; Bliss et al., 2018; Fenn et al., 2017). Other studies (e.g. Grijalva-Eternod et al., 2018; Sibson et al., Houngbe et al. (2017) did however not find any impact of CVA on children’s risk of being wasted, even though the interventions consistently contributed to improved household food security and dietary diversity[[15]](#footnote-15). Despite the lack of documented impact in some studies, Fenn (2017) concludes that there is a limited but growing number of studies with statistically significant results showing positive impacts of CVA on the risk of wasting among children between six and 59 months in both emergency and development programmes.

As compared to wasting, the evidence base for the impact of CVA on *stunting* is stronger, particularly in development settings. Bastagli et al. (2016) found statistically significant positive changes in anthropometric outcomes for stunting in 5 out of 13 studies. More recent studies also documented statistically significant impacts of CVA on stunting in both development (Ahmed et al. in Bangladesh) and humanitarian settings. Fenn et al. (2017) in Pakistan looked at the effectiveness of different CVA modalities (single cash, double cash[[16]](#footnote-16), fresh food vouchers) on nutrition outcomes. They found that all three modalities reduced stunting (increased mean height-for-age score (HAZ)) at both 6 months and 12 months of follow up, but only double cash had an impact on wasting and only at 6 month of follow up. Fenn (2017) concludes that there is growing number of studies with statistically significant results showing positive impacts on the HAZ score.

The evidence of statistically significant improvements in underweight is more limited than measures for wasting and stunting and evidence in improving micronutrient status is inconsistent (Fenn, 2017).

***Immediate determinants of maternal and child nutrition***

As remarked previously, CVA does usually not directly act upon the immediate determinants but does so indirectly through the underlying determinants. The evidence base for the impact of CVA on the dietary intake of children and women is less robust compared to the evidence at household level. Nevertheless, there is growing evidence that CVA often leads to an increase in *expenditure on food for children[[17]](#footnote-17)* and to improvements in the *dietary diversity of children (and women)* in both development and humanitarian settings (see for example Fenn et al., 2014; Fenn et al., 2017; Grijalva-Eternod et al., 2018; Kurdi et al., 2019a; OPM, 2019).

There is very limited evidence on the impact of CVA on treatment of child illness (Fenn, 2017). CVA can increase the uptake of health services, which is likely to improve the health of children thus resulting in reduced perceived need for treatment. A number of organisations have begun to use service vouchers to enable access to reproductive, maternal and new-born care services as well as treatment of child illness in humanitarian settings. Grellety et al. (2017) studied the impact of cash transfers provided alongside the treatment of children with severe acute malnutrition (SAM) in the Democratic Republic of the Congo (DRC). They found that children in households that received cash transfers gained weight faster, were more likely to recover from SAM and less likely to default or fail to respond to treatment compared with children in the control group.

***Underlying determinants of maternal and child nutrition***

There is strong evidence from both development and humanitarian settings suggesting that CVA consistently increases *household* *food expenditure* and improves *household food consumption* and *household dietary diversity* (Fenn, 2017; Bastagli et al., 2016; REFANI, 2015; de Groot et al., 2015; Manley et al., 2013; Bailey et al., 2012;). There is an ongoing debate on whether cash transfers or vouchers are better suited to improve household food security and how this compares with in-kind food assistance. In general, CVA may be more effective than food transfers for improving dietary diversity while food transfers may more effective than CVA at increasing caloric intake (Fenn, 2017; Bailey, 2013). However, as Gentilini (2016) points out, the relative effectiveness of different transfer modalities cannot be generalized and although some differences emerge in terms of food consumption and dietary diversity, average impacts tend to depend on context, programme objectives and design.

Evidence from development settings seems to suggest that cash transfers, both conditional and unconditional, can improve *uptake in preventative health services*. Bastagli et al. (2016) reviewed 15 studies reporting overall effects on the use of health facilities and services, of which nine report statistically significant increases. Furthermore, three studies tested the effect of conditionalities, two finding that conditions on attending health visits led to a higher number of visits compared to transfers with no conditions. The evidence from humanitarian settings is much more limited. A study in Somalia (UCL and Concern, 2020) found that conditional cash transfers were associated with a strong and significant increase in the odds of vaccination, thus supporting the finding from other studies that conditional cash transfers may be better suited to promote health seeking behaviour than unconditional transfers. On the other hand, a study in Mali (Le Pont et al., 2019) did not find any evidence for the incentive value of conditional cash transfers.

There is limited evidence on the impact of CVA on *Water, Sanitation and Hygiene* (WASH) as experiences on using CVA for WASH outcomes are only emerging. However, there is emerging evidence that CVA modalities have a positive effect on access to water, sanitation and hygiene items (GWC, 2020).

There no evidence for the impact of CVA on aspects of *care behaviours*, such as feeding behaviours and psychosocial care for child. Nonetheless, there is growing evidence that CVA can contribute to positive *gender-based violence* (GBV) outcomes, which might have a positive impact on care behaviours. Cross et al. (2018) reviewed 28 studies related to CVA and GBV and found that the clear majority of CVA interventions (71 per cent) had a positive impact on aspects of GBV, while only 4 per cent had a negative impact. The positive impact was concentrated in in intra-household decision-making and most interventions with positive impact on decision-making targeted women as beneficiaries. Beneficiaries felt improved joint decision-making and/ or increased bargaining power in their households following CVA.

As for *intimate partner violence* (IPV), Cross et al. (2018) found that eighty percent of the evidence indicates that the impact of CVA on IPV is positive. Positive results are mainly due to a reduction in income-related tension, frustration, and fighting. IPV tended to increase when there were not enough resources to meet basic needs, when there was unemployment, and when heads of households felt powerless to provide for their families. Also, they note that the most common positive spill-over effect from CVA cited across the literature was psychosocial wellbeing of women receiving CVA. Little to no evidence was found on the impact of CVA on other aspects of GBV, such as early or forced marriage, asset ownership, or exposure to sexual harassment, exploitation or abuse.

Some programmes reviewed by Bailey et al. (2012) have shown that cash transfers reduced the time spent away from home and increased time for domestic activities, including caring for children.

***The impact of programme design on nutrition outcomes***

Studies from development contexts suggest that higher **transfer amounts** showed positive effects on HAZ and weight-for-height score (WHZ) and access to preventative health care. There is a consensus that the transfer amounts need to represent a significant contribution to the household economy (e.g. transfers of between 15% and 30% of the overall household expenditure) if it is to have an impact on nutritional status (Fenn, 2017). Only one study is looking at the impact of different transfer amounts on nutrition outcomes in humanitarian settings. Fenn et al. (2017) looked at the impact of four different interventions in Pakistan (two different-sized unconditional grants, a fresh food voucher, and a control group). They found that the amount of cash given was important and only in the group that received the higher amount were the odds of a child being wasted significantly lower compared to the control group.

In a study in Niger, Aker et al. (2014) compared the effect of **delivery mechanisms** (the effect of mobile payment mechanisms compared to manual cash delivery) on household dietary diversity. The results suggest that mobile payments in Niger led to a statistically significant improvement in dietary diversity of around 16 percentage points. Also, households receiving mobile transfers consumed more meals per day. The authors attribute the results to two factors: time-saving (i.e. recipients spent less time traveling to and waiting for their transfer) and increased intra-household bargaining power of women who received the mobile payments. Apart from the Niger study, there is no evidence to suggest that some delivery mechanisms are better suited to achieve nutrition outcomes than others.

The determinants of malnutrition are often seasonal and are likely to change in response to shocks and disasters. Consequently, the **timeliness of initiation and duration** of CVA are likely to be important factors affecting its ability to prevent undernutrition (REFANI, 2015). Bastagli et al. (2016) identified seven studies that looked at the effect of the duration of receipt in development settings, five of which found a significant improvement in child anthropometric measures and increasing use of health care due to a longer duration in a programme. As for timing, Bailey (2008) in a qualitative study in Niger observed that cash given before or during the hungry season would be most likely spent on food whereas cash given at the end or after the hungry season would more likely be used for productive assets and paying off debts. [Sibson et al., (2018](#_Studies_that_cannot)) in Niger compared the impact of two unconditional cash interventions where one group received four transfers during the ‘lean season’ between June and September and the other group six transfers which were initiated prior to the lean season (April to September). The cumulative amount of cash received by the groups was equal, i.e. FCFA 130,000 (approx. US$220). They found no difference in the prevalence of GAM between the two interventions and no evidence that early initiation of assistance prior to the lean season would have a positive impact on children’s nutritional status.

As for the **frequency** of transfers, some evidence from development settings suggests that regular payments (e.g. monthly) have a greater short-term impact on nutrition outcomes and the underlying causes of undernutrition, such as food expenditure, while less frequent and lump sum transfers are more likely to be invested in productive activities such as agricultural production (REFANI, 2015). Ecker et al. (2019) assess the mitigation effect of the national cash transfer program of the Social Welfare Fund on child malnutrition in Yemen. They found that the mitigation effect tends to be larger the more regular payments are received, as regular assistance allows beneficiary households to smooth their food consumption and other demands influencing child nutrition outcomes.

# Annex 3: Peer reviewed studies and operational examples from Somalia

Peer reviewed studies are summarised in green boxes and operational examples are in orange boxes.

|  |  |
| --- | --- |
| **Research:** A cash-based intervention and the risk of acute malnutrition in children aged 6–59 months living in internally displaced persons camps in Mogadishu, Somalia: A non-randomised cluster trial | |
| **Authors:** [Grijalva-Eternod](https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002684) et al. (2018) | **Location:** Somalia, Mogadishu |
| **Intervention:** The study implemented a non-randomised cluster trial in IDP camps, located in peri-urban Mogadishu. The intervention group received a monthly unconditional cash transfer of US$84 for 5 months, a one-off distribution of a non-food-items kit, and the provision of piped water free of charge. The control group did not receive anything. | |
| **Results:** Diet diversity appeared to improve in children from households receiving the cash transfers and an apparent improvement in diet and food security was also observed in their mothers or primary carers. However, the study did not observe an associated reduction in the risk of children becoming acutely malnourished in camps receiving cash transfers. | |
| **Learning:** It is unclear why the intervention did not appear to reduce the risk of malnutrition in children. Future work is necessary to understand whether modifications to this intervention, such as adding specific nutritious foods or SBC, could positively affect its ability to prevent children from becoming acutely malnourished. | |

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| --- | --- |
| **Research:** Cash and voucher assistance and children's nutrition status in Somalia | |
| **Authors:** Doocy et al. (2020a, 2020b) | **Location:** Somalia |
| **Intervention:** The study examined the impact of CVA on prevention of child and maternal acute malnutrition in 2017/2018 in the context of the Somalia food crisis. Changes in diet and acute malnutrition were measured over a 4-month period among children age 6–59 months and pregnant and lactating women from households receiving household assistance of approximately US$450 (over 4 months) delivered either as food vouchers or a mix of in-kind food, vouchers, and cash. | |
| **Results:** The study found that household food security was similar for both intervention groups at endline; however, households receiving mixed transfers consumed meals more frequently. Children in households receiving mixed transfers also had more diverse diets at the end of the study period; however, the magnitude of change in dietary diversity over the study period was similar for children in mixed transfers and vouchers. Acute malnutrition prevalence was higher among children in households that received vouchers at both baseline and endline. The change over time in both mean MUAC and acute malnutrition prevalence was similar for both interventions, suggesting that mixed transfers and food vouchers had similar preventative effects on child nutrition status. | |
| **Learning:** Alongside other evidence regarding beneficiary preferences for cash and lower implementation costs compared with vouchers, evidence supports continuing use of cash and voucher assistance in Somalia and considering expanded use of cash transfers. | |

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| --- | --- |
| **Research:** Cash for Improved Nutrition in Somalia (CINS) | |
| **Authors:** UCL Institute for Global health and Concern Worldwide | **Location:** Somalia |
| **Intervention:** The CINS study was conducted in IDP camps in the Afgooye Corridor, an area that contains the largest IDP settlements in Mogadishu. The study used a 2x2 factorial randomised cluster trial design, where IDP camps were designated as clusters. A total of 23 clusters/camps were selected and included in the study. All households with children aged less than 5 years (n=774) within the study clusters were selected to receive $70 in the first three months (humanitarian cash) and $35 for another six months (safety net cash).  The 23 clusters were initially randomised to receive either conditional or unconditional cash. The randomisation was then repeated to allocate the clusters to receive either mHealth or no mHealth. The conditionality was for caregivers to take any children below 5 years of age to the local health clinic for a health screening, where they were issued with a health record card. The mHealth component consisted in weekly voice messages, delivered directly to the caregivers’ mobile phone. The voice messages covered the following topics: vaccinations; IYCF; WASH; identifying serious illness & health seeking; prevention, recognition and treatment of acute malnutrition; and maximizing health and nutrition for all household members. | |
| **Results:** The CCT intervention was associated with a strong and significant increase in the coverage of EPI vaccination and a reduction in measles infection. The mHealth intervention did not have any measurable impact on knowledge of health and nutrition topics among mothers/caregivers of children aged <5 years. It did however lead to an increase in household expenditure on food and an improvement in the child dietary diversity score., as well as significantly reducing the risk of mortality in children aged <5 years. Unexpectedly, the CCT was associated with an increased risk of acute malnutrition, and the mHealth intervention appeared to reduce measles vaccination coverage in children aged 9-59 months and was associated with an increased the risk of measles infection. | |
| **Learning:**   * Integrated Cash+ approaches are important to achieve key health and nutrition outcomes in humanitarian contexts such as Somalia. * Conditional cash transfers can improve the uptake of life saving vaccination services. * Linking cash transfers to health facility access can create demand for service provision and enhance reach. * mHealth interventions can increase household expenditure and improve child dietary diversity. | |

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| **Organisation:** FAO | **Location:** Somalia |
| **Programme and duration:** Improving and sustaining food security in rural Somalia (emergency cash), 2019-2020 | **Documents reviewed:**  FFP project proposal |
| **Intervention**: The project follows FAO’s cash plus approach and build on past projects using household cash transfers (through unconditional transfers or CfW) and livelihood support. The programme aims to meet the immediate needs of shock-affected vulnerable communities while restoring their own food production. It combines household cash transfers based on 100% of the minimum food basket, a livelihood support package tailored to livelihood group, technical training on different livelihood activity (e.g. good agricultural practices and nutrition SBC activities. The cash component is provided monthly for 3-6 months, depending on the duration of the lean season. The livelihood support package consists of:   * seeds for cereal (sorghum or maize), pulses and vegetables targeting farmers, * a vegetable kit and basic micro-irrigation supplies targeting women in IDP settlements, * feed blocks, milk containers and deworming for the animals targeting herders, * fishing gear and equipment targeting coastal communities.   SBC activities aim to improve food choices and utilization and include nutrition and food safety messages and cooking demonstrations. They are implemented through community nutrition champions who were previously trained as community trainers. The SBC trainings and activities focus on the different nutrition needs of people throughout the life cycle (i.e. from infancy to old age) as well as care practices, with an emphasis on women and children. | |
| **Results and learning**: Previous projects that provided household cash transfers in combination with an agricultural livelihood package achieve positive results household food consumption and production.  A livestock impact assessments conducted by FAO in March 2019 showed that out of the beneficiaries who received two rounds of cash disbursements, 98.2% used the first payment on food while in the second round, 83% prioritised purchasing food for the household. Despite a majority of the beneficiaries using their money on food, 62% had a low dietary diversity score. This provides a clear entry point for influencing behaviour changes with regard to food choices and care practices. It is an opportunity to influence consumption. 2019 Gu Crop Yield assessment for the agropastoral beneficiaries showed that only 40% had a low dietary diversity score as opposed to 53% of non-beneficiaries. This clearly shows that the cash plus modality has an impact on the dietary diversity of households.  Current anecdotal evidence from implementing partners suggests that project beneficiaries previously did not know how to utilise some of the vegetables provided, however, because of the nutrition training and messages, they are keen to purchase, produce and consume more fruits and vegetable for the nutrition, health and wellbeing of their households. 2020 Impact assessments to be done at the end of the implementation period will be used to verify this information as well as to capture more nutrition sensitive indicators such as impact on-farm diversity, MDDW and MAD.  FAO is currently piloting a long-term cash modality that provides smaller amounts of cash over a longer period of time (1 year), livelihood inputs as well as village savings and loans trainings. The main aim of the long-term cash project is to provide options for vulnerable communities to diversify their livelihoods and therefor build their resilience against the recurrent shocks that are common in Somalia. | |

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| **Organisation:** BRCiS Consortium, led by NRC | **Location:** Somalia |
| **Programme and duration:** Shock-responsive safety net pilot, 2019-2021 | **Documents reviewed:** Concept note, Minimum package for health and nutrition, nutrition lens guide |
| **Intervention**: The programme implemented by the BRCiS consortium provides a package of interventions with the aim to promote the resilience of rural populations that are likely to be displaced by drought and/or urban IDP populations. It operates in 16 districts across Somalia aiming to target 2146 households in total. Households are selected through community-based targeting using Community Resilience Committees. The first component of the package consists of unconditional cash transfers of USD 20 per household per month that are provided over 24 months. The programme allows for a vertical expansion up to USD 40 per household per month. The cash component is implemented alongside a minimum package of health and nutrition intervention. | |
| **Results and learning**: NA | |

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| **Organisation:** World Food Programme | **Location:** Somalia |
| **Programme and duration:** e-vegetable programmeFresh food vouchers, 2016-ongoing | **Documents reviewed:** Inputs from project team |
| **Intervention**: WFP started to use fresh food vouchers to assist pregnant and lactating women in 2016. FFV (e-vegetables) are provided together with specialized nutrition products (Plumpy doz for children under two and super cereal plus for PLW) during pregnancy and until 6 months after the delivery (PLW). They aim to diversity diets and behaviour change. Voucher assistance is conditional on the attendance to Mother and Child Health and Nutrition (MCHN) centres, where women receive preventative health services (including ANC, PNC, growth monitoring and immunization) as well as nutrition alongside social behaviour change communication (SBCC) on health, nutrition and diet diversity. | |
| **Results and learning**: The latest Post-Distribution Monitoring (PDM) from November 2019 on the e-vegetable programme for pregnant women enrolled in the MCHN intervention suggests 23.7 percent of children 6-23 months consumed minimum acceptable diet that is higher than the national MAD rate of 9 percent (Somalia Infant and Young Child Nutrition Assessment, 2016). The survey results also revealed that 68% of women met the minimum dietary diversity (MDD-W) threshold of having consumed more than 5 food groups out of 10 in the past 24 hours (excluding fortified foods). | |

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| **Organisation:** ICRC | **Location:** Somalia |
| **Programme and duration:** Commodity vouchers plus SC to prevent deterioration in the nutrition situation, September 2017-May 2018 | **Documents reviewed:** Learning document (ICRC, 2018) |
| **Intervention:** To prevent further deterioration in the nutrition situation and reduce malnutrition prevalence, the ICRC designed a two-phase intervention using an unconditional cash transfers, food vouchers and SNF. In the first phase (December 2017), a SMART Nutrition Survey was conducted to evaluate the nutritional status of the IDPs in a targeted location. The results showed that the prevalence of Global Acute Malnutrition required additional nutritional support for the population and all eligible households received an unconditional cash transfer of $200 plus BP5 (12 small boxes) for the 1st round (December 2017). For the 2nd and 3rd rounds (February and March 2018), all households with children below 5 received a food commodity voucher and Super Cereal. In addition, children who were found suffer from SAM were referred for treatment at a mobile Outpatient Therapeutic Program (OTP) run by the Health Unit and the Somali Red Crescent. The combination of commodity vouchers plus SC distribution was later on replicated in other regions in Somalia. | |
| **Results and learning**: Two months after the third round of assistance, ICRC conducted a second SMART nutrition survey (May 2018) targeting the same population. The results showed an improvement of the GAM rate, especially for SAM. PDM from subsequent interventions using commodity vouchers and SC confirmed the positive impact on GAM prevalence. In the context of Somalia, food commodity vouchers have proven to be an effective tool to reduce the prevalence of malnutrition. This is particularly true where malnutrition is the result of an inadequate diet due to the loss or lack of income, and when the assistance is complemented with supplementary food, nutrition sensitization sessions and/or treatment of malnutrition. | |

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| **Organisation:** ICRC | **Location:** Somalia |
| **Programme and duration:** Cash transfers for caregivers of SAM children, July 2015-July 2018 | **Documents reviewed:** NA |
| **Intervention:** The project provided unconditional cash transfers to caregivers whose children were treated for SAM in stabilisation centres (in-patient) in Baidao and Kismayo. The objective of the cash transfer was to cover transportation costs, stabilize household food security following discharge and prevent relapse of children into SAM. Caregivers do not get assisted if they quit the stabilisation centre before the treatment is finalized or if they return for treatment. They were eligible to three cash payments of USD 100 each commencing once the child has completed treatment and has been formerly discharged. | |
| **Results and learning**: To what extent the programme was able to achieve its objective is not clear. ICRC decided to conduct a study/evaluation on March 2018 (after 2 years and half the beginning of the activity) to review the outcomes and the pertinence of the programme and address the questions that have been raised inside the organization. Unfortunately, for security reason leading to lack of access of the international staff in Somalia, ICRC could not start the study and had to stop the cash transfer component in July 2018. Until today, we haven’t been able to go back. | |

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| **Organisation:** UNICEF | **Location:** Somalia |
| **Programme and duration:** Safety Net Cash Programme,2019-2020 | **Documents reviewed:** Concept note |
| **Intervention:** The programme implemented by UNICEF started in 2019 and planned to provide caregivers of children with SAM with monthly cash transfers of USD 20 over 9 months following their enrolment at the treatment centre. The aim of the cash transfer was to enhance the impact of therapeutic care and prevent children from relapsing into acute malnutrition. The programme also included SBC and counselling around optimal maternal and child feeding, and care practices targeted towards beneficiary households and the communities that host them. Due to operational and funding constraints, the programme was cut short and only provided three cash transfers (the last payments are ongoing). | |
| **Results and learning**: Due to operational constraints related to Covid-19, regular monitoring activities had to be cancelled or postponed. | |

# Annex 4: Monitoring of CVA for nutrition outcomes

*From: GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.*

Proper monitoring of the CVA component and its contribution to nutrition outcomes is essential in further building the evidence base for the use of CVA in nutrition.

The definition of indicators to *monitor outcomes* largely depends on the programme objective and is as such not tied to the assistance modality. Nutrition outcomes are usually assessed by looking at the prevalence of acute or chronic malnutrition within communities, the nutrition status of targeted individuals (typically measured through WHZ, HAZ, MUAC, WAZ and micronutrient status), indicators related to food consumption and dietary diversity at population level or targeted individuals and access to health services.

To understand the impact of household CVA on maternal and child nutrition, it is important to move beyond the household level indicators such as the Household Dietary Diversity Score (HDDS) or the Food Consumption Score (FCS), which do not capture the nuances of intra-household distribution of food and cannot be extrapolated to the individual level. Indicators such as [Minimum Dietary Diversity for Women](https://www.fantaproject.org/monitoring-and-evaluation/minimum-dietary-diversity-women-indicator-mddw) (MDD-W), [Minimum Acceptable Diet](https://inddex.nutrition.tufts.edu/data4diets/indicator/minimum-acceptable-diet-mad) (MAD), [Minimum Dietary Diversity](https://inddex.nutrition.tufts.edu/data4diets/indicator/minimum-dietary-diversity-mdd) (MDD) for children 6-23 months and [Minimum Meal Frequency](https://www.who.int/nutrition/databases/infantfeeding/data_source_inclusion_criteria/en/#:~:text=Minimum%20meal%20frequency%20(%25)&text=Minimum%20meal%20frequency%20is%20defined,breastfed%20children%206%E2%80%9323%20months) for children 6-23 months can help to capture intra-household differences in food consumption habits and to highlight consumption patterns that are deficient in micronutrient-rich foods (AAH, 2017).

Another interesting indicator that is particularly relevant for interventions including a household cash transfer component is the [coping strategy index](https://www.spring-nutrition.org/publications/tool-summaries/coping-strategies-index-field-methods-manual-2nd-edition) (CSI). The CSI was originally developed as a food security and measures how households manage to cope with a shortfall in food for consumption. It can however be expanded to include other sectoral such as health and WASH[[18]](#footnote-18), and be used to measure the impact of household cash transfers.

How households and individuals use CVA can be considered as an intermediate outcome and should be closely monitored when using CVA as part of a nutrition response. Specifically, expenditure on food, the composition of purchased food, expenditure on accessing health services and expenditure related to water and sanitation should be collected at sub-category level (i.e. what kind of food was purchased, what kind of expenditure to access health services occurred, and what water and hygiene goods and services were obtained). From expenditure data, vulnerability indicators such as the [household food expenditure share](https://inddex.nutrition.tufts.edu/data4diets/indicator/household-food-expenditure-share?back=/data4diets/indicators) or the [percentage of household expenditure on health](https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4844) can be extrapolated.

The definition of indicators to *monitor process and outputs* is very much linked to the assistance modality. Typical indicators for CVA include the number of households or individuals (disaggregated by gender) that have received CVA per distribution, the number of vouchers redeemed per distribution, the total amount transferred per distribution, the percentage of payments made according to schedule, the percentage of beneficiaries who report satisfaction with process and methods of implementation, etc.

*Market price monitoring* should at minimum cover the nutrition-relevant goods and services included in expenditure basket. *Risks* identified in step 4 need to be monitored and updated, including risks related to protection and safety of recipients.

# Annex 5: CVA for nutrition outcomes in times of COVID 19

* Impact of Covid-19 on food market systems: could prevent the use of CVA to access a nutritious diet
* Impact of Covid-19 on supply chains of specialized nutritious foods: could push actors to do more CVA because of potential supply shortages specialized nutritious foods
* Important to understand and anticipate changes to market systems for local nutrition dense foods and supply chains for specialized nutritious foods (🡪 linkages to FSC and CWG)
* Measures that can be taken to reduce the risk of CVA contributing to transmission: see [CaLP guidance](https://www.calpnetwork.org/publication/cva-in-covid-19-contexts-guidance-from-the-calp-network/)

1. Nutrition outcomes shall be defined as improvement of the nutritional status (typically measured through WHZ, HAZ, MUAC) and improvement in the dietary intake of individuals (typically measured through MAD, MDD and MDD-W). [↑](#footnote-ref-1)
2. A nutritious diet is one that meets requirements for macro and micro-nutrients, including protein, vitamins and minerals, but does not exceed an individual’s energy and fat requirement. [↑](#footnote-ref-2)
3. While the specific behaviours to be targeted through SBC will depend on context, they will typically include the following: pregnancy nutrition and care; optimal breastfeeding; appropriate complimentary feeding (including frequency, quantity, diversity); hygiene and sanitation; and quantity and diversity of complementary foods. [↑](#footnote-ref-3)
4. Priority health services include services that can significantly impact the nutritional status of the population. They include vitamin A supplementation on admission for children 6-60 months, and 6 weeks postpartum for women; deworming treatment of all children; measles vaccination for all children between 9 months and 15 years of age; supplementation of iron and folic acid for PLWs; pre- and post-natal care. [↑](#footnote-ref-4)
5. If CVA can replace the traditional response modality, the objective of CVA is equivalent to the objective of the response itself. [↑](#footnote-ref-5)
6. Household assistance shall be defined as assistance that is provided at household level in the form of in-kind, cash or vouchers based on average household requirements for food/nutrition and sometimes (but not necessarily) other basic needs. Household in-kind assistance typically includes general food distributions (GFD) and non-food item (NFI) distributions. Household CVA includes cash transfers or vouchers. Household cash transfers can be based on household food/nutrition requirements alone or on needs across different sectors, i.e. multi-purpose cash (MPC). [↑](#footnote-ref-6)
7. Individual feeding assistance shall be defined as assistance that is provided to meet the macro and micro-nutrient requirements of individuals (typically PLW or children under 59 months) in the form of in-kind foods, cash or vouchers. It includes supplementary feeding, complementary feeding and micronutrient supplementation. [↑](#footnote-ref-7)
8. Multipurpose Cash Transfers (MPC) are transfers (either periodic or one-off) corresponding to the amount of money required to cover, fully or partially, a household’s basic and/or recovery needs. The term refers to cash transfers designed to address multiple needs, with the transfer value calculated accordingly. MPC transfer values are often indexed to expenditure gaps based on a Minimum Expenditure Basket (MEB), or other monetized calculation of the amount required to cover basic needs. All MPC are unrestricted in terms of use as they can be spent as the recipient chooses. (CaLP Glossary) [↑](#footnote-ref-8)
9. Sphere food assistance standard 6.1.: Design food and cash-based assistance to meet the standard initial planning requirements for energy, protein, fat and micronutrients. [↑](#footnote-ref-9)
10. Direct costs can include consultation fees, diagnostic tests and/or medicines. Indirect costs can include transport or accommodation costs. [↑](#footnote-ref-10)
11. The calculation is based on an average household size of 6. For the purpose of the calculation, red sorghum was selected as the cereal. [↑](#footnote-ref-11)
12. The lowest cost nutritious diet was estimated for a model household of five members, which included a breastfed child 12–23 months, a child 6–7 years, an adolescent girl 14– 15 years, a lactating woman and an adult man. [↑](#footnote-ref-12)
13. Since the 2008 Lancet series, there is a broad consensus within the nutrition community that good nutrition within the first 1000 days, i.e. the time period from child's conception through to her second birthday, has lasting benefits on the cognitive and physical development of children. [↑](#footnote-ref-13)
14. This table is adopted from De Groot et al., 2015, and Fenn, 2017, and updated based on new evidence. [↑](#footnote-ref-14)
15. Grijalva-Eternod et al. (2018) acknowledge that they cannot satisfactorily explain the lack of impact of the intervention on the risk of malnutrition in children and raise the question whether modifications to these interventions such as adding specialized nutritious foods or SBC activities could make a difference. Sibson et al. (2018) suggest that the surge in malaria limited the effectiveness of the intervention. Houngbe et al. (2017) suggest that the transfer amount might have been too low to address the needs of the household and the children’s specific needs. [↑](#footnote-ref-15)
16. Double cash was twice the amount of single cash (disbursed at the same time?) [↑](#footnote-ref-16)
17. Increased expenditure on food for children does not automatically translate into improved nutrition status. Bliss et al. (2016) researched the factors associated with the risk of acute malnutrition among children aged 6 to 36 months in households targeted by emergency cash transfers in Niger. They found that food expenditures for children and other diet-related factors were not associated with the risk of acute malnutrition. Rather, low baseline weight-for-height Z-score (WHZ), baseline household poverty status, and the occurrence of child illness were significantly associated with high risk. [↑](#footnote-ref-17)
18. An example for a multi-sectoral CSI developed in Afghanistan can be found [here](https://reliefweb.int/sites/reliefweb.int/files/resources/gd-afghanistan-multisector-copying-strategy-index-240518-en.pdf). [↑](#footnote-ref-18)