



Cash and Voucher Assistance (CVA) for Nutrition in Emergencies: Frequently Asked Questions (FAQ)

Prepared by the Global Cash & Voucher Assistance for Nutrition Outcomes Global Working Group



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1. Who should the target group be for projects using CVA for nutrition in emergencies?

CVA for nutrition projects can be designed and implemented to benefit different types of individuals and groups, considering their needs and constraints and the services available in their communities.

Targeting individuals or households. CVA can be used for individual feeding assistance or for meeting the needs of the entire household. Combining household and individual feeding assistance (by a top up, for instance) is recommended by the Evidence and Guidance Note for Nutrition outcomes¹, to have a greater impact on dietary diversity and reduce the risk of sharing the transfer resources across the household.

Target groups and program objective. The decision on what group to target in a project that uses CVA for nutrition outcomes should be guided by the project objective and not by the modality used. Eligibility criteria are best decided in coordination with the nutrition cluster, health partners and cash working groups and should be integrated into a practical set of criteria that are feasible to assess.

Eligibility criteria will depend, primarily, if the project aims to prevent malnutrition or improve treatment outcomes.

i. When CVA is used to prevent malnutrition, the main target is usually nutritionally at-risk individuals and groups. Individuals and groups are categorized as “at risk of malnutrition” when they may not yet be confirmed to be malnourished but:

- are in a phase of **the life cycle when they are most vulnerable to malnutrition** (children under five, pregnant and breastfeeding women (PBW), adolescent girls, amongst others);
- **live in geographic areas** with a high prevalence of malnutrition, acute food insecurity (defined as limited availability of, access to nutrient-dense foods), poverty, or in areas with limited access to health services addressing diarrhoea and other high-risk factors.

Additional criteria can be used to further prioritise poor and vulnerable households with individuals at higher risk of malnutrition. This may include households with any woman of reproductive age, female-headed households, elderly-headed households, households with many children, children 0 to 59 months of age with diarrheal diseases; etc.

ii. When CVA is used to improve wasting treatment outcomes and prevent relapse after treatment, the main target groups are usually:

- Children 0 to 59 months of age enrolled in treatment programmes.

¹ Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies | Global Nutrition Cluster

- PBW enrolled in supplementary feeding programmes.
- In addition, malnourished people living with chronic illness such as HIV or tuberculosis may be targeted.

Projects that aim to prevent relapse of wasting should identify wasted children and malnourished PBW from the registers at health facilities/ supplementary feeding sites. Children and women should be identified just before or as they are discharged from the treatment / supplementary feeding programme.

Promising practices on targeting include:

- **Determining CVA recipient:** decide which adult member within the household will receive CVA (regardless of objective) based on a risk assessment and gender analysis and only with the buy-in from the affected community, as recommended by the Evidence Guidance Note on CVA for Nutrition Outcomes.
- In projects that promote a women centred programming, use a ‘woman plus’ approach where additional services or benefits other than cash being offered to the other household members and spouses. A ‘delegation component’ for receiving cash and benefiting from the transport service can also help in cases where the cash recipient (e.g. PBW and/or care giver) does not have the time or the capacity to travel to access the distribution point.²
- When CVA is used to prevent relapse and improve treatment outcomes, clarify the package of interventions to be offered to wasted children and PBWs in treatment/ supplementation programmes after discharge and communicate it well to partners to ensure understanding of needs and existing interventions for the CVA design, thus avoiding overlap with the cash or voucher assistance.

2. Can targeting of households with wasted children or targeting of pregnant and breastfeeding women for CVA cause harm?

The risk of creating negative perceptions. Although evidence is very limited³ and mixed⁴, adopting a targeting strategy based on a single eligibility criterion of a household having a wasted child or PBW as a family member could create a negative incentive, like ‘rewarding’ households with a malnourished member or encourage non pregnant women to use negative practice to be enrolled in a CVA program.

Using malnutrition as a sole and explicit criterion for households to receive cash could encourage parents/ caretakers in difficult circumstances to cause their children to become or continue to be wasted. Promising practices to mitigate this potential risk are:

- Use several criteria to identify vulnerable households and communicate this full set of criteria well to target communities, staff and volunteers.
- Only use the nutritional status of household members to target for CVA when the CVA component is well integrated with the treatment of malnutrition, as recommended in The Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies.⁵
- Invest in CVA targeting strategies to both prevent malnutrition and improve treatment outcomes. Investing more in CVA for prevention will be more inclusive and mitigate any risk of negative incentives.
- Good project planning, risk analysis and identification of mitigation measures with the communities are also instrumental to reduce the risk of negative practices.

2 Further guidance and tools on targeting can be found in the CALP Programme Quality Toolbox.

3 (Grellety et al., 2017; Poulson and Fabre, 2017; Dunn et al., 2012).

4 Evidence and Guidance Note, “Provide CVA to caregivers of SAM and MAM children: AAH, UNICEF and WFP consortium in Nigeria”; CARE Somalia (n.d.). Cash plus and Nutrition Outcomes.

5 Dürr (2020). Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies, “Provide CVA to caregivers of SAM and MAM children.

Similarly, common concerns around cash transfers and the risk of incentivising pregnancy or increased fertility are not held by the evidence. Global review of cash transfers found that most cash programs decreased the likelihood of pregnancy or giving birth⁶. To mitigate this risk, recommendations from practitioners include:

- combine demographic targeting with other vulnerability criteria, to avoid that women consider that by becoming pregnant, they can immediately access assistance.
- conduct risk analysis, monitoring pregnancy rates in the communities of intervention when possible and use a one-off registration process for enrolment of PBW.
- specify what is the appropriate period for enrolment to reduce inclusion and exclusion errors: define which trimester enrolment will start in and how pregnancy will be verified in a culturally appropriate and sensitive way (as first trimester is usually very difficult to confirm)⁷. In addition, communicate clearly, what the duration of the programme will be in the context of funding.⁸

3. How is the value of the cash or voucher assistance calculated in a CVA for nutrition project?

When CVA is provided to improve nutrition outcomes, the transfer amount should be designed to reflect the beneficiaries' needs, what they can purchase and the services they can access in the local markets. The CVA transfer value can be designed to cover households or individual needs; however, for higher impact, the Evidence and Guidance Note recommends designing a program and transfer value that covers both the collective needs of the household as well as the individual needs of all its members.

The calculation method and tools used to inform the calculation depends on the objective of the programme (prevention of stunting or wasting, improving dietary diversity, facilitating access to treatment services etc.) and the contextual factors (level of food insecurity/poverty/malnutrition prevalence in the population, food

availability and access, supportive nutrition, and other sectoral programming in place etc.).

The tool used to calculate the transfer amount is called the **expenditure basket**. The content of the expenditure basket depends on the objective of the CVA component. According to the Evidence and Guidance Note on CVA for Nutrition outcomes⁹, CVA can be designed to meet **three main typologies of objectives**:

- A. to access a **nutritious diet**;
- B. to access basic goods and services, including a nutritious diet;
- C. to access preventive health and nutrition services.

The most used expenditure basket in humanitarian responses is the Medium Expenditure Basket (MEB), a tool that helps to identify and quantify basic needs items and services at the household level that are accessible through local markets and services (CaLP, 2019).

Most of the time when CVA is provided as part of a multipurpose cash assistance (MPCA) or food security response, the transfer value is often designed to ensure the household's food security and does not necessarily include nutrition considerations. Reaching consensus on the appropriate transfer value to meet nutrition goals can be particularly challenging. Food Security, Nutrition and Health Clusters should be mobilised to work with the Cash Working Group (CWG) to determine an appropriate transfer value.

A. CVA TO ACCESS A NUTRITIOUS DIET

In the current practice, when CVA is provided as part of a food security response, it is designed as a standard **Food Basket**, which can be a standalone expenditure basket or considered as the **food component of the MEB**. The standard food basket is an average per person per day target (i.e. applies the same Kcal target to all individuals regardless of age, activity level etc) that is used to calculate the cost of a food basket for a typical household in the local context; it is indeed designed in a way that does not allow households to purchase a nutritious diet. To be nutrition sensitive, the food basket (or food MEB) should be designed to meet the specific macro (energy, protein, fat) and micronutrient (vitamins, iron, calcium etc) needs of households or individuals.¹⁰

6 by Bastagli et al. (2016), Handa and al. (2017), Maternal and Child Cash Transfers Programs in Nigeria and Myanmar, Save the Children.

7 Despite global recommendation is to support this category from the moment of conception until the second year of the child (the 1000 days windows), the experience of practitioners suggest that it can be challenging to target pregnant women in the first trimester, when pregnancy is not visible and the linkage with antenatal care is not guaranteed.

8 Due to the short duration of humanitarian programs (and funding cycle) this timeline can be different and should be based on context specific periods of vulnerability (e.g.: pregnancy since the first trimester, and breastfeeding until the age of 12 months).

9 [Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies | Global Nutrition Cluster](#), Design the CVA Component, Expenditure Basket and Transfer Amount.

10 Information about macro and micronutrient requirement are available at NutVal.Net

be disbursed before or at the time of the attendance of health and nutrition services.

CVA alone is not enough. Despite increased attention to integrate nutrition considerations in the calculation of transfer amount, distributing cash grants will only boost people's purchasing power but may not change their willingness to buy more nutritious food. If nutrition practices are a barrier to nutrition, you need to craft a Social and Behaviour Change approach to sharing adequate knowledge and providing support on how to better allocate the extra resources given for spending on food and services that are essential to nutrition.

4. How can we influence the use of CVA to contribute to nutrition outcomes?

Cash transfers are unrestricted by nature and recipients can use the money received for what is the most important to them. To influence the use of the transfer for nutrition purposes, the provision of CVA should be systematically combined with a strong social and behaviour change (SBC) intervention. SBC interventions aim to empower individuals/households/communities with knowledge and skills, to leverage facilitators of good practice and to reduce barriers for adoption of recommended nutritional practices. SBC activities may include social and behaviour change communication (SBCC) as well as other approaches such as peer support groups, role modelling and influencing policy to create an enabling environment for behaviour change.

Advantages & constraints of SBC. Evidence suggests that cash transfers combined with SBC can improve child and maternal diets and nutritional status in humanitarian or fragile contexts.²⁰ However, for SBC to be effective in short-term CVA for nutrition programming, it requires quick planning and focused efforts with the program participants. It requires knowledge on existing (including pre-crisis) nutrition behaviour and practices as well as existing groups and platforms so they can be leveraged and strengthened to enable behaviour change within a short timeframe.

To maximise the effect of an SBC component for CVA:

- Design the SBC intervention to influence spending decisions in addition to promoting recommended nutrition behaviours. Spending decisions at the household level are a critical factor when it comes

to the direct impact of CVA on nutritional status of women and children.²¹ Continuous sensitization and counselling for beneficiaries on how to spend their money can encourage spending patterns that are in line with improving nutrition outcomes.

- To In addition, and particularly relevant when transferring cash, SBC may also tackle household decision making (such as control over resources, resource allocation, purchase of nutritious foods), household dynamics (such as food sharing and prioritising nutritional needs) and financial management.²²
- Ensure that SBC addresses discriminatory social and gender norms that prevent women and children from claiming their full and equal rights. Gender inequality commonly creates barriers to nutrition and health, e.g. via limited decision-making power, mobility, literacy.²³
- Identify the appropriate audience for SBCC and engage influencers (including fathers and other family members) or retailers, based on a good understanding of decision-making power within the household and the community. SBCC messages must also create conditions for a supportive care environment that encourages a child-centred use of household resources.
- Ensure that the SBC strategy and activities are designed based on a dialogue with and are appropriate for the target group (e.g. PBW) and include a mix of individual, community and systems/policy level activities through multiple communication channels/approaches, following the socio-ecological model;
- Develop your nutrition messages so they address the main drivers for behaviours related to preventing malnutrition. The messages need to be designed to cater to preferences of different population groups and household members.
- include indicators to measure shifts in behaviour change and social norms in the monitoring of program activities periodically and plan mitigation steps and course correction based on findings.
- When feasible and accessible to the target audience, consider the use of mobile phones for conveying nutrition nudges directly to caregivers of SAM and MAM children. These would be discrete and hence reduce stigma of having a SAM or MAM child as part of the household.

20 TASC (2021). How to Promote Better Nutrition through Social Assistance A Guidance Note

21 [Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies | Global Nutrition Cluster](#)

22 [Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies | Global Nutrition Cluster](#)

23 [Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies | Global Nutrition Cluster](#)

To date, most of the evidence on the effectiveness of the combination of CVA and SBC for the prevention of malnutrition is from the development context. Partners are encouraged to invest more in evidence generation and dissemination around the impact of nutrition sensitive CVA programs from humanitarian settings and document the impact on the immediate and underlying determinants of maternal and child nutrition.

5. Would conditional assistance be helpful to create nutrition incentives for project beneficiaries?

As a general principle, conditions are not recommended when the conditioned services are not available or not affordable for recipient households.

Conditionality refers to prerequisite activities or obligations that a recipient must fulfil to receive assistance.²⁴ Conditionality may be tempting to encourage certain behaviours but can lead to barriers in accessing assistance. For projects that use conditional CVA, where-in the cash assistance is attached to the attendance of nutrition services or SBC sessions, experience has shown that exogenous factors (e.g. physical access barriers) could prevent certain beneficiaries from meeting the condition and accessing CVA.²⁵ The use of conditionality might increase attendance to health and nutrition services, however, there is a wide range of evidence on the negative effect that conditionalities can have on other outcomes, such as gender and protection.²⁶

In conclusion, providing conditional CVA assistance might be perceived as helpful to ensure attendance to nutrition services, however the varying impacts of conditionalities on different groups should be more closely examined and considered to avoid doing harm to the most vulnerable.

If possible, opt for providing unconditional rather than conditional CVA for two main motivations. First, empowering crisis affected households to make their own decisions is a sign of respect. Second, imposing conditions requires costly monitoring and enforcement

24 CALP Glossary (2018)

25 Child Outcomes of Cash Transfer Programming: A synthesis of the evidence around survival, education, and protection in humanitarian and non-humanitarian contexts | Save the Children's Resource Centre: the evidence suggests that conditionalities may effectively discriminate against the most isolated and socially excluded recipients, who may find it more costly or difficult to access services and a greater challenge to consistently meeting the demands of conditionalities.

26 [Family-oriented cash transfers from a gender perspective: Are conditionalities justified? | UN Women – Headquarters](#): the brief discusses the impact of conditionalities on the lives of poor women and detrimental effects in contexts where there aren't quality public services or where there are pre-existing discriminatory conditions.

27 Caldes, Natalia, and John Maluccio (2005). The Costs of Conditional Cash Transfers.

28 Alderman (2015). Leveraging Social Protection Programs for Improved Nutrition

structures to be put in place. One detailed estimate put the administrative costs of a conditional cash transfer scheme as high as 63% of the transfers made over the first three years of the program.²⁷ There is little evidence to suggest these added costs produce commensurate benefits.²⁸ Therefore, practitioners are inclined to adopt unconditional transfers, or just soft conditionality e.g. by encouraging beneficiaries to attend SBC sessions, but not excluding those who are not able to attend.

6. Which indicators are recommended to measure CVA contributions to improving nutrition?

The identification of appropriate indicators to include in the monitoring and evaluation of the CVA programme component is key for understanding the contribution of the programme to nutrition outcomes as well as to interpret any deviation from the expected outcome.

The selection of indicators is context-specific, but below are some key considerations when selecting relevant indicators:

- **List the underlying factors and specific problems that the response is trying to address.** Developing a programme impact pathway or theory of change can help identify the key indicators along the pathways of interest to track progress and measure.
- **Select outcome indicators based on the main objectives and duration of the programme.** These should be linked to the main intermediate outcomes (e.g. food, health, wash, women's empowerment etc.) that the CVA is expected to change within the given time period. For instance, CVA can aim to improve dietary diversity and feeding practices or help individuals access health services. When CVA is combined with complementary health and nutrition interventions, consider monitoring the anthropometric indicators for the population of interest. (See table 1).

- **Consider including indicators to track any unintended effects due to the provision of CVA**, such as increased use of breastmilk substitutes (BMS) or, in some contexts, excessive consumption of (ultra)processed foods.
- **Make sure you pick indicators that you have the capacity to collect, analyse and utilise in a timely way** for adaptive management, impact assessment and program re-design purposes. This is particularly important in emergency contexts, where access to vulnerable populations and time for in-depth assessment and monitoring can be limited and face to face monitoring may not be always feasible.
- **Move beyond household level indicators as these do not capture the nuances of intra-household distribution of food** and cannot be extrapolated to all individuals in the household. CVA for nutrition indicators should focus on the nutritionally vulnerable individuals that are the target of the intervention.
- **Monitor output and process indicators for both the CVA component and any relevant to the nutrition/ health/ WASH activities.** These are in addition to the relevant outcome indicators listed in Table 1. They will help identify bottlenecks arising from programme implementation and help interpret the outcomes These should include:
 - 🍷 **Standard CVA output indicators:** Total transfer value by individual, total number of individuals receiving transfers disaggregated by sex and age as relevant, and total number of transfers by individual.
 - 🍷 **Standard CVA process indicators.** For example, timely distribution of transfer, value of the transfer, adequate transfer accessibility/ connectivity, full redemption of the transfer. Data collection should be frequent - usually after each payment cycle and should be validated with internal financial records, as self-reported data may be incomplete or affected by recall bias.
 - 🍷 **Nutrition-related output and process indicators.** These should be developed from the outcome level indicators chosen and reflect the change pathways the intervention expects to influence. Examples include number of carers participating in behaviour change communication/ health education sessions each month, number of children admitted for treatment of severe wasting.

🍷 **Process indicators to check if the required goods/food/services are available, at reasonable prices and at minimum standards.** This might include monitoring food prices, availability of nutritious food, challenges with markets, health service provision, etc. Existing tools and monitoring systems should be utilised where possible for this, including WFP's mobile Vulnerability Analysis and Mapping (mVAM) and REACH Joint Monitoring Initiative (JMMI).

Below you can find a table with a brief list of illustrative indicators for specific outcomes a programme using CVA to improve nutrition might use. Indicators should be chosen based on the intended impact pathways. All the indicators require expertise in measurement, and some require specific technical knowledge to carry out e.g. anthropometric measurements or assess vaccination status. Resources are provided below the table, but programme teams engage the right expertise to measure these correctly.

Table 1: Illustrative list of outcome indicator categories that may be considered, following the UNICEF concept framework of undernutrition

Relevant nutrition outcome	Illustrative indicators	Comment
Anthropometric status	<ul style="list-style-type: none"> • Prevalence of child wasting and/or nutritional oedema (also known as acute malnutrition). % of children 6-59 months with MUAC less than 125 mm and/or nutritional oedema or % of children 6-59 months with weight-for-height (WHZ) <-2 and/or nutritional oedema. (WHO 2019) • Prevalence of wasting among women. % of women with MUAC less than 210 mm (OCHA indicator bank) 	<ul style="list-style-type: none"> • The women included in MUAC indicator must be indicated. For example, pregnant women and mothers breastfeeding infants under six months is often used but the sub-group of women can be adjusted
Diet adequacy	<ul style="list-style-type: none"> • Minimum Dietary Diversity for children (MDD-Ch). % children 6-23 months with minimum diet diversity (at from 5 out of 8 standardised food groups) (WHO 2021) • Minimum Dietary Diversity for women (MDD-W). % of women with minimum diet diversity (or average dietary diversity score for women) (FAO 2021) • Minimum Meal Frequency for children (MMF). % of children 6–23 months of age who consumed solid, semi-solid or soft foods (but also including milk feeds for non-breastfed children) at least the minimum number of times during the previous day. (WHO 2021) • Minimum Acceptable Diet (MAD). % of children 6–23 months of age who consumed a minimum acceptable diet during the previous day. (WHO-UNICEF 2021) 	<ul style="list-style-type: none"> • Diet diversity can also be calculated as an average score. DD must use the standard food categories but adapted to the context. • MDD-W - the exact sub group of women must be defined (e.g. women of reproductive age, or women who are pregnant or breastfeeding) • MAD is a combination of minimum diet diversity and food frequency for children.
Wasting treatment outcomes	<ul style="list-style-type: none"> • Recovery rate. % of children with severe or moderate wasting/ acute malnutrition exiting the programme that reach recovery criteria. (Sphere 2018) • Defaulter rate. % of children with severe or moderate wasting/ acute malnutrition exiting from the programme that default from services (are absent for 2 consecutive treatment visits) (Sphere 2018) • Inpatient treatment adherence: % of children referred for inpatient treatment who stayed for full treatment (discharged as stable to outpatient therapeutic services) (custom) • Relapse rate: % of children discharged recovered from wasting treatment services who relapse (return with admission criteria within a specific period defined by national treatment protocols) (custom) 	<ul style="list-style-type: none"> • Defaulting rate should reduce with DVA by assisting HH to attend treatment services. As recovery rate increases, default rate (as well as death rate and non-recovery rate) should decrease. They are all relative to one another. • Relapse rate is not always tracked well in standard wasting treatment programmes (it requires matching names of children when they return up to three months later) so may require special focus. It would be expected to reduce with CVA.

Health and nutrition services coverage	<ul style="list-style-type: none"> • Coverage of treatment services for wasted children: % of children with severe and/or moderate wasting enrolled in treatment services (ideally measured by coverage survey but other proxy measures possible) (Sphere 2018) • Primary health care utilisation rate: total patients seeking PHC services as a portion of the total catchment population per month (Sphere 2018) • Measles vaccination coverage: % of children 9 – 23 months who have received measles vaccination (or other standard vaccination coverage indicator) (DHS 2022) • Antenatal care service uptake % pregnant women who attended at least one ANC visit during the previous three months (custom) 	<ul style="list-style-type: none"> • Coverage surveys can often be expensive and complex to implement so proxy measures may need to be explored. • Note the antenatal care service uptake indicator is adapted from the standard % of women of reproductive age (15 – 49 years old) who received antenatal care (ANC) from a skilled provider for the most recent birth during the two years before the survey. (DHS 2022)
Infant and young child feeding (IYCF) and care practices	<ul style="list-style-type: none"> • Exclusive breastfeeding. % of children under six month exclusively breastfed (see WHO 2021) • Care seeking for child illness. % of children who were ill during the previous two weeks who were brought for care at an appropriate health facility/ provider (DHS 2022) • For other more detailed IYCF indicators see Guidance on IYCF Indicators (WHO/ UNICEF 2021) • Knowledge of key feeding and care practices. Where practice is difficult to achieve or measure, an alternative knowledge indicator could be used e.g. % of primary carers of children under five/ under two who know correct answers to questions on key topics (custom indicator) 	<ul style="list-style-type: none"> • Selection of the IYCF and caring practices should be tailored to the social and behaviour messaging included and how the programme expects CVA to impact behaviours (and knowledge)
WASH Practices	<ul style="list-style-type: none"> • Access to handwashing facilities. % of households having access to a functioning handwashing facility with water and soap (or ash) at home (CALP 2022) • Latrine use. Households reporting that all household members have access to a safe, secure, clean, and well-maintained toilet, including water and anal cleansing materials (CALP 2022) • Knowledge of handwashing. % of individuals who know at least three (3) of the five (5) critical times to wash hands (common but no specific source found) • Meeting household water needs. % households reporting that all HH members have access to an adequate quantity of safe water for drinking, cooking, personal and domestic hygiene (CALP 2022) 	

Here a list of tools/guidance that can be consulted:

- [Recommendations for data collection, analysis and reporting on anthropometric indicators in children under five years old](#). WHO 2019.
- [Indicators for assessing infant and young child feeding practices](#). WHO/UNICEF, 2021
- [Multipurpose outcome indicators and guidance. Grand Bargain Cash Workstream/ CALP, 2022](#)
- [Multipurpose-cash-assistance-\(MPCA\) monitoring-evaluation-accountability-and-learning \(MEAL\) toolkit](#). Save the Children, 2022
- [The Sphere Handbook](#). Sphere 2018.
- [Demographic and Health Surveys, DHS8 Tabulation Plan for Key Indicators – Tab 9](#). DHS 2022
- [Inter-Agency Social Protection Assessment tool for Food Security and Nutrition \(ISPA-FSN tool\)](#): Assessing social assistance programmes for better food security and nutrition and ISPA-FSN [e-learning course](#). FAO and World Bank 2020.
- [How to promote better nutrition through social assistance](#). Technical Assistance to Strengthen Capabilities (TASC) Project 2021.
- [Compendium of indicators for nutrition-sensitive agriculture](#). FAO, 2016.
- [Humanitarian cash transfer monitoring and evaluation guidance](#). UNICEF 2018.

