

Case study: Documentation of experiences using CVA for nutrition outcomes in Nigeria

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1 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.

The Nutrition Cluster Coordination Team and partners in Nigeria has expressed interest to accommodate one of the case studies on the use of CVA for nutrition outcomes. The nutrition situation in Nigeria, particularly in the North-East of the country, remains extremely worrying¹. The main objectives of the nutrition sector in 2020 are to strengthen the quality and scale of preventative and curative nutrition services for most vulnerable groups through systematic identification, referral, and treatment of acutely malnourished, supplementary feeding, promotion of appropriate infant and young child feeding practices, micronutrient supplementation and optimal maternal nutrition². There is a strong interest to better explore the potential of CVA modalities in preventative and curative strategies in the context of Nigeria.

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 minimum expenditure basket (MEB) and existing multi-purpose cash interventions
- To the extent possible, review whether a CVA approach could be used for the treatment of moderate acute malnutrition (MAM)
- Document how CVA is being integrated into nutrition responses and results
- 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

¹ Food insecurity driven by conflict, insecurity, and population displacement, remains the highest driver of need. The Cadre Harmonise analysis in October 2019 indicates that 2.9 million people across the BAY states (Borno, Adamawa and Yobe) are food insecure (CH/IPC Phase 3 to 5) – a 72 per cent increase from October to December 2018 post-harvest period findings. Besides, around 3.8 million people are projected to be food insecure in June to August 2020 and considered to be facing crisis or emergency (CH Phase 3 or 4). The nutrition situation is equally worrying, compounded by weak healthcare systems, limited access to safe drinking water and sanitation services, poor infant and young child feeding practices and poor living conditions in congested camps; up to 1.1 million children and women need immediate nutrition services. Global acute malnutrition (GAM) in children aged six to 59 months increased from 6.7 percent in 2017 to 11 percent in 2019, exceeding the WHO threshold of 10 per cent (OCHA Humanitarian Response Plan 2020 for Nigeria)

² OCHA (2020). Humanitarian Response Plan for Nigeria.

Methodology

The GNC cash advisor was meant to visit Nigeria, Maiduguri, in March to conduct interviews with partners, review project documentation 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 (AAH, WFP, Nutrition Cluster, IMC, ICRC) were conducted remotely.

Table 1 provides an overview on ‘nutrition projects’ with a CVA component and on the project documentation reviewed as part of this case study.

Org.	Duration	States LGAs	Project	Documents reviewed
AAH (Action Against Hunger)	2016 to 2017	Yobe	Protecting and promoting the food and nutrition security in the Yobe State, Phase II	Final evaluation report
AAH	2018 to 2019	Borno <i>MMC, Yere</i>	Improving food and nutrition security in Borno state	Project proposal (internal) Endline report (internal) Final evaluation report (internal) Porridge Mom case study
AAH	2019 to 2020	Borno, Yobe <i>Several</i>	Improving food and nutrition security of conflict affected communities in North East Nigeria.	Project proposal (internal)
ICRC	May 2019 - Dec 2019	Borno <i>Jere</i>	Relief Assistance for the IYCF beneficiaries	Project Proposal (internal)
Consortium (AAH, WFP, UNICEF)	2016 to 2017	Borno, Yobe	Integrated basic nutrition response	ACF learning document
Consortium (AAH, WFP, UNICEF)	2017 to 2019	Borno, Yobe <i>3 LGAs in Yobe, 6 LGAs in Borno</i>	Integrated basic nutrition response plus (INP+) to the humanitarian crisis in Borno and Yobe	Project proposal
Consortium (AAH, WFP, UNICEF)	2017 to 2019	Borno, Yobe <i>Shani, Nagere</i>	INP+ multi-sectoral pilot	Baseline report (internal) Midline report (internal)
WFP	2019 to 2020		Multisectoral programme (MSP)	NA

Table 1. Overview on reviewed projects and documentation

Content

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’ and contains a short section on the potential of CVA to substitute specialized nutritious foods. Chapter 3 reviews past and ongoing nutrition responses with a CVA component with a particular focus on design, results and learning. Chapter 4 looks at the broader CVA response in Nigeria and reviews the nutrition sensitivity of multipurpose cash (MPC) in Nigeria. Chapter 5 concludes the case study and provides some recommendations for next steps.

2 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:

- 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 items, safe water, health services and medication, transportation, and productive inputs.
- If provided conditionality, CVA can promote participation in nutrition social and behavioural change (SBC) activities³ and attendance to priority health services⁴.
- The temporary increase in household budget can have additional positive or 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 much better 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 an 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 various ways.

Components of nutrition response	Traditional response modality	Possible role of CVA	Primary objective of CVA
<i>Nutrition sensitive response options</i>			
Household assistance	In-kind general food distribution (GFD) And	Replace in-kind assistance through general household CVA	<ul style="list-style-type: none"> Improve household food security and dietary diversity Protect nutritional status

³ While the specific behaviours to be targeted through SBCC 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.

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.

Can complement any nutrition-specific response option	non-food item distribution (NFI)		<ul style="list-style-type: none"> If provided in combination with individual feeding: Reduce sharing of specialized nutritious foods If provided in combination treatment: Reduce defaulting, non-response to treatment and relapse.
Livelihood support	Cash grants Livelihood in-kind inputs (seeds, tools, etc.)	Cash grants and vouchers for productive inputs commonly used in livelihood support interventions	<ul style="list-style-type: none"> Enhance food production and/or income generation
Nutrition-specific response options aimed at preventing malnutrition			
IYCF through social and behavioural change activities	Communication and counselling services	CVA can be provided conditional on attendance in SBCC activities	<ul style="list-style-type: none"> Incentivize participation in SBCC activities
Blanket supplementary feeding	Specialized nutritious foods: LNS-MQ; fortified blended foods	Replace in-kind food products through <ul style="list-style-type: none"> Cash top-up amount based on the nutrient requirements of at-risk groups (Fresh) food vouchers value and composition based on the nutrient requirements of at-risk groups 	<ul style="list-style-type: none"> 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. Increase access to fresh and nutritious foods
Complementary feeding	Specialized nutritious foods such as fortified foods and micronutrient powders targeting children 6-23 months	Replace in-kind specialized nutritious foods through <ul style="list-style-type: none"> Cash top-up amount based on the nutrient requirements of at-risk groups (Fresh) food vouchers value and composition based on the nutrient requirements of at-risk groups 	<ul style="list-style-type: none"> 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 specialized nutritious foods: Vitamin & mineral powder; LNS-LQ/MQ; fortified blended foods	Complement nutrition supplements through general household CVA	<ul style="list-style-type: none"> to reduce the prevalence of micro-nutrient deficiencies
Provision of breast milk substitutes (BMS)	Provision of in-kind BMS	Replace in-kind BMS vouchers to access BMS	<ul style="list-style-type: none"> Provide BMS to infants that cannot be breastfed
Provision of priority health services	Health service provision: vaccination, deworming, pre-post-natal care, growth monitoring	CVA can be conditional on attendance to priority health services Complement: CVA to cover costs associated with accessing health service	<ul style="list-style-type: none"> Promote attendance to priority health services Cover transportation costs Cover out-of-pocket expenditure Reduce opportunity costs
Nutrition-specific response options aimed at treating malnutrition			
Targeted supplementary feeding (for treatment of MAM)	<ul style="list-style-type: none"> Health service provision (routine treatment) Specialized nutritious foods: fortified blended foods; RUSF 	Complement: <ul style="list-style-type: none"> CVA to cover costs associated with accessing health service General household CVA 	<ul style="list-style-type: none"> Improve access to health services Cover transportation costs Cover out-of-pocket expenditure Reduce opportunity costs In-patient care: cover food and accommodation costs of caregivers
Therapeutic care (for treatment of severe acute malnutrition, SAM)	<ul style="list-style-type: none"> Health service provision Specialized nutritious foods: RUTF 		
Treatment of micro-nutrient deficiency disease	<ul style="list-style-type: none"> Health service provision Oral supplement tablet or capsule 		

Table 2. The role of CVA in different nutrition response options⁵

In principle, CVA can replace the traditional response modality if it can achieve the same results. This is the case for household level assistance in the form of general food distribution (GFD) and non-food items (NFI) assistance. In the last couple of years and in many humanitarian contexts, GFD and NFI have been fully or partially replaced by mainly cash transfers but also vouchers.

CVA can also replace some forms in-kind individual feeding assistance but special attention needs to be paid to nutrient density. Infants and young children have comparatively high energy requirements per kilogram of body weight and have limited capacities to consume food. They need complementary foods with a high nutrient density (particularly for iron and zinc), with a texture and a density that is palatable and likeable by children, taking into account their capacity to chew, the small size of their stomach, and safety considerations. Their nutritional requirement is often easier to achieve with specialized nutritious foods as compared to locally available foods.

In preventative strategies, CVA equivalent to the nutrient value of the take-home ration can be considered an alternative to certain specialized nutritious foods (lipid nutrient spread (LNS) and fortified blended foods (FBFs)) if nutritious foods with the required micro and macronutrients are available, accessible and can be prepared with sufficient nutrient density. When it comes to preventing micro-nutrient deficiencies, **CVA is should not be considered an alternative to nutrition supplements (micro-nutrient powders) to prevent micro-nutrient deficiencies.** Similarly, **CVA should not be considered an alternative to specialized nutritious foods for the treatment of MAM and SAM** where a specific lack in nutrients needs to be addressed.⁶

3 The use of CVA in the nutrition response in Nigeria

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. According to the 2020 HRP, six projects mainly under prevention of acute malnutrition interventions will be implemented through cash and voucher transfers, with a total financial requirement of \$28.7 million, or 30 per cent of the Sector's overall financial requirement.

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 SBC, providing cash transfers conditional on attendance to priority health services, and providing cash transfers in combination with SAM treatment.

3.1 Providing cash transfers with nutrition social and behavioural change communication

In programmes where CVA and SBC are combined, CVA can be provided either conditionally (i.e. the assistance is tied to the participation in interpersonal SBC activities) or unconditionally (i.e. the assistance is not tied to the participation in interpersonal SBC activities). There is relatively strong peer-reviewed and

⁵ Table extracted from GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.

⁶ This section has been extracted from GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.

operational evidence that combining 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 SBCC component seems to promote nutrition-sensitive and child-centred spending decisions while the cash transfer allows caregivers to put some of the learning into practice. Therefore, when providing cash transfers to achieve nutrition outcomes, the integration of nutrition SBCC is indispensable⁷.

Since 2016, **Action Against Hunger (AAH)** has implemented three subsequent projects aiming to improve food and nutrition security of crisis-affected populations and Borno and Yobe states. These projects followed a similar approach and combined general household assistance (i.e. the provision of food, cash and/or vouchers) to increase immediate food consumption for food-insecure households and nutrition behaviour change interventions targeting pregnant and lactating women (PLW) with a focus on adoption of optimal infant/young child feeding practices by caregivers.

The transfer amount of the household assistance ranged between 17,000 to 21,000 NGN per household per month. This represented between 70% to 100% of the minimum food or expenditure basket. Project evaluations from Yobe and Borno found that the cash and voucher assistance helped households to improve diversify their diets. Also, cash transfers helped recipients to pay for immediate medical needs. The Borno evaluation found that cash transfers were more effective for increasing dietary diversity and quality, while food vouchers had a greater impact on per capita daily caloric intake.

The implementation of the nutrition SBCC approach varied between projects and states:

In In *Yobe* state, 1,500 PLWs benefited from infant and young child feeding (IYCF) counselling through *care groups*. The aim of the IYCF activities was to equip women with skills and knowledge on how to prepare healthy and nutritious meal from the locally available food for all children under five years of age and pregnant and lactating women in order to prevent children detected MAM during screenings from deteriorating into SAM and referred the SAM case to nearest outpatient therapeutic program (OTP) site before onset of medical complications, especially in view of the approaching lean season. The project evaluation revealed that the IYCF activities had a positive impact on the rate of exclusive breastfeeding, which increased from 26% at baseline to 72% at endline.

In *Borno* state, AAH continued with the *Porridge Mum* approach⁸. AHH during the 2018-2019 project supported 100 porridge mom groups that comprised of a total of 1,500 PLWs. Each group received a set of cooking utensils including a locally made fuel efficient stove, an electronic food voucher to purchase the ingredients for the daily cooking demonstration and a cash transfer to cover additional costs related to transportation and cooking. The food voucher and cash transfer was administered by each group's treasurer. Also, each group was trained on preparation and cooking of nutritious foods. The evaluation found that the knowledge on complementary nutrition activities through porridge mum were highly satisfactory resulting in long-term impact and contributing to households positive coping mechanism. However, the evaluation also found that kitchen-based activities, i.e. the daily preparation of nutritious

⁷ GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.

⁸ The Porridge Mum approach provides a platform for women to come together, learn and discuss issues related to improved child caring and feeding practices. Porridge Mum groups ensure that children under five and pregnant and lactating women (PLW) receive one supplementary nutritious meal per day. The groups also provide a strong foundation for promoting optimal IYCF practices, offering breastfeeding support, creating "safe spaces" for sharing and discussion among women, and screening regularly for undernutrition in children under five.

meals, were stopped at same time when AAH assistance stopped by end of March 2019. For the follow up project, AAH changed its porridge mum approach and reduced the number of cooking demonstrations and feeding sessions to twice weekly. Instead of providing food vouchers and cash transfers to the porridge mom group, AAH now provides food vouchers at NGN 5000 per month directly to PLWs. With these monthly transfers, each PLW is expected to contribute to the cooking demonstration requirements of their groups.

The **ICRC** initiated a project aimed at improving IYCF practices for caregivers in Muna Garage IDP camps in May 2019. The intervention consisted of IYCF counselling on maternal nutrition, early Initiation of breastfeeding and exclusive breastfeeding. The project team noted that most women were experiencing low milk supply associated with an inadequate diet and lack of food intake. In response, the ICRC introduced food and cash assistance to 350 lactating women. The aim of the assistance is to improve food consumption of lactating women and thereby prevent malnutrition of both women and the breastfed children. The assistance is comprised of a one-off food ration and two rounds of unconditional cash transfers of NGN 30,000 per month.

3.2 Providing cash transfers conditional to the attendance of priority health services

There is strong evidence form development settings suggesting that cash transfers can improve the uptake in priority health services and some evidence that conditional cash transfers might be better suited to do so. However, the evidence base for humanitarian settings remains weak and operational experience remains scarce. Nevertheless, the learning from Nigeria is encouraging and showcases different approaches to conditionality and positive results on improving attendance to health services.

A consortium including AAH, WFP and UNICEF implemented the Integrated Nutrition Programme plus (INP+) from 2017 to 2019 in Borno and Yobe states. The project included a whole range of nutrition sensitive and specific interventions, including maternal dietary supplementation, micronutrient supplementation, breastfeeding and complementary feeding promotion, dietary supplementation for children, community management of acute malnutrition (CMAM), Long Lasting Insecticide–treated Nets (LLIN) distribution, and cash transfers. The cash component provided a conditional cash transfer of NGN 5,000 per month to cover the additional nutritional requirements of PLWs and the children during pregnancy and until the child turns two (first 1000 days window of opportunity). The assistance was conditional on the initial enrolment at the health centre. Once enrolled, PLWs were actively encouraged to access health services, such as antenatal care or vaccinations, and their attendance was monitored ('soft conditionality'⁹). PLWs were also referred to mother to mother support groups during their enrolment and actively encouraged to participate in SBC sessions ('soft conditionality'). The project led to a significant uptake of ANC visits and immunizations and improvements in the dietary diversity of PLWs and children.

The INP+ multisectoral pilots implemented in Shani and Nagere local government area (LGA) from July 2017 to March 2019 adopted a similar approach as the INP+ but included additional sectoral interventions

⁹ Soft conditionality means that targeted individuals and households are actively encouraged to fulfil the conditionality (i.e. participate in a SBC intervention or attend a health service) and possibly followed up if they fail to do so. They are however not excluded from the assistance if they fail to comply with the conditionality.

such as WASH support and livelihood support for PLWs. The midline surveys conducted in 2018 show that over about one-year duration of implementation of multi-sectoral interventions (comparing with the baseline), indicators such as under-five mortality rate, exclusive breastfeeding, minimum dietary diversity and minimum acceptable diet for children, household dietary diversity and access to safe and clean water supply improved across the surveyed LGAs. The conditional cash component seemed to have increased ante-natal care attendance, which resulted into the increase in the proportion of women who received Iron and folate supplementation in pregnancy.

The midline survey further found that stunting improved across board irrespective of whether the LGA is an intervention site or not. Population-based anthropometric measurements (GAM) for children aged 0 – 59 months across the interventions LGAs appear not to have improved¹⁰. In terms of negative consequences, some participants in focus group discussions (which were conducted as part of the mid-term survey) stated that the cash assistance causes disharmony in the family at the initial period of implementation especially in Nangere LGA, because their wives suddenly became rich and resisted sharing the money with them.

As a follow-up project to INP+, WFP has been implementing the multi-sectoral programme (MSP) since 2019. As in the INP+, the MSP is providing cash transfers of NGN 5,000 to PLWs conditionally on their enrolment at a health centre for antenatal care. At the same time, the PLWs are enrolled in mother to mother support groups, where they receive counselling on maternal and child nutrition and IYCF practices. According to WFP internal learning, the conditional cash assistance has increased uptake and utilization of basic health care services. The enrolment of PLWs at the health centres seem to positively impact health seeking following the enrolment. Also, the enrolment in mother to mother support groups and active encouragement of PLWs' participation in these groups (soft conditionality) significantly improved the participation of women in the health/nutrition education session at the community level.

3.3 Provide general household CVA to caregivers who access SAM treatment

Providing CVA to parents who bring their malnourished children for treatment at health/stabilization centres is a controversial approach among humanitarian practitioners and nutritionists, the common argument being that cash transfers tied to the nutrition status of children might incentivise caregivers to make or keep their children (or at least one of them) undernourished¹¹.

In Nigeria, AAH, UNICEF and WFP implemented the integrated basic nutrition programme (INP) from 2016 to 2017, providing financial support to caregivers of children who were admitted with SAM for treatment. The programme aimed to address underlying financial causes of child malnutrition and mitigate the risk of relapse. Households were registered on a continuous basis over the course of one year and were provided with monthly cash assistance for 6 months following enrolment. The transfer amount of approximately NGN 20,000 was based on the cost of the minimum food basket for a household.

¹⁰ This may be partly connected with the survey methodology (surveying the whole LGAs in a situation where the intervention services have not yet covered significant proportion of the LGAs); short term duration of implementation and uneven distribution of interventions within the LGAs in questions

¹¹ GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.

The programme seems to have contributed to several negative unintended consequences: both health workers and programme staff reportedly accepted bribes to enrol children who did not meet the criteria. There were rumours that services were sometimes denied to children whose caregivers could not pay. Based on these experiences, AAH suggests the following lessons: 1) to avoid using nutrition status as targeting criteria; 2) to systematically ensure independent verification of household eligibility; 3) to determine a contextually appropriate transfer amount; and 4) to ensure sufficient internal controls including monitoring and accountability systems are available for communities to share anonymous feedback¹². Based on these learnings and thanks to more sustained donor funding opportunities, the organizations decided to shift towards a preventative approach, which resulted in the INP+ approach.

There are currently no organisations that are using this approach in Nigeria. The INP experience was rather sobering from a protection perspective. Experiences in other contexts have been a bit more promising¹³. Nevertheless, from existing limited peer-reviewed and operational evidence, it is hard to come to a clear verdict on coupling cash transfers with SAM treatment¹⁴ (GNC, 2020).

4 Cash transfers in Nigeria

The use of CVA has been expanding rapidly in Nigeria over the past years. The financial requirement for CVA rose from \$22.3 Million (out of 248 million in total) in 2016 to \$473 Million (out of 869 million in total) in 2020. In the 2020 HRP, 86 out of a total of 264 projects have a CVA component. The majority of projects are in the food security and early recovery / livelihoods sector and an increasing number of projects are considered as multi-purpose cash transfers¹⁵.

The Nigeria Cash Working Group has devised a collaborative model for MPC in North-East Nigeria. The model proposes a harmonization of programme design and common tools: program objective, targeting criteria, outcome indicators, MEB design, transfer value alignment, price monitoring, joint PDM mechanisms, and other collaborative actions. For more information, please see the document 'Multi-Purpose Cash Grant – a collaborative model for North-East Nigeria'.



2018.09.25 - MPCG
Guidelines and recom

The Minimum Expenditure Basket for Nigeria consists of basic food items, condiments and supplements, cooking fuel (charcoal, firewood), water, laundry soap, bathing soap, sanitary pads, transportation,

¹² AAH (2017). A protection perspective on cash and nutrition. Learning review.

¹³ The only peer-reviewed study on this approach ([Grellety et al., 2017](#)) in DRC found that cash transfers provided to caregivers significantly improved the treatment outcomes of children treated for SAM. 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. Furthermore, all nutritional outcomes in the intervention group were significantly better than those in the control group.

¹⁴ GNC (2020). Draft evidence and guidance note on the use of CVA for nutrition outcomes.

¹⁵ 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)

communication. An incidental of 6% is added to cover unexpected needs. These items are what beneficiaries are likely to consider as most urgent needs and are all available in the local markets. The MEB adopted the Food Basket developed by the Food Security Sector. While modelling the food basket, several factors were considered including beneficiary preference, availability, and the ease with which households can prepare the items in the food basket compared to availability of fuel. The transfer amount calculation takes further into account household size and average household income. For more detailed information, please see the document 'Minimum Expenditure Basket for North East Nigeria - Justification and recommendations'.



2018 11 07 - MEB
Justification - Guidelir

From a nutrition perspective, it is important that an MEB contains locally available food items that satisfy the macro and micro-nutrient requirements of average households as well as specific at-risk groups within households. In addition, it is advisable that the MEB contains transportation expenses and health related expenses (related to out-of-pocket payments and other health related expenditure) that can facilitate access to health services.

Expenditure on transportation and health are both 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 calorie requirements (equivalent to kcal 2150), but is unable to meet the requirements for protein and most micronutrients (vitamins and minerals). In fact, the food component of the MEB is unable to adequately cover any of the micronutrient requirements apart from Selenium and Vitamin E. For more details, please see the NutVal Nigeria calculation¹⁶.



NutVal-4.0_Nigeria
MEB.xls

Several actions can be taken to make MPC interventions more nutrition sensitive. One of them is to appropriately reflect nutrition in the MEB and transfer amount calculation (see previous paragraph). Other measures include pairing cash transfers with nutrition SBC and choosing nutrition sensitive targeting criteria.

We have seen before that pairing nutrition SBC interventions with CVA is an absolute must if the CVA is meant to achieve nutrition outcomes. In the context of Nigeria, partners recommend that the delivery of the MPCG should be accompanied by sensitization on nutrition and hygiene messages (see MPC collaborative model document). It is however unclear to what extent efforts have been made to systematically incorporate nutrition SBC in MPC interventions.

¹⁶ It is important to highlight the limitations of the attached calculation: the MEB does not include detailed specifications for its food items (e.g. salt can be iodized or non-iodized, there are many different types of beans with different nutritional values, etc.). The author thus made certain assumptions when creating the ration content in the NutVal tool, which can be revised any time based on more detailed specifications.

As for targeting, in contexts where malnutrition rates are high, targeting strategies for MPC could pay specific attention to at risk groups, which includes the first 1000 days¹⁷ (PLWs and children below 2 years of age) but also children below the age of 5, the elderly or people living with HIV (GNC, 2020).

5 Conclusion

The context of Nigeria 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.
- Cash transfers have a much better chance to impact nutrition outcomes of mothers and children if provided alongside context-specific nutrition SBC.
- Conditional cash transfers can increase the attendance to priority health services.
- Targeting CVA based on the nutritional status of children in a treatment response can incentivize caregivers to keep or make their children malnourished.

We further saw that CVA and particularly MPC have been rapidly expanding in the Nigeria context, which offers the opportunity of better integrating nutrition considerations in the design and implementation of MPC. A short analysis of the food component of the MEB seems to suggest that the MEB is not sufficient to address the micronutrient needs of the broader population. While partners recognize that integrating nutrition SBCC into MPC could be beneficial from a food security and nutrition perspective, but limited progress has been made to advance this agenda. Lastly, targeting could offer another way to improve the nutrition sensitivity of MPC in the context of Nigeria.

¹⁷ 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. Evidence from the development literature indicates that targeting interventions to PLW and younger children during the first 1000 days has greater impact on child nutritional outcome. Most development organisations have since revised their strategies to address undernutrition focused on the 1000 days during pregnancy and the first 2 years of life. The focus of emergency nutrition programmes remains children between 6 and 59 months of age. (GNC, 2020, draft evidence and guidance note)

6 Recommendations

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

To the Nutrition Cluster:

- Engage more on documentation for 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, opportunities to improve nutrition sensitivity of MPC including integrate nutrition SBC activities into MPC implementation, MEB and transfer amounts, etc. This is something that was already planned for 2019/2020 but has so far not materialized¹⁸

To the Cash Working Group:

- Set up a regular exchange forum with the Nutrition Cluster (see above)
- Consult the Nutrition Cluster on discussions around MEB and transfer value calculation for MPC
- Advise as required nutrition partners on technical aspects of CVA and market assessment

To nutrition partners:

- Document and disseminate learning on CVA in nutrition responses

Comment: considering the significant increase in workload related to the ongoing COVID-19 pandemic, the concerned actors have to decide whether and how these recommendations can be integrated into the workplans. Please see annex 3 for some reflections on CVA for nutrition outcomes in times of COVID-19.

¹⁸ From the CWG work plan 2019: Set-up the task force to work on best practices, lessons learnt, capacity building
From the 2020 HRP: The [nutrition] sector will enhance its participation in the CWG and has identified opportunities and challenges in scaling-up cash and voucher assistance programmes as an alternative to in-kind assistance and services or to complement traditional interventions.

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 barriers		Supply barriers
<ul style="list-style-type: none"> - Nutritious food not affordable - Transportation to markets not affordable - Markets physically not accessible - Inadequate storage and preparation of food at household level - Food usage and sharing within households is not child or women centred 	Barriers to adequate food	<ul style="list-style-type: none"> - Insufficient food production and/or importation - Insufficient availability of nutritious food in local markets - Insufficient quality of available foods - Food prices instability - Inadequate storage of foods, especially fresh foods
<ul style="list-style-type: none"> - Inadequate care for mothers and parenting capacities Insufficient awareness of caregivers on quality complementary feeding - Nutrition dense complementary foods not affordable - Lack of caregivers' control over resources - Lack of caregivers' time for optimal feeding and care due to other priorities (e.g. work or mono-parental families) - Inadequate physical and mental well-being of caregivers 	Barriers to adequate feeding and care	<ul style="list-style-type: none"> - IYCF policies and regulation 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 - Lack of social protection policies (e.g. maternity leave/support, support to families with multiple young children etc.)
<ul style="list-style-type: none"> - Inadequate health seeking behaviour (e.g. lack of knowledge of malnutrition and other disease, traditional beliefs and perceptions) - Lack of knowledge on health services - Health services not affordable due to out of pocket expenses (e.g. consultation, medication, food and accommodation during hospitalisation, etc.) - Transportation to health services not affordable - Opportunity costs of seeking health and nutrition services are considered too high - Health services physically not accessible - Lack of awareness on hygiene and sanitation practices - Hygiene items for general and specific needs (e.g. new-born hygiene, menstrual hygiene, etc.) not affordable - Safe water and water treatment not affordable 	Barriers to healthy environment	<ul style="list-style-type: none"> - Lack of knowledge on existence of services - Health services not available - Health service of insufficient quality - Therapeutic foods, medication or vaccinations are not available - Unfavourable disease environment - Hygiene and sanitation items 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.

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 more and more studies are looking at humanitarian settings as well. 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 (Harvey et al., 2018).

Underlying determinants

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 (de Groot et al., Fenn 2017, Manley et al., Bailey et al., REFANI 2015, Bastagli et al.). There is ongoing debate where cash transfers or vouchers are better suited to improve household food security and how this compares with in-kind food assistance. Brief, CVA may be better than food transfers for improving dietary diversity while food transfers may be better than CVA at increasing caloric intake (Fenn 2017, Bailey). 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, specific objectives, and programme design.

Studies from development settings seems to suggest that cash transfers, both conditional and unconditional, can improve uptake in 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. 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. See chapter 3.2.3 for more information.

While there are no peer-reviewed studies looking specifically at the impact of CVA on **care practices**, some programme evaluations 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.

There is increasing evidence that CVA can increase the involvement of women in **decision-making** within the household and decrease **intimidate partner violence** (IPV). Cross et al. (2018) reviewed 28 studies related to CVA and gender-based violence. They found that seventy-one percent of CVA interventions had a positive impact on the equal distribution of decision-making power. Beneficiaries felt improved joint decision-making and/ or increased bargaining power in their households following CVA. On IPV, they found that eighty percent of relevant studies indicates that CVA led to a reduction in IPV, mainly due to a reduction in income-related tension, frustration, and fighting. Only one study indicated an increase in IPV associated with CVA. Also, they note that the most common positive spill-over effect across the literature was psychosocial wellbeing of women receiving CVA.

Immediate determinants of adequate nutrition

As remarked previously, CVA does 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 and to improvements in the dietary diversity of individual children and women in both development and humanitarian settings (see for example Fenn et al. 2014, Fenn et al. 2017, Grijalva-Eternod et al., Kurdi et al., OPM).

However, 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.

There is very limited evidence on the impact of CVA on treatment of child disease (Fenn, 2017). As discussed previously, 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.

Nutrition outcomes for 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 (Bliss et al. in Niger, Kurdi et al. in Yemen, Fenn et al. in Pakistan). Other studies did however not find any impact of CVA on children's risk of being wasted (Houghbe et al., Sibson et al., Grijalva-Eternod et al.), even though the interventions contributed to improved household food security and dietary diversity. 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 SBCC could make a difference. Sibson et al. (2018) suggest that the surge in malaria might have limited the effectiveness of the intervention. Houghbe et al. (2017, 2018) suggest that the transfer amount might not have been enough to address the needs of the household and the children's specific needs. Despite the lack of documented impact in some studies, Fenn (2017) concludes that there is limited but growing number of studies with statistically significant results showing positive impacts on reduced risk of being wasted 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 (Kurdi et al. in Yemen, Fenn et al. in Pakistan). Fenn et al. (2017) in Pakistan looked at the effectiveness of different CVA modalities (cash, cash double amount, fresh food vouchers) on nutrition outcomes. They found that all three modalities reduced stunting (increased mean HAZ) at both 6 months and 12 months of follow up, but only cash double amount 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.

Annex 3: 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](#)
- horizontal and vertical expansion existing National Social Safety Nets Project (NASSP) for existing chronic poor as well as transient poor (vulnerable households and individual to be affected by COVID-19 crisis) → advocate for SBC integration?