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VERSION 1:

OPERATIONAL GUIDANCE FOR USE OF CASH AND VOUCHER ASSISTANCE TO IMPROVE NUTRITION OUTCOMES IN NORTHWEST SYRIA

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https://www.humanitarianresponse.info/en/operations/stima/nutrition

Author: Abigael Nyukuri, NWS Nutrition Cluster Coordinator in collaboration with Northwest Syria Cash Voucher Assistance Technical Working Group Members.

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List of Acronyms

AAP	Accountability to Affected Population
BMS	Breast Milk Substitute
CMAM	Community-based management of acute malnutrition
CU2	Children under the age of 2 years
CU5	Children under the age of 5 years
CVA	Cash and Voucher Assistance
CWG	Cash Working Group
EPI	Expanded Programme for Immunization
FSA	Food Security and Agriculture
FSL	Food Security and Livelihoods
FSP	Financial Service Provider
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
GFD	General Food Distribution
HAZ	Height for Age
HB	Hemoglobin
HNO	Humanitarian Needs Overview
IDD	Individual Dietary Diversity
IDP	Internally Displaced Persons
IYCF	infant and young child feeding
MAD	Minimum Acceptable Diet
MDD	Minimum Dietary Diversity
MDD-W	Minimum Dietary Diversity for Women
MEB	Minimum Expenditure Basket
MFB	Minimum Food Basket
MUAC	Mid Upper Arm Circumference
MIYCN	Maternal Infant and Young Child Nutrition
MPCA	Multi-Purpose Cash Grant
MUAC	Mid-Upper Arm Circumference
NIE	Nutrition in Emergencies

NWS	Northwest Syria
OTP	Outpatient Therapeutic Programmes
PLW	Pregnant and Lactating Women
SAM	Severe Acute Malnutrition
SBCC	Social and behavioral change and communication
SMART	Standardized Monitoring and Assessment of Relief and Transition
SMEB	Survival Expenditure Basket
SOP	Standard Operating Procedures
TSFP	Targeted Supplementary Feeding Program
UNICEF	United Nations Children's Fund
USD	United States Dollar
WAZ	Weight-for-age score
WFP	World Food Programme
WHZ	Weight for Height

Operational Definition of Key Terms[1]

Cash Voucher Assistance (CVA) refers to all programs where cash transfers or vouchers for goods or services are directly provided to recipients. In the context of humanitarian assistance, the term is used to refer to the provision of cash transfers or vouchers given to individuals, households, or community recipients, not to governments or other state actors. This excludes remittances and microfinance in humanitarian interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash). The terms 'cash' or 'cash assistance' should be used when referring specifically to cash transfers only and includes the provision of money (physical currency or electronic cash) to targeted recipients. Vouchers can be provided in paper or electronically and can be exchanged for a set quantity or value of goods or services, denominated either as value voucher (e.g. US$ 15), commodity voucher (e.g. one cooking set, 5kg or rice) or service voucher (e.g. milling), or a combination thereof. CVA is one type or modality of humanitarian assistance, among others, such as in-kind aid and service delivery. CVA has several synonyms, including Cash-Based Interventions, Cash-Based Assistance, and Cash Transfer Programming. Cash and Voucher Assistance, or CVA for short, is the recommended term.

CVA in Nutrition in Emergencies…	
Is:	**Is NOT:**
Cash for at-risk groups to purchase nutritious foods	Payments of incentives for volunteers or community health workers
Cash for at-risk groups to pay for transportation to access (preventative) health services	Payment of per diems for volunteers or community health workers
Cash to facilitate access to treatment of malnutrition	Grants to health facilities
Cash assistance to caregivers of children with SAM	Performance based financing of health facilities
Vouchers for at-risk groups to purchase nutritious foods in preselected shops	
Vouchers to purchase fresh foods in preselected shops	
Vouchers for at-risk groups to pay for transportation to access health services	
Vouchers to caregivers of children with SAM	

Table 1: CVA for NIE Definition adapted from CVA briefing note developed by the Global Nutrition Cluster

Conditionality refers to prerequisite activities or obligations that a recipient must fulfil in order to receive assistance. Conditions can in principle be used with any kind of transfer (cash, vouchers, in-kind, service delivery) depending on the intervention design and objectives. Some interventions might require recipients to achieve agreed outputs as a condition of receiving subsequent tranches.

Soft conditionality/Listing** means that targeted individuals and households are actively encouraged to fulfil the conditionality (i.e. participate in Social Behaviour Change (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. Note that conditionality is distinct from restriction (how assistance is used) and targeting (criteria for selecting recipients). Examples of conditions include attending school, building a shelter, attending nutrition screenings, undertaking work, training, etc. Cash for work/assets/training are all forms of

[1] Terms pertaining to cash and voucher assistance (CVA), including MEB and SMEB, are adapted from the glossary produced by the Cash Learning Partnership (CaLP), https://www.calpnetwork.org/resources/glossary-of-terms

conditional transfer. The most common conditionalities in nutrition programming are related to participation in SBC interventions or attendance to health services.

Unconditional transfers are provided without the recipient having to do anything to receive the assistance, other than meet the intervention's targeting criteria (targeting being separate from conditionality). **It is important to note that cash transfers should be in principle unrestricted, and individuals or households should take their own decisions on how best to spend the money**. These decisions might or might not be nutrition sensitive and/or child centered. The precise pathways of CVA for adequate nutrition are, to a large extent, determined by the spending decisions of households and individuals, which are again determined by social and cultural norms, programmatic decisions in relation to design and targeting and other contextual factors.

Vouchers are by nature restricted and usually earmarked towards specific sectoral purchases (e.g. vouchers to access fresh and fortified foods or transport vouchers). Despite these restrictions, vouchers or the items obtained with them can be monetized, as it is the case for in-kind aid, if households consider other needs as more pressing.

Nutrition outcomes are defined as improvement of the nutritional status typically measured through weight-for height score (WHZ), height-for-age score (HAZ), Middle Upper Arm Circumference (MUAC), weight-for-age score (WAZ) and micronutrient status including anaemia. Improvement in the dietary intake of individuals, typically measured through Minimum Dietary Diversity for Women (MDD-W), Minimum Acceptable Diet (MAD), Minimum Dietary Diversity (MDD) and Minimum Meal Frequency for children are also considered as critical nutrition outcomes.

Minimum Expenditure Basket (MEB): A Minimum Expenditure Basket (MEB) requires the identification and quantification of basic needs items and services that can be monetized and are accessible in adequate quality through local markets and services. MEB looks at the needs that are covered, partially or fully, through the market. It sets a monetary threshold, which is defined as what households require in order to meet their essential needs. The starting point for constructing a MEB is usually household expenditure data. This data is analyzed and triangulated with sector-based needs information to obtain a measure of the minimum cost of essential needs based on the population of interest's actual demand pattern and consumption priorities. Items and services included in an MEB are those that households in each 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. It can be calculated for various sizes of households.

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. In addition to staple foods, the MFB should also contain locally appropriate fruits, vegetables, and animal source products. It can further consider the household composition and specific nutritional needs of vulnerable household members such as PLW, children or adolescent girls. The MFB is often based on the caloric requirements of average households and falls short of providing access to a nutritious diet.

Survival Minimum Expenditure Basket (SMEB): This is a subset of the MEB. SMEB requires the identification and quantification of goods and services for ensuring that a household's minimum survival needs only are addressed. Items included in a SMEB are those which can be monetized and are accessible in adequate quality through local markets. A SMEB is inherently multisectoral and based on the average cost of the items composing the basket. It can be calculated for various sizes of households. Delineating the threshold for survival and differentiating a SMEB from a MEB is not currently a standardized process.

Nutrition Social Behaviour Change and Communication (SBCC) are a set of interventions that systematically combines elements of interpersonal communication, social change and community mobilization activities, mass media, and advocacy to support individuals, families, communities, institutions, and countries in adopting and maintaining high impact nutrition-specific and nutrition sensitive behaviors or practices. Effective nutrition SBCC leverages enablers of behaviors and reduces barriers to adopting and maintaining behaviors over time.

Specialized Nutritious Foods are foods designed and produced for nutritional purposes as a form of dietary supplement. They range from fortified blended foods and micronutrient powders to ready-to-use foods and high-energy biscuits. They are usually not commercially available in local markets in humanitarian settings.

1. Background and introduction.

1.1. Nutrition Situational analysis in Northwest Syria

Eleven years of one of the worst crisis and emergencies in modern history have resulted in the forced displacement of over 11 million people and the large-scale destruction of homes, public infrastructure, and services, including health care and water and sanitation systems in Syria. According to the 2022 Humanitarian Needs Overview (HNO 2022), 14.6 million people are in need humanitarian assistance in Syria, the great majority of them being women and children. Approximately 3.77 children and 1.7 million pregnant and lactating women (PLW) are in dire need for life-saving nutrition interventions.

In Northwest (NWS) Syria, emerging evidence shows a deteriorating nutrition situation as all the determinants of malnutrition continue to be on the rise. The deterioration of the nutrition situation is attributed to the constrained access to basic services, impacts of COVID-19 pandemic, continued deterioration of the economic situation, mass displacements, food insecurity as well as suboptimal maternal, infant and young child feeding and care practices. Children aged 6-59 months and women of reproductive age are among the most affected by malnutrition. The burden of COVID-19 has further aggravated the situation of the Internally Displaced Persons (IDPs) residing in hard-to-reach locations as efforts to reach these populations with humanitarian services is constrained- further exposing children and women to malnutrition related morbidity and mortality.

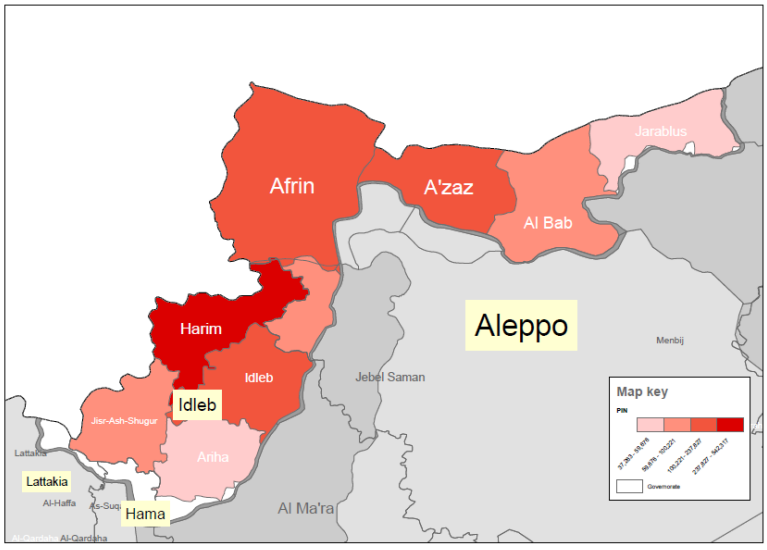

Figure 1: NWS Nutrition Cluster 2022 PIN

The July 2022 NWS surveillance report survey indicate a deteriorating nutrition situation with Global Acute Malnutrition (GAM) levels of 5.0 %. The Severe Acute Malnutrition (SAM) prevalence rate by MUAC doubled from 0.8% in 2021 to 1.3% in 2022 and increased from 0.4% in 2021 to 0.9% in 2022 by WHZ. This translates to 50,823 children with SAM, with 4,620 of them expected to suffer from SAM with medical complications. SAM

is the worst form of malnutrition; children having SAM stand a 10-12% imminent risk of malnutrition related deaths compared to their normal peers. Similarly, the survey results indicated anaemia prevalence among children and women of serious public health concern. 33% of children under 5 and 53% of women of reproductive age, including pregnant and lactating women (PLWs) are anemic. This translates to 954,428 children under 5 and 396,315 PLWs with anaemia within the next 12 months. Maternal malnutrition in NWS is evident, and compounds to the vicious inter-generational cycle of malnutrition. 36% and 53% of children and pregnant and lactating women (PLW) respectively suffer from iron deficiency anemia according to the 2022 SMART Survey. A classification of 20-39% anaemia prevalence is ranked as 'serious' while over 40% is considered 'extremely catastrophic according to the global nutrition severity ranking scale'. Maternal anaemia increases the risk of low birth weight, preterm birth and perinatal mortality. Improving maternal nutritional status and iron supplementation during pregnancy are important for reducing these adverse outcomes. Similarly, anaemia can decrease school performance, productivity in adult life, quality of life, and the general income of affected individuals. Anaemia should be prevented in the first year of life to avoid long-term negative effects on individual development. The survey result indicated that underweight among children has increased to 8.5%, mostly attributed to maternal malnutrition and compromised diets.

The economic deterioration including depreciation of the Syrian pound and loss of livelihoods has severely impacted households' purchasing power ultimately creating negative coping mechanisms such as increased rates of early child marriage and negative food based coping strategies like skipping of meals and consumption of less nutritious foods since these are less expensive. The infant and young child feeding practices, which are crucial to the survival and health of infants and young children, are sub-optimal across NWS; compounded by sub-optimal access to adequate and safe water, sanitation and hygiene services. Hence, less than 10% of children aged 6-23 months consume the minimum acceptable diet (MAD) while only 53.4% of infants aged 0-5 months are exclusively breastfed.

1.2. Global evidence-base for use of CVA to promote nutrition outcomes

A wealth of evidence exists on use of Cash and Voucher Assistance (CVA) on improving maternal and child nutrition by impacting on the determinants of optimal nutrition and care-practices.

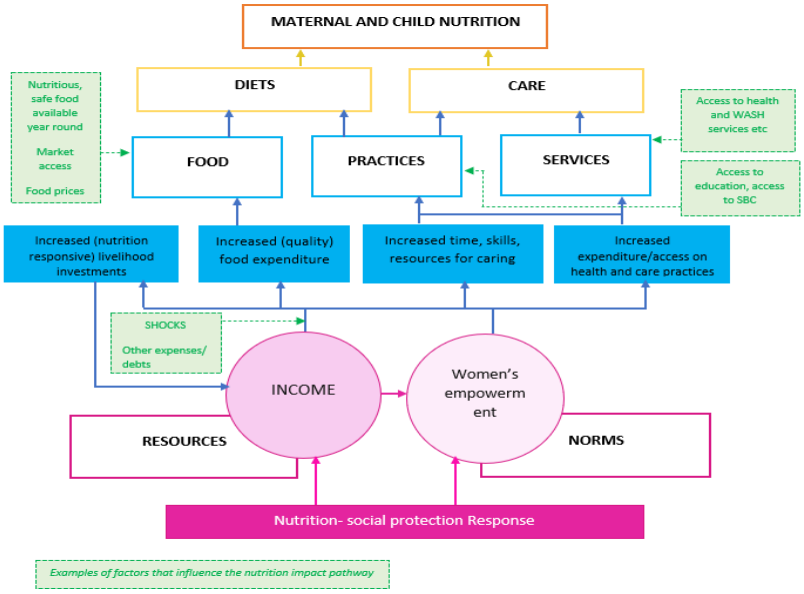

Figure 2: Modified from UNICEF conception framework on the determinant of maternal and child malnutrition 2020

In summary, use of CVA promotes nutrition outcomes in the following ways;

i. 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.
ii. CVA can promote participation in nutrition social and behavioral change (SBC) activities and attendance to priority health services.

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. Empowering women in their access and control over dietary decisions can facilitate better and informed decisions over what they want to eat without thinking of the economic pressures. However, this is dependent on the primary recipient of assistance and HH dynamics in terms of who spends the money. This Operational guidance was developed collaboratively with NWS Nutrition sector member agencies with close collaboration with the Cash Working Group (CWG) and Food Security Cluster. **The guidance aims at providing a set of operational guidance, using lessons learnt across the sector and NWS humanitarian Response to contextualize, harmonize and standardize commonly agreed approaches and methodologies to improve nutrition outcomes through cash and voucher assistance in NWS.**

This guidance will be a living document and will **serve as a basis to better define the use of CVA to promote nutrition outcomes by providing practical context specific recommendations** and ensure alignment and complementarity with CWG CVA standards.

2. Key Principles for CVA to promote nutrition outcomes

- **Target the nutritionally vulnerable**: Tin the context of limited resources such as NWS, targeting strategies should be based on both socio-economic and nutritional vulnerability. Focus should be on pregnant and lactating women (PLWs) and care-takers of children aged below 2 years and households having children during the first 1,000 days (from pregnancy to their second birthday). This is meant to break the inter-generational cycle of malnutrition and poverty by ensuring the healthy growth and mental development of children.
- **Incorporate explicit nutrition objectives, indicators and outcomes** to enhance the positive impact of CVA interventions on nutrition.
- **Integrate nutrition education and promotion into CVA**, since increasing incomes or food availability at the household level will not automatically translate into improved nutrition outcomes.
- **Empower women and make them the recipients of CVA,** where appropriate, given that women are generally responsible for household cooking and feeding habits as well as infants and young children feeding and care practices.[2]
- **Promote strategies that enable households to diversify their diets and livelihoods.** Seek to promote access not only to staple foods, but as far as possible to **a diversified and safe diet**, including micronutrient supplements where appropriate.
- All lessons **learned to inform future CVA programmes and to inform global community of practice should be captured, documented and shared**.

[2] Commodity- and cash-based interventions that minimize possible negative impacts are designed and selected; consult women during CVA feasibility assessment phase on risks and preferences

3. Entry points for use of CVA to promote nutrition specific outcomes

To increase the impact of CVA interventions it is important to take a 'cash plus' approach. **CVA responses must be integrated within a comprehensive nutrition response** that includes the provision of in-kind support (such as micronutrients, oral rehydration therapy/zinc and treatment of vitamin deficiency), promotion and support of infant and young child feeding, and access to nutrition/health services. All these 'cash plus' add-ons ensure that the programme achieves its intended outcomes on improving nutritional outcomes including:

– The prevention of negative coping responses to food scarcity, such as reducing the portion sizes or number of meals per day , consumption of less costly/less nutritious meals.

– An improved dietary intake by children and women, both in terms of quantity of meals per day as well as the diversity of the diet.

– Increased expenditure on and access to adequate and nutritious food.

– The appropriate use of ready-to-use therapeutic food by children with SAM.

– Improved demand, coverage and utilization of priority health and nutrition services

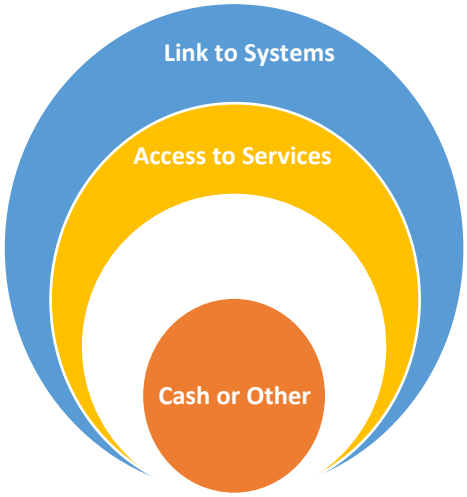

Figure 3: Cash Plus Approach

The table below summarizes the entry points on use of CVA to improve nutrition specific outcomes.

Components of nutrition response	Traditional response modality	Possible role of CVA	Primary objective of CVA
Improve MIYCN through social and behavioral change communication (Practices)	Communication and counselling services	CVA can be provided with soft conditions linked to attendance in SBCC activities	• Incentivize participation in SBCC activities, particularly on improving maternal, infant, and young child feeding practices.
Improve access and consumption of age-appropriate complementary food and maternal diets (Diets)	Specialized nutritious foods such as fortified foods and micronutrient powders targeting children 6-23 months	**Replace** in-kind specialized nutritious foods through cash top-up or (Fresh) food voucher: Value to be based on the nutrient requirements of at-risk groups.	• PLWs and Children between 6-23 months receive sufficient macro and micro-nutrients for their growth and development
Prevention of micro-nutrient deficiencies among CU5, PLWs and adolescent girls (Diets)	Variety of options, including Vitamin & mineral powder; fortified blended foods.	**Complement** nutrition supplements through general household CVA	• To prevent and reduce the prevalence of micro-nutrient deficiencies among CU5, PLWs and adolescent girls.
Improve access and utilization of priority health and nutrition services. (Services)	Health and Nutrition service provision: Treatment of severe malnutrition, ANC/PNC attendance, vaccination, and growth monitoring.	CVA can be **conditional** on attendance to priority health and nutrition services **Complement**: CVA to cover costs associated with accessing and utilizing nutrition and health service.	• Promote attendance to priority health and nutrition services • Cover transportation costs • Cover out-of-pocket expenditure • Reduce opportunity costs

Table 2: Entry points for use of CVA to promote nutrition specific outcomes

4. Decision Framework on Use of CVA to promote nutrition outcomes (Nutrition Specific CVA)

4.1. Targeting Criteria.

CVA for Nutrition should focus on the nutritionally vulnerable with the aim of improving nutrition outcomes for the first 1000 days. This includes;

- Pregnant women from the first trimester
- Lactating women with children aged below 24 months.
- Primary caregivers of un-breastfed infants below the age of 6 months in exceptionally difficult circumstances.
- Primary care-givers of children under 2
- Adolescent girls in areas with high anemia and wasting rates among women of reproductive age
- Households with children aged below 2 years suffering from under-nutrition.

4.2. Guiding principles and decision framework

1. APPROPRIATENESS – Is the modality appropriate given the market conditions?
Analysis and strategy - Given the typical or current food consumption patterns of the target populations, will increasing the purchasing power of and/or demand for nutritious foods on the part of the target population enable them to buy foods that fill the identified food consumption and micro- and macro-nutrient gaps? ● Yes, if the population increases their nutritious food intake they will help reverse and prevent malnutrition including undernutrition (low calories) and micronutrient deficiencies (anemia being over 50% and MDD very low). CVA will provide access to fresh foods and/or cover their basic needs enough to start prioritizing foods/health or nutrition services. ● CVA can also support direct access to health/nutrition services via covering transportation costs/cover the cost of time needed for caregivers to take their children to treatment (daily wage economy)/achieve better hygiene through purchase of soap or access to water.
Supply - Are diverse foods for an adequately nutritious diet available in sufficient quantities in local markets? Are both staple food and nutrient dense food prices stable or stabilizing relative to historical and seasonal trends? What affects the supply of nutritious foods in local markets? How are nutritionally dense foods traded and stored? ● Diverse foods for an adequately nutritious diet are available to a considerable extent where markets are available. ● Market prices have fluctuated greatly due to the economic crisis including the devaluation of the SYP and TL recently. The use of USD/TL is more common. Food prices continue to increase significantly. ● Availability of nutritious food is impacted by the Turkish market since some items are imported, by the weather due to dry spells and heavy winters, and by conflict in farming locations.

- Availability of nutrition supplies/services (RUTF/RUSF) relies on UN agencies and thus on cross-border resolution and international shipments.

Market integration - Are local and regional food markets well integrated to adjust to fluctuations in supply and demand with market actors able to restock as necessary? Are there any significant barriers to food trade? If so, what food categories do those barriers affect?

2. **FEASIBILITY** – Do the proposed modality and delivery mechanism combinations have a reasonable chance of success and reduce programming risks for participants, the implementing organization, and local market actors?

- It is important to factor in mixed modality cash/in-kind. If the implementing organizations have a framework in place for Financial Service Providers and is tested and tried, there is a minimal risk for beneficiaries and IPs.

Humanitarian actor and local alignment - Does the proposed intervention align with Nutrition Cluster recommendations, other requirements, and nutritional standards as outlined by updated 2018 Sphere standards?

Market infrastructure - Are vulnerable populations able to access markets safely and predictably within a reasonable distance from their home? Are there safe and reliable delivery mechanisms for conducting the modality-specific resource transfers? Will it be possible to monitor the supply, price, and quality (relative to local or applicable humanitarian standards) and price of key foods on the market

Vendor engagement - Where cash/vouchers are considered, how/to what extent will you integrate with and/or inform market vendors of the nutrition-promotion support activities for the cash/voucher recipients?

3. **OBJECTIVE** – Which modality or modalities are best suited to increase nutrition- sensitivity of programming?

Preferences - Does the modality complement and integrate with the local diet to improve dietary adequacy for the target groups/individuals? For cash or vouchers, are consumers willing to buy the necessary foods for their own consumption? For in-kind food, do beneficiaries know how to prepare, and are they willing, to prepare the foods offered?

Demand - What are the observed or hypothetical demand barriers to adequate nutrition for the different sub-groups (age, gender, diversity) within the target populations? To what extent are these barriers consistent across the target geographic areas and population sub-groups? Are consumers/target population transitive/consistent in their preferences for nutritious foods? To what extent can target households be expected to purchase and/or consume more high-value foods for their own consumption or will they put it to other uses (sharing with extended families, bartering, trading for other household needs, etc.)?

Nutritional resilience - What will facilitate resilience or sustainability of nutrition gains and dietary pattern improvements? Is there a role for the private sector?

Intervention design - How can the activity's targeting, conditionality, transfer amount, frequency , delivery mechanism, timing, and duration be designed to maximize the potential impact on target population sub-groups' nutrition, while minimizing risks?
● Number of rounds based on the purpose of CVA, if it's for CMAM then it should be enough to cover a case until malnutrition discharge (2-5 months), if it's a prevention approach or for micronutrient deficiency in vulnerable populations (3 months as a minimum). ● Soft conditionality can be introduced with SBCC (mainly in the mother to mother supporting groups approach). ● In case of integration with FSL, transfer amount (top-up) increase access to nutritious dietary foods items. ● Transfer amount should utilize a cost of diet analysis.
Individual targeting - Which household member(s) is the transfer intended to benefit? For household rations, how will benefits translate to nutritionally vulnerable groups, depending on the modality chosen?
Conditionality - If you plan to impose conditions on participation, how will the program manage and monitor those considerations related to the modality of transfer and the impact on nutrition? Does the conditionality affect cost-efficiency, cost-effectiveness?
Gender - How will the modality selection and delivery mechanisms affect gender roles and dynamics for the target population, such as time and labor burdens, decision-making at the household level, civil conflict, or gender-based violence and security risks?
Supporting interventions - What accompanying package of interventions will you include with the selected modality to optimize nutrition/food security impact? How will community members support cash/voucher programs/food distributions? What is their role?
Mixed modalities - If applicable, how does your analysis support sequencing plans for using cash, voucher, and/or in-kind approaches for providing a quality diet or for evolving needs? How does your analysis support the determination of the part allocated to each modality (i.e., multipurpose cash and fresh food voucher) for covering basic needs while safeguarding a quality diet?
Evidence - Does current evidence support the achievement of nutritional outcomes through this modality?
Indicators - Which indicators will you use to measure results? How will you assess, monitor, and address the potential for sharing or ration dilution? What transfer duration is necessary to achieve or maintain consumption sufficient to meet targeted food and/or nutritional gaps?
4. COST – Is the modality cost efficient and/or cost effective relative to others?
Trade-offs - What trade-offs exist between transfer size, duration, eligibility criteria, nutritional value of rations, and coverage? How will either relative cost savings or greater effectiveness in delivering cash

transfers, vouchers, or in-kind assistance achieve better outcomes toward nutrition or food security objectives?
Timing, duration and frequency; Despite relatively weak evidence on the impact of programme duration on nutrition outcomes, there is strong logic that a longer duration of assistance and especially if it is tied to higher cumulative transfer amounts could be associated with improved nutrition outcomes (Fenn, 2017). Furthermore, since the 2008 Lancet series, there is a broad consensus within the nutrition community that good nutrition within the first 1,000 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. Duration and timing of assistance to prevent acute malnutrition irrespective of the modality should be based on the scale and severity of the emergency, the GAM prevalence and other factors such as food security, seasonality of food security and/or epidemic patterns of infectious diseases (GNC, 2017). Household or individual CVA for nutrition outcomes that aim to provide a safety net during the first 1,000 days can be provided throughout that period. Irrespective of the specific objective, household or individual CVA should not be provided for less than three months. Timeframes that are too short are unlikely to have any impact on nutrition outcomes. As for the frequency of transfers, monthly transfers are recommended if CVA aims to provide access to a diverse and nutritious diet, and a minimum of six months should be considered for all interventions.
Cost-effectiveness factors - What other factors have you identified (e.g., greater agency, empowerment, flexibility, speed, market strengthening) that may increase the nutritional cost-effectiveness of the intervention?
Mixed modalities - If designing multiple modalities, how will greater effectiveness in meeting nutrition and related food security objectives offset start-up costs and timeframes? How have you determined whether sequencing or layering multiple modalities is a more cost-effective approach?

Table 3: Guiding principles on use of CVA for Nutrition

5. Cash Transfer Values.

Nutrition Top Up	$25	If households are receiving food assistance (in-kind)	Well-nourished PLWs and families having children under 2, **not attending priority nutrition services** only receive this top-up and SBCC for nutrition alongside the food baskets.
Attendance to priority nutrition services (transportation costs/and out of pocket expenses)	$50	**Criteria** ● Minimum 3-7 days continuous stay in SCs and discharge to OTPs. ● Minimum 6 visits in PHCs for SAM treatment, MIYCN counselling, growth monitoring and routine EPI (Entire package). ● Minimum 6 visits attending Mother to mother support groups, MAM treatment alongside PNC/ANC visits (Entire package). ● BMS support up to 6 months of age as last resort in exceptionally difficult circumstances and done in controlled environments in PHCs. ($100USD/Month regardless of whether a family is getting food assistance.)	Under-nourished PLWS as well as caregivers of children under 2 attending priority nutrition services.

Table 4: Cash Transfer Values

6. Cash Transfer Frequency

Components of nutrition response	Frequency
Improve MIYCN through social and behavioral change communication	• Monthly
Improve access and consumption of age-appropriate complementary food and maternal diets	• Monthly
Prevention of micro-nutrient deficiencies among CU2 and PLWs	• Monthly
Improve access and utilization of priority health and nutrition services 1. SAM treatment combined with MIYCN counselling, growth monitoring, hygiene promotion and routine EPI in health facilities. 2. Controlled BMS support up to 6 months of age only within BMS programming context in exceptionally difficult circumstances for infants less than 6 months, who have been fully assessed by a lactation specialist and when all options to explore breastfeeding have been fully explored and failed. No Blanket distribution or promotion to the general public. 3. Promote attendance to Mother-to-mother support, combined with multiple micro-nutrient supplementation, MAM treatment, PNC/ANC attendance and referrals to mental health, FSL and WASH programmes, PSEA/GBV support as appropriate.	• For OTPs, Monthly for a period of 6 months . • For SCs, $50 upon admission and the remaining $50 after discharge, resume after one month with $50 given monthly when admitted in OTP for 5 months. • For BMS support as a last resort, $100 a month until the infant attains six months and switch to LW support. • For PLWs, $50 Monthly for 6 months alongside SBCC.

Table 5: Cash Transfer Frequency

7. Referral Pathways between Food Security and Nutrition Cluster Partners.

7.1. FSL to Nutrition

- FSL to include PLW and CU2 as part of their inclusion/selection criteria.
- FSL partners to leave a 5% margin for their beneficiary targets **to allow for admission of new vulnerable beneficiaries (CU2 and PLWs)** during the project implementation phase.
- FSL partners are encouraged to refer all PLW and CU2 to the nearest nutrition delivery sites.
- FSL workers to be trained on conducting MUAC screening and referral for identified malnutrition cases
  - ➢ Requires FSL partners to be equipped with up-to-date nutrition services mapping
  - ➢ FSL staff to be trained on child protection policies and have female staff
  - ➢ FSL partners to receive MUAC tapes from Nutrition Cluster Lead Agency

7.2. Nutrition to FSL

- PLW and CU2 admitted in treatment programmes to be referred to FSL for admission
  - ➢ Requires nutrition partners to be equipped with up-to-date FSL services mapping

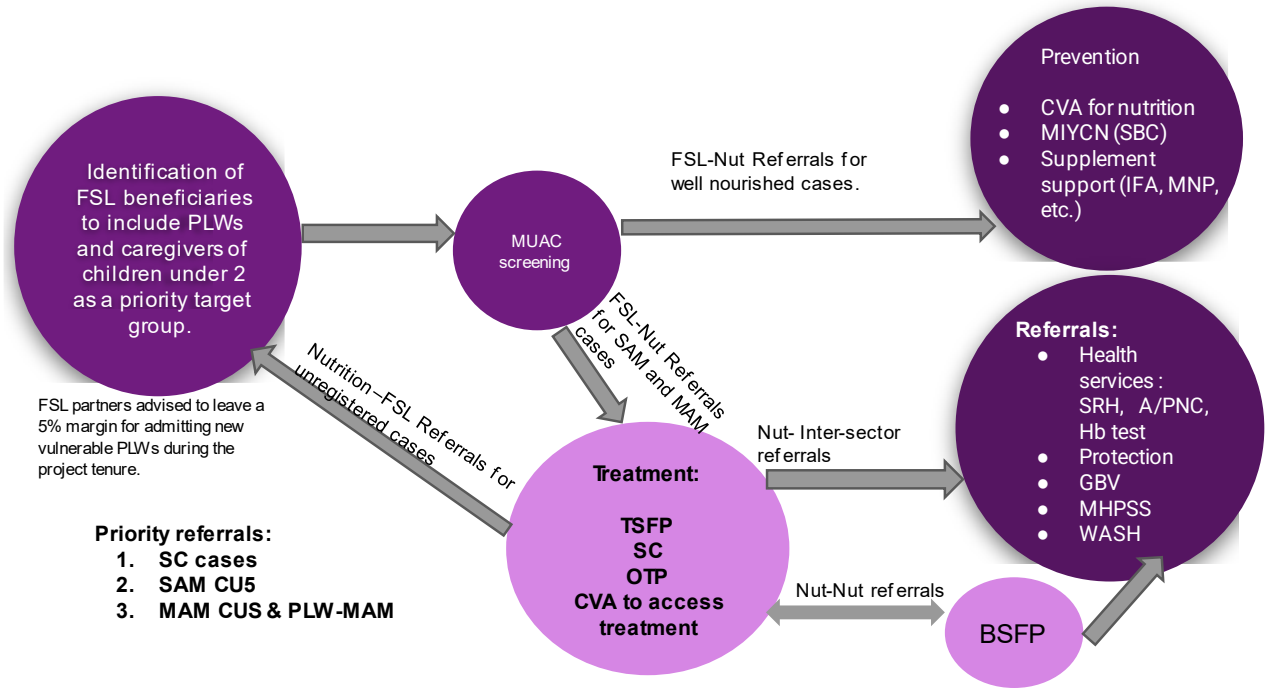

Figure 4: Referral Pathways between FSL and Nutrition Interventions

8. Inter-sectoral Convergence and Linkages (Nutrition Sensitive CVA)

8.1. The Role of 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, SMEB and transfer amounts, etc.
- Build capacities among CVA practitioners on nutrition and raise awareness on nutrition related issues.
- Harmonized targeting and monitoring should be conducted by the Food Security and Nutrition sectors wherever feasible and appropriate, through close linkages between food assistance and livelihoods support, and preventive nutrition services.

8.2. Recommendations to Cash Working Group

- Set up a regular exchange forum with the Nutrition Cluster to discuss reporting, learning and dissemination, opportunities to integrate CVA modalities in the nutrition sector, opportunities to improve nutrition sensitivity of MPC, MEB and transfer amounts, etc.
- Consult the Nutrition Cluster on discussions around S/MEB and transfer value calculation for MPC (for household with PLWs or children under 5 years old), although, cash transfer value to PLWs and children under 5 years individually.
- Advise as required nutrition partners on technical aspects of CVA, risk and market/vendor assessment, and price monitoring tool and frequency.
- Set up clear CVA SOPs and documentations/workflow required to meet cash SOPs for reporting and documenting CVA for nutrition outcomes.

8.3. Recommendations to Food Security Sector and Livelihood

- In order to increase the nutrition impact of programs, it is recommended to target the most nutritionally vulnerable. This includes not only socially vulnerable groups such as smallholder and marginal farmers, landless laborers, women, indigenous people, food insecure households, households living in at risk areas, but also the physiologically vulnerable, such as adolescent girls, women of reproductive age, pregnant women and small children, people with chronic diseases, women with post-partum depression. elderly and disabled people. Targeting criteria for CVA or Food Assistance packages therefore should mainstream nutritional vulnerability, at minimum, prioritizing households with children under the age of 2, pregnant and breastfeeding women (the first 1000 days window of opportunity).
- Both SMEB and MFB should be designed to meet the macro and micronutrient needs of households or individuals. They should further consider the household composition and specific nutritional needs of vulnerable household members such as PLW and children under 2. It should be designed based on needs assessments and in coordination with the nutrition sector. Monthly or fortnightly food assistance, sufficient to fulfil the basic nutritional and caloric requirements of a household among the targeted group should be provided.
- Mainstream inclusion of nutrition outcomes in all MPCA programs: advocating for a better and systematic inclusion of nutrition sensitive indicators, at a minimum MDD-W and MAD for children 6-23 months.
- Establish and strengthen referral pathways between FSL and Nutrition interventions.

8.4. Recommendation to Health Sector

- Where CVA caters for consultation or transportation costs to promote health outcomes, collaborate with the nutrition sector and include essential nutrition services as part of primary health service package.
- Set up a regular exchange forum with the Nutrition Cluster to discuss reporting, learning and dissemination, opportunities to integrate CVA modalities in the nutrition sector.
- To include PLWs and or Malnutrition cases into selection, entry, eligibility criteria for cash assistance.

8.5. Recommendations for Cross cutting sectoral linkages

- Targeting criteria for WA CVA should include nutritional vulnerability, therefore prioritize households with children under age 2, pregnant or breastfeeding women.
- Mainstream general nutrition awareness within sectorial SBCC alongside CVA interventions. Consult nutrition sector for updated context specific messages and delivery modalities. Set up a regular exchange forum with the Nutrition Cluster to discuss reporting, learning and dissemination, opportunities to integrate CVA modalities in the nutrition sector, opportunities to improve nutrition sensitivity of MPC, MEB and transfer amounts, etc.
- Consult the Nutrition Cluster on discussions around MEB and transfer value calculation for MPC (for household with PLWs or children under 5 years old), although, cash transfer value to PLWs and children under 5 years individually.
- Train workers in all different sectors to conclude basic nutrition check (MUAC, and breastfeeding status identification) as well deliver nutrition messages into their regular messages they disseminate during their awareness/education sessions under different sectors.
- Establish, strengthen, and support referral pathways to the available cash/nutrition services.

9. Accountability to Affected Population

9.1. Mainstreaming AAP in Programme Design

- Carry out community awareness sessions to introduce the programme beneficiaries targeted, and how to utilize it to the utmost. Be clear about targeted beneficiaries, programme objectives and nutrition outcomes to be promoted, complimentary with other section, transfer value and distribution modalities and the programme timeframe.
- Set up a community feedback and grievance mechanism to allow the community's feedback on the functionality, safety, and acceptance of the service to avoid and timely mitigate risks.
- Include the disabled community members in the initial discussions and ensure the programme design fully factors their perceptions and specific needs.

9.2. Mainstreaming AAP in Programme Implementation.

- All programme data collected should be disaggregated by sex, age, gender and disability, with a specific focus on monitoring the needs of vulnerable and minority groups throughout the program cycle to enable programme interventions to be adapted accordingly.
- Work closely with local council/camp management to coordinate service delivery and safety of nutrition/health staff and beneficiaries.
- Ensure a 'Do No Harm" strategy while providing nutrition services to vulnerable people. The implemented modality should not exacerbate community tensions, encourage behaviors that will lead to ill health or malnutrition or pose significant risk to targeted beneficiaries.

- Strengthen community feedback mechanisms and raise awareness amongst communities to use them to report any inclusion errors. Community feedback mechanisms, spot checks, and third-party monitoring data should be triangulated of data to ensure close monitoring.

9.3. Mainstreaming AAP in Programme Monitoring and Evaluation

- Conduct regular post-distribution monitoring to better understand beneficiary preference, satisfaction and feedback to further inform and guide programming.

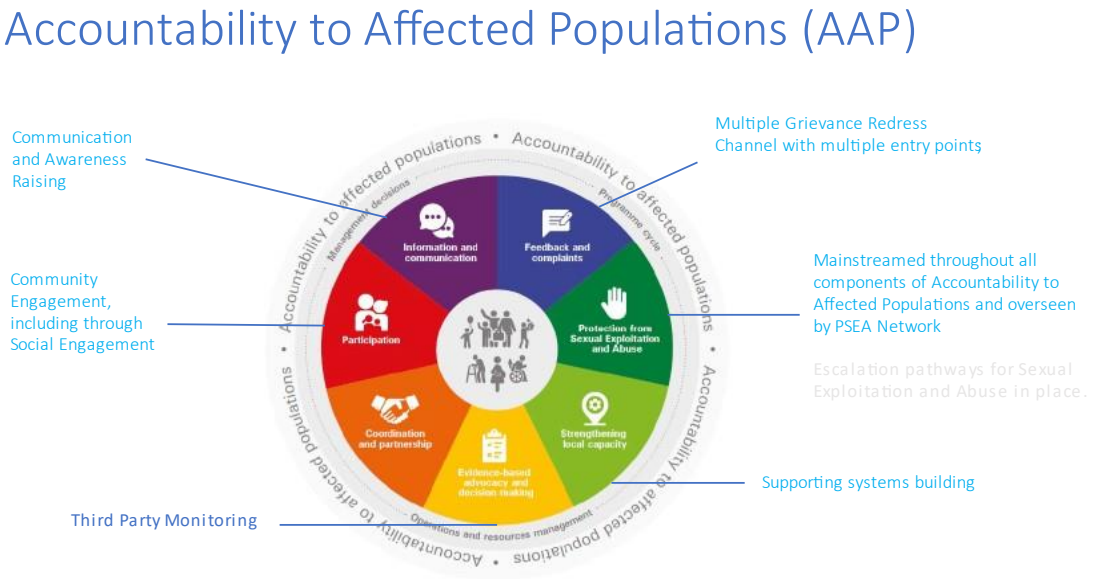

Figure 5: AAP Framework

10. Monitoring and Evaluation Framework

The following should be closely consulted with the Nutrition Cluster and the CWG as needed:

- Start with a clear, nutrition-based primary objective in consultation with the Nutrition Cluster (see Section 4)
- Based on the selected CVA component of the nutrition response, identify **relevant** key output, outcome, and process, gender, AAP indicators aligned with the primary objective (See section 8.1 to 8.7).
- Develop a light but robust set of monitoring tools appropriate to the CVA programme design (baseline, mid-line as needed, and post CVA distribution/end line).
- Where possible, conduct a short-Focused Group Discussion to complement the end line assessment. The FGD group should comprise a good cross-section of people representative of the community, who were not recipients of CVA for nutrition.

- Share monitoring tools, plans. and findings with the Nutrition Cluster towards a harmonized approach and potential opportunity to pool monitoring resources for data collection and analysis. This means monitoring responsibilities could be shared across partners and/or with the nutrition surveillance teams, promoting efficiency and survey fatigue. Remember: (i) data collection should be disaggregated by gender and age; (2) long surveys take time away from PLWs and other household members, who could otherwise be using the time on productive activities.

10.1. Nutrition Specific Indicators

Components of nutrition response	Impact Indicators	Outcome Indicators	Output Indicators
Improve MIYCN through social and behavioral change communication (Practices)	• Prevalence rate (%) of stunting in children 0 to 59 months of age based on height-for-age z-score less than -2 standard deviations of the median of the standard population (WHO 2006) • Prevalence rate (%) of severe acute malnutrition in infants less than 6 months of age based on presence of bilateral pitting oedema and weight-for-height z-score less than -3 standard deviations of the median of the standard population (WHO 2006)	• Percentage of children born in the last 24 months who were put to the breast within one hour of birth. • Percentage of children born in the last 24 months who were fed exclusively with breast milk for the first two days after birth • Percentage of infants 0–5 months of age who were fed exclusively with breast milk during the previous day • Percentage of children 12–23 months of age who were fed breast milk during the previous day. **Indicator Calculation:** https://www.who.int/publications/i/item/9789240018389	• Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive one-one skilled counselling and support on appropriate maternal, infant and young child feeding and care-practices. • Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive CVA support linked to a nutrition objective.
Improve access and consumption of age-appropriate complementary food and maternal diets (Diets)		• Percentage of children 6–23 months of age who consumed foods and beverages from at least five out of eight defined food groups during the previous day. • Percentage of children 6–23 months of age who consumed solid, semi-solid or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more during the previous day. • Percentage of children 6–23 months of age who consumed a minimum acceptable diet during the previous day. Percentage of children 6–23 months of age who consumed selected sentinel unhealthy foods during the previous day. "sentinel unhealthy foods are high in sugar, salt and/or unhealthy fats. **Indicator Calculation:** https://www.who.int/publications/i/item/9789240018389 • The proportion of women of reproductive age (WRA) who achieve this minimum of five food groups out of ten in a population. Indicator Calculation: https://www.fao.org/3/i5486e/i5486e.pdf • Percentage of targeted households with acceptable Coping Strategy Index (CSI)	• Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive one-one skilled counselling and support on appropriate maternal, infant and young child feeding and care-practices. • Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive CVA support linked to a nutrition objective.

	• Prevalence rate (%) PLW with MUAC less than 210-230 mm	**Indicator Calculation** https://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp211058.pdf	
Prevention of micro-nutrient deficiencies among CU5 and PLWs. **(Diets)**	• Proportion of children below five years of age with Hb concentration of <11 g/dL • Proportion of women in reproductive age with Hb concentration of <12 g/dL	• Proportion of women of child-bearing age who received iodine supplements. • Proportion of children 6-23 months of age who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home.	• Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive CVA support linked to a nutrition objective. • Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive one-one skilled counselling and support on appropriate maternal, infant and young child feeding and care-practices. • Number of boys and girls aged 6-59 months reached with MNPs. • Number of ANC clients who received multiple micro-nutrient supplements and were given information about a healthy diet, EBF, LAM, and other FP options.
Improve access and utilization of priority health and nutrition services. **(Services)**		• Percentage of severe acute malnutrition (SAM) cases with access to treatment services (coverage). • Average length of stay in OTPs and SCs • Proportion of discharges from therapeutic care who have died, recovered or defaulted. • Percentage of Code violations donations of breastmilk substitutes (BMS), liquid milk products, bottles and teats dealt with in a timely manner.	• Number of Pregnant and Lactating Women (PLWs) and care-takers of children under 2 who receive CVA support linked to a nutrition objective. • Number of mothers of children aged 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child • Number of children below 5 years with severe acute malnutrition newly admitted for treatment. • Number of boys and girls aged 0-59 months enrolled in growth monitoring at health facility level. • Number of PLWs enrolled in MTMSG. • Number of ANC clients who received multiple micro-nutrient supplements and were given information about a healthy diet, EBF, LAM, and other FP options.

			• Number of infants who have access to Code-compliant supplies of appropriate breastmilk substitutes (BMS) and associated support for infants who require artificial feeding.

Table 6: Nutrition Specific Indicators

10.2. Post-Payment Distribution Indicators

INDICATOR	DEFINITION	HOW TO MEASURE	SOURCE	WHEN TO MEASURE	DISAGGREGATION
Total number of people assisted with cash/voucher	The number of individual people assisted with (and directly benefiting from) cash/vouchers.	Count/sum the total number of individuals benefitting from cash/voucher assistance. This should include any members of recipient families who benefit from distributed multipurpose cash assistance (*not only the head of household or person attending a distribution*).	Financial and distribution records (e.g. receipt forms, digital tracking (LMMS), etc.)	Each distribution	Age/Sex of HoHH (*and family members for total people reach – MWBG*) Other vulnerability
Total USD value or cash or vouchers transferred to beneficiaries	Total value/amount of cash transferred to beneficiaries (or value of vouchers) as a total value ($USD or local currency)	Count/sum the total value of cash/voucher assistance provided to individuals with each distribution.	Bank and finance records	Monthly	N/A
Total amount /value of vouchers redeemed by beneficiaries	The value of all the redeemed vouchers at the contracted shops in exchange of approved goods and services ($USD or local currency)	Count/sum the total value of cash/voucher assistance provided to individuals that is withdrawn/utilized by program recipients.	Vendor sales records Bank and finance records	Monthly	Vendor Location

% of households who received their cash transfers/vouchers in accordance with established timeline	Received: got/obtained the cash/voucher Established timeline: the timeframe in which beneficiaries were informed that cash/vouchers would be provided	Q1. Did your household receive your cash or voucher entitlement on time? Yes/No Calculate the total number of respondents who select "Yes". Divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey/ OSM survey	Monthly	Age/Sex of HoHH
% of households who received the correct amount of cash transfers/vouchers	Received: got/obtained the cash/voucher Correct amount: the amount of cash/voucher value that the recipient was told they would receive (by project staff/FSP)	1. Do you know the value of your cash/voucher entitlement? Yes No 2. If yes, what was your entitlement? ___ (in local currency) 3. During the most recent distribution, did you receive your full entitlement? Yes No Don't know 3b. If not, why not? (adapt options) Examples: a. Some cash was taken by an agent b. Some cash/voucher value taken by organization staff c. No explanation given to me d. I was informed that the value would be reduced this distribution e. I did not attend the distribution f. Other: _____(specify) Calculate the total number of respondents who select	HH Survey - PDM OSM *To be spot-checked against distribution lists.*	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions)	Age/Sex of HoHH

		"Yes" to Question 3. Divide by the total number of respondents. Multiply by 100 to get the percentage. This should be crosschecked against distribution lists to verify the amounts provided.			

Table 7: Post-Payment Distribution Indicators

10.3. Access Indicators

INDICATOR	DEFINITION	HOW TO MEASURE IT	SOURCE	WHEN TO MEASURE	DISAGGREG-ATION
% of households who report experiencing any problem(s) related to time spent getting their cash/voucher	Problems: any issue, challenge or difficulty Time spent getting their cash/voucher: This relates to the time (minutes/hours) it takes for program recipients to obtain their cash/voucher assistance (get to/from the distribution point/hawala/FSP/etc., wait in line at a distribution, etc.)	1. Did you face any problems related to the time it took to get your cash/voucher assistance? Yes/No 2. If yes, please describe (open ended) OR offer options: Options may include (but are not limited to): a. it took too long to get to the distribution point/collection point b. It took too long waiting in line for my cash/voucher c. The hours of the distribution were in the middle of the workday d. The hours of the distribution were too early in the morning e. *Add other options as relevant* 3. (Optional- for more information) How long (in minutes/hours- TBD based on context) did it take you to travel to the distribution point/collection center? Insert relevant options or allow text. Calculate the total number of respondents who select "Yes" for Q2 and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey/ OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions)	Age/Sex of HoHH
% of households who report experiencing any problem(s) related to	Problems: any issue, challenge or difficulty Costs incurred: this includes costs/money spent on getting	1. Did you face any problems related to the costs related to getting or spending your cash/voucher assistance? Yes	PDM Survey/ OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM	Age/Sex of HoHH

costs incurred for getting their cash/voucher	to/from the distribution/collection point OR getting to/from shops/markets where individuals can use the cash/voucher provided. These may be transportation costs or other opportunity costs (i.e. childcare costs, loss of income due to missed work, etc.)	No 2. If yes, please describe (open ended) OR offer options (e.g. include (but not limited to): a. Too expensive getting to/from the distribution point b. Too expensive getting to/from shops where I can redeem the voucher c. The shopkeeper charged me a fee for using my voucher d. I had to miss work to get to the distribution on time and lost income e. I had to pay for childcare while I went to the distribution Calculate the total number of respondents who select "Yes" for Q1 and divide by the total number of respondents. Multiply by 100 to get the percentage.		should be at distributions)	
% of households who report facing any security risks while getting their cash/voucher assistance	Security risk: this includes any risk that puts the individual or HH member at risk in terms of their physical safety	1. Did you face any risks on the way to the collection center/distribution point? Yes/No If yes, please describe: 2. Did you face any risks while waiting at the collection center/distribution point? Yes/No If yes, please describe: 3. Did you face any risks while leaving the collection center/distribution point? Yes/No If yes, please describe: Calculate the total number of respondents who select "Yes" for at least one of the 3 questions. Divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions)	Age/Sex of HoHH
% of households who report that they faced connectivity challenges to access their money during the last *[online/mobile]* payment process *(relevant for programmes using mobile money/online delivery mechanisms)*	Connectivity issues - this is in relation internet or telecommunications connectivity that impact peoples' ability to access online accounts, mobile money transfers, send/receive funds, etc.	Q1. Did you face any difficulties or challenges due to connectivity that impacted your ability to access your cash/voucher assistance? Yes No Q2. If no, what issues did you face? (Text, or offer options. Calculate the total number of respondents who select "Yes" and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions)	Age/Sex of HoHH

% of households who report facing problems getting to/from the market	Problems: any issue, challenge or difficulty Getting to or from the market includes issues about the route/roads, transportation mode or costs, risks along the way, etc.	Q1. Have you faced any transportation, safety, or other types of problems getting to or from the market? Yes No Q2. If yes, what was the problem? [free text, or provide options] *Examples:* Roads are dangerous to travel on Roads are closed Transportation is too expensive Transportation is unsafe I cannot move freely There are checkpoints that I cannot cross Other (please describe_____) Count the total number of respondents who say "yes" to Q1. Divide by the total number of respondents and multiply by 100 to get the percentage.	PDM Survey OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions	Age/Sex of HoHH
% of households who report that accessing vendors to use their cash/voucher assistance was easy	accessing vendors: getting to/from or being able to interact with sellers, vendors, markets, shops. easy: individuals did have face problems, difficulties or challenges (related to social issues, security, and/or physical access) in accessing relevant sellers.	Q1: How easy or difficult was it for you to travel to the sellers where you could use [specify the modality] to buy whatever you needed? *Alt wording: Would you say that it was very easy, somewhat easy, rather difficult or impossible to reach the vendors where you could use your assistance?* 1) it was very easy 2) it was somewhat easy 3) it was rather difficult 4) it was impossible 5) the respondent did not try to use the modality Q2: [If "rather difficult" or "impossible"] Can you please explain why it was difficult? (adjust the answers depending on the local context; multiple answers possible) 1) due to poor security / fear of travel 2) due to roadblocks / checkpoints	PDM Survey OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions	Age/Sex of HoHH

		3) due to no/poor means of transport (bus, car, motorbike, etc.) 4) due to large distance 5) due to no money for transport 6) due to poor health 7) due to physical disability 8) due to lack of time 9) due to lost identification card (ID, passport) 10) due to not knowing where the sellers are 11) family did not allow her/him to travel 12) other – specify: …… To calculate the indicator's value, divide the number of respondents who said that accessing the sellers was very easy or quite easy by the total number of respondents. Multiply the result by 100.			
Average time spent traveling to and from the nearest market with available key commodities	Key commodities: based on a consultative process, key commodities should be defined by the community. These will likely overlap with commodities included in a MEB. Average time: the minutes/hours it takes project participants to reach a market(s) with the key commodities they need in supply.	Q1. How long (in minutes/hours- TBD based on context) did it take you to travel to the market where you can buy the key commodities you need? _____ Minutes OR insert relevant options.	PDM Survey OSM Survey	Monthly (PDM should be done within 30 days of distribution. OSM should be at distributions	Age/Sex of person who travels to/from the market

Table 8: Access Indicators

10.4. Utilization Indicators

% of households who save part of their income	Saving: not using/spending part (or all) of household income Income: total amount of money earned in a given time period (e.g. month) within a household unit (combined across all working family members)	Q1. How much of your household income did you save last month? (insert relevant options in local currency) Calculate the total number of respondents who respond to Q1 with more than 0/no ne. Divide by the total number of respondents. Multiply by 100 to reach the percentage.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of households who invest in productive assets by type	Investing: buying/renting Productive assets: any item, goods or supplies that supports the generation of	Q1. Have you bought or rented any of the following items using the cash/voucher received? (list relevant productive assets by type- e.g. seeds, farming equipment, tools, material/textiles, etc.)	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:**

	cash/profit/production (e.g. Seeds, Tools, Livestock, Equipment, etc. (types)	Calculate the total number of respondents who select any productive assets in each 'type' category. Divide by the total number of respondents to get the proportion for this indicator. Multiply by 100 to reach the percentage.		Bi-monthly or quarterly
% households who report experiencing problems related to spending the cash/voucher	Problems**:** any issue, challenge or difficulty Spending**:** using the cash/voucher to purchase items or services	Q1. Did you face any problem while spending your cash/voucher assistance? Yes No Q2. [For additional information] If yes, what problems? *Examples:* The shop(s) near me did not have items I needed The shop would not accept the voucher (with follow up, why?) The card reading (or voucher scanning) machine at the shop was broken (with follow up, which shop?) The shopkeeper did not want to sell to me (with follow up, why?) Other: _____ Calculate the total number of respondents who select "Yes" for Q1 and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly

Table 9 : Utilization Indicators

10.5. Accountability Indicators

of beneficiaries reporting that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner	Safe[16]: Assistance prevents and minimizes as much as possible any unintended negative effects of the intervention which can increase people's vulnerability to both physical and psychosocial risks. Accessible: Aid agencies arrange for people's access to assistance and services–in proportion to need and without any barriers (e.g. discrimination); and pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services. Accountable: Aid agencies use power responsibly through an active commitment to include the people affected by	Based on ECHO's protection mainstreaming indicator guidance, include all 7 questions below: Safe: Questions #5,6 Q5. Did you feel safe while receiving the assistance? Yes/No Q6. Did you feel you were treated with respect by NGO staff during the intervention? Yes/No Q6b. If not, please describe why not: (free text) Accessible: Questions #2,15 Q2. Was the assistance appropriate to your needs or those of members of the community? Yes/No/Partially/Don't Know Q15. Do you think there are people deserving who were excluded from the assistance? Yes/No Accountable: Questions #18,18.1 Q18. Have you or anyone you know in your community ever raised any concern on the assistance you received to the NGO using one of the above mechanisms? Yes / No Q18.1. If yes, are you satisfied with the response you have received? Yes / No / Partially / Response never received Participatory: #1 Q1. Do you know of anyone in your community having been consulted by the NGO on what needs are and how the NGO can best help? Yes/No For each question individually, add up the total number of respondents who chose 'YES' and divide this by the total number of respondents who answered the question. This will give a % respondents who answered 'Yes' for each of the seven questions. This information is used to obtain scores for each question and to calculate a total mark for the group of surveyed beneficiaries. Refer to detailed scoring instructions here: https://drive.google.com/file/d/1Ci2kQff9Gy4rYgSjsrw9r8NLCD5jfz68/view.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly

	humanitarian crises in decision-making and use appropriate mechanisms through which affected populations can measure the adequacy of interventions and address concerns and complaints. Participatory: Beneficiaries and affected populations have been involved in the different stages of the project, including needs assessment, project design, response, and monitoring; specific mechanisms are in place to enable beneficiaries and affected populations to provide feedback and complaints. Assistance supports the development of self-protection capacities and assists people to claim their rights.			
% of beneficiaries who know how to redeem vouchers/collect cash assistance	How well individuals understand where/how to access their voucher assistance (e.g. which vendors are participating, how to use the voucher amount) or collect their cash (e.g. how to withdraw money from an ATM, how to access funds from an FSP, etc.)	Q1. Do you know how to redeem your voucher/ access the cash assistance? Yes/Somewhat (I have some questions)/No [For additional info] Q2. If “Somewhat” or “No”, what part of the voucher redemption/cash collection process is unclear? *Insert relevant options, examples:* I don’t know which shops will accept my voucher I don’t know how to check my voucher balance I don’t know which items/services I can use my voucher for Calculate the total number of respondents who say "Yes" to Q1 and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey	*TBD in line with programme implementation* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who are satisfied with the cash transfer modality	How satisfied beneficiaries feel about the assistance provided- i.e. content, pleased, happy or happy with the modality (form of assistance) of cash/voucher programming provided.	Q1. How satisfied are you with the type of cash/voucher assistance you received? Very satisfied / satisfied / rather unsatisfied / very unsatisfied Q2. If "rather unsatisfied" or "very unsatisfied", please describe why: _____ (open ended, or offer options) Calculate the total number of respondents who say "very satisfied” or “satisfied” to Q1 and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:**

				Bi-monthly or quarterly
% of beneficiaries who are satisfied with the complaints and feedback mechanism	Relates to the way individuals respond and feel about complaints mechanism in place- i.e. content, pleased, happy or happy, in terms of: a) information provided about the mechanism, b) the channels used to share information about the mechanism, c) the options for providing feedback/complaints, d) the response time.	Q1. Are you satisfied with the following aspects of the complaints and feedback mechanism? Yes/No for each of the suggested categories: 1) Information provided about the CRM; II) Communication channels used to provide information about the CRM; III) Communication channels available to submit complaints or feedback; IV) Timeliness of the response to your complaint/feedback. Q2. If no, what would increase your level of satisfaction? (give space for each category- Free text) Calculate the total number of respondents who say "Yes" for each category used divided by the total number of respondents. Multiply by 100 to get the percentage for that category. Take the average % across the various categories to combine the averages for an 'overall' satisfaction with CRM.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who are satisfied with the distribution process	Relates to the way individuals feel about the distribution process and how/where/when they received their assistance (e.g. the location, timing, wait time, safety measures)	Q1. How satisfied are you with the distribution process for the cash/voucher assistance you received? Very satisfied / satisfied /rather unsatisfied / very unsatisfied Q2. If "rather unsatisfied" or "very unsatisfied", please describe why:_____ Offer options, for example: a. The distribution point is too far b. The hours/time of the distribution is difficult to manage c. The waiting period for my assistance was too long d. I was treated poorly by ORGANISATION staff e. I was treated poorly by other individuals in line/at the distribution f. There were no safety measures at the distribution (e.g. social distancing, handwashing, sanitizer, etc.) Calculate the total number of respondents who select “very satisfied” or “satisfied” and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report that agents/Financial Service Providers (FSPs) treated them with respect *(This indicator may also be adapted to focus specifically on ORGANISATION or partner staff)*	The proportion of interviewed beneficiaries who said that they are treated with respect when they receive their money from FSPs/agents (This indicator may also be adapted to focus specifically on ORGANISATION or partner staff)	Q1. How were you treated by FSP representatives/agents? *(or- modify the indicator to ask about other individuals/entities who may have been involved in cash/voucher disbursement or utilization)* I was treated respectfully I was treated with indifference I was treated disrespectfully I don’t know Q1b. If the response was disrespectfully, please describe how so: (free text)_____ Count all the people who answer “I was treated respectfully”, divide by the total number of respondents. Multiply by 100 to get the %.	PDM survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report that they were informed/aware of the key information about World Vision	Proportion of the total interviewed beneficiaries who report that they were informed about World Vision and its operations	Q1. Were you informed of the following information about World Vision? Yes/No for each category: Information about what/who World Vision is Expected ORGANISATION staff behavior ORGANISATION programmes and activities How to complain and give feedback Q2. [Optional for additional info] Of the channels used to share information, which one did you find most useful? (select one – modify as relevant to local context) Face to face Radio TV PA system/megaphones Printed materials (flyers, leaflets) Social media (fb, WhatsApp Phone (calls/SMS) Other – please give details Calculate the total number of respondents who say "Yes" for each category used divided by the total number of respondents.	PDM Survey/ OSM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:**

		Multiply by 100 to get the percentage for that category. Take the average percentage across the various categories to combine the averages for 'overall' satisfaction.		Bi-monthly or quarterly
% of beneficiaries who report that they were informed and aware of key project information	Proportion of the total interviewed beneficiaries who report that they were informed about the project particulars: the amount they would receive, targeting criteria, project objectives, timeline	Q1. Were you informed of the following project information? Yes/No for each category: - the transfer value you would receive - how people were selected - the aim/goals of this project - the duration of this project Q2. [Optional for additional info] Of the channels used to share information, which one did you find most useful? (select one) Face to face Radio TV PA system/megaphones Printed materials (flyers, leaflets) Social media (fb, WhatsApp Phone (calls/SMS) Other – please give details Calculate the total number of respondents who say "Yes" for each category used divided by the total number of respondents. Multiply by 100 to get the percentage for that category. Take the average percentage across the various categories to combine the averages for 'overall' satisfaction.	PDM Survey/ OSM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report that they received a timely response to complaints or questions they have submitted	Respondents who report that they submitted at least 1 feedback or complaint and received a response in a timely manner (timely to be defined locally based on the SOPs/CRM system in place, but in general, this should not be more than 2 weeks).	Q1. Have you submitted any complaints, feedback or questions to ORGANISATION ? Yes/No *If no, do not include the respondent in the count of total individuals who submitted complaints/feedback.* If yes, ask: Q2. How satisfied were you with the time it took to close your complaints/feedback? Very satisfied / fairly satisfied / rather unsatisfied / very unsatisfied Q2b. If “rather unsatisfied” or “very unsatisfied”, how long did you wait for a response? Example options: Less than 1 week 1-2 weeks 2-3 weeks 3-4 weeks More than 1 month Count respondents who answered “yes” to Q1. This is your total # of people who submitted complaints/feedback. Count the total number of people who answered “Very satisfied” or “Fairly satisfied” in Q2. Divide by the total # of people who submitted complaints/feedback. Multiply by 100 for the %.	PDM Survey OSM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who know how to reach ORGANISATION if they face challenges related to accessing their assistance	Whether respondents know how to contact ORGANISATION if they face challenges related to their assistance (e.g. accessing their funds, redeeming vouchers, checking their balance, etc.)	Q1. Do you know how to contact ORGANISATION if you face challenges accessing your assistance? Yes/No Q2.[optional for additional info] If yes, what would you do? Example options: a. Call the ORGANISATION hotline b. Submit a complaint using a suggestion box	PDM Survey OSM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:**

Table 10: Accountability Indicators

10.6. Do No Harm Indicators

Before including these indicators and/or asking these questions it is important to consider Do No Harm principles and ensure you are not putting anyone at risk, or if there are better ways to capture the needed information in your context. Work with a protection colleague and/or DNH specialist to identify appropriate questions and the best way forward

% of beneficiaries who report experiencing increased tensions within their household as a result of CVP	increased tensions: tension may be felt or perceived and related to any aspect of daily life, including decision-making, roles/responsibilities, attitude/behavior	Q1. Do you believe that receiving cash/voucher assistance has increased tension within your household? Yes/No Q1b. If yes, please explain/describe (open ended): Calculate the total number of respondents who say "Yes" to Q1 and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey **try to speak to different members of the HH (not just the HoHH) if the situation/context allows without risk of doing harm.*	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report experiencing tensions within their community as a result of CVP	increased tensions: tension may be felt or perceived and related to any aspect of daily life, including decision-making, roles/responsibilities, attitude/behavior	Q1. Do you believe that the cash/voucher programme has led to any increased tension between individuals or groups within your community? Yes/No Q1b. If yes, between which individuals or groups? E.g. options: People who received assistance and those who did not People who received different amounts of assistance People within the same family/household Other (describe) Q1c. If yes, please explain/describe why (free text, or provide some options). Examples: People think selection criteria is unfair People think assistance should be provided to everyone People think other people are not truthful about their situation Other (describe) Calculate the total number of respondents who say "Yes" to Q1 and divide by the total number of respondents. Multiply by 100 to get the percentage.	PDM Survey	*TBD in line with programme implementation (duration, frequency of distributions)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report decreased trust within their community as a result of the cash/voucher programme	This indicator relates to the perception of individuals about the level of trust between community members, whether between different people who are all receiving assistance, or people who are receiving assistance with those who are not, or others.	Q1. Have you noticed any changes in the level of trust amongst different community members or groups since the project started? Yes No Q2. If yes, were these changes negative or positive? Negative Positive	PDM survey	*TBD in line with programme implementation (duration, frequency of distributions, volatility)* **Suggested:** Bi-monthly or quarterly

		Q2a. If negative, please describe: _____ Q2b. If positive, please describe: _____ Q3. If yes, were these changes related to the cash/voucher project? Yes No Q3a. If yes, how so? (describe)_____ Count the total number of individuals who responded "Yes" to Q1 and "Negative" to Q2 and "yes" to Q3. Divide by the total number of respondents and multiply by 100 to get the %.		
% of beneficiaries who report feeling unsafe in the market/shops	Feeling "unsafe' may include any feeling that an individual or family is at risk of physical danger or exploitation, worried/anxious for their safety, etc.	Q1. Do you ever feel unsafe in the market or shop(s)? Always Sometimes Never Q2. If always or sometimes, why? [Example options, to be tailored to the context/risks:] The vendor/shop keeper threaten me/my family There are armed groups patrolling the market There are checkpoints in the market	HH Survey – PDM OSM	*TBD in line with programme implementation (duration, frequency of distributions, volatility)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report feeling unsafe in the market/shops	Feeling "unsafe' may include any feeling that an individual or family is at risk of physical danger or exploitation, worried/anxious for their safety, etc.	Q1. Do you ever feel unsafe in the market or shop(s)? Always Sometimes Never Q2. If always or sometimes, why? [Example options, to be tailored to the context/risks:] The vendor/shop keeper threaten me/my family There are armed groups patrolling the market There are checkpoints in the market	HH Survey – PDM OSM	*TBD in line with programme implementation (duration, frequency of distributions, volatility)* **Suggested:** Bi-monthly or quarterly
% of beneficiaries who report feeling unsafe in the market/shops	Feeling "unsafe' may include any feeling that an individual or family is at risk of physical danger or exploitation, worried/anxious for their safety, etc.	Q1. Do you ever feel unsafe in the market or shop(s)? Always Sometimes Never Q2. If always or sometimes, why? [Example options, to be tailored to the context/risks:] The vendor/shop keeper threaten me/my family	HH Survey – PDM OSM	*TBD in line with programme implementation (duration, frequency of distributions, volatility)* **Suggested:** Bi-monthly or quarterly

		There are armed groups patrolling the market There are checkpoints in the market		

Table 11 : Do No Harm Indicators

10.7. Market Indicators

# of critical market actors directly assisted through market system rehabilitation activities	market actors include producers, suppliers, traders, or processors that have directly received cash, access to finance, or training to help them restart or improve their market function. Critical market actors will be defined in your project but refers to market actors who perform essential functions to a market system that plays a major role in disaster-affected people's survival or livelihoods and who are not able to perform these functions as needed because of the disaster. These actors might be anywhere in the value chain and may or may not directly interact with the ultimate beneficiaries of the project (the most affected/most vulnerable).	Count the number of market actors who directly received program assistance (small loans/grants, training, etc.). Work with the program manager to determine who constitutes a market actor for the purposes of this indicator.	Project records	Quarterly/ Bi-annually
# of key commodities (by type) in markets that show price shifts of more than xxx%	Key commodities: based on a consultative process, key commodities should be defined by the community. These will likely overlap with commodities included in a MEB. Price shift: a change in the unit price of goods/items- for this indicator, a price shift of X% in either direction (increase or decrease in price) should be tracked/counted. The % change	Use a market monitoring survey to monitor the cost of key commodities on a regular basis (TBD based on context and expected level of fluctuation). Each week/month collect the price for a standard unit of the commodity (e.g., 1kg, 1 packet, etc.) and compare costs across time. Calculate price shifts. Count the number of key commodities with price shift of more than X% and divide by the total number of key commodities. Multiply by 100.	Markets/ Price monitoring tool	*TBD based on context/* *volatility* Weekly/ Monthly

	may be based on guidelines from technical colleagues, coordination groups, etc.			
Average % change in supply of key commodities (by type) across markets does not exceed ± xxx %	Key commodities: based on a consultative process, key commodities should be defined by the community. These will likely overlap with commodities included in a MEB. Supply: refers to the amount of stock vendors/shop keepers have of key commodities that can be sold/be available for consumers, usually measured in a standard way (e.g. KGs, Boxes, Packets, etc.)	Use a market monitoring survey to monitor the supply of key commodities on a regular basis (TBD based on context and expected level of fluctuation). Each week/month collect the stock availability of key commodities in a standardized sample of stores/vendors and compare over time. Take the average % change from each monitoring period to show the trends.	mark it/ Price monitoring tool	*TBD based on context/* *volatility* Weekly/ Monthly By marketplace
Number of key commodities that are available in the different markets	Key commodities: based on a consultative process, key commodities should be defined by the community. These will likely overlap with commodities included in a MEB (where it is used) . Different types of markets: source markets, central markets, local markets, etc.	Use a market monitoring survey to monitor the availability of key commodities on a regular basis (TBD based on context and expected level of fluctuation). Each week/month ask about the availability of key commodities in a standardized sample of stores/vendors and compare the number of key commodities that are in supply over time, across different market types.	markets/ Price monitoring tool	*TBD based on context/* *volatility* Weekly/ Monthly
Price of key commodities in different types of markets	Price: cost per unit (unit TBD locally or in line with working group/cluster agreement) Key commodities: based on a consultative process, key commodities should be defined by the community. These will likely overlap with commodities included in a MEB (where it is used) Different types of markets: source markets, central markets, local markets, etc.	Use a market monitoring survey to monitor the prices of key commodities (per standard measurement, e.g. $/kilo, $/package) on a regular basis (TBD based on context and expected level of fluctuation). Each week/month ask about the unit price of key commodities in a standardized sample of stores/vendors and compare over time, across different market types.	mark it/ Price monitoring tool	*TBD based on context/* *volatility* Weekly/ Monthly

Quality of key commodities in different type of markets	Quality: standard of items as compared against other items in similar vendors/markets Key commodities: based on a consultative process, key commodities should be defined by the community. These will likely overlap with commodities included in a MEB. Different types of markets: source markets, central markets, local markets, etc.	Use a market monitoring survey to monitor the quality of key commodities on a regular basis (TBD based on context and expected level of fluctuation) through observation or production standards as defined by cluster/working group, Sphere, etc. Each week/month observe the quality of key commodities in a standardized sample of stores/vendors and compare over time, across different market types.	markets/ Price monitoring tool	*TBD based on context/* *volatility* Weekly/ Monthly

Table 12: Market Indicators

11. List of Annexes

11.1. Annex 1: Summary of Risk associated with Nutrition sensitive CVA programming

SN	Key Risk Area	Risk Description	Impact level	Likelihood	Risk	MITIGATION
1	Operational	Shortage of nutrition supplies due to supply chain and logistics related challenges.	5	3	15	* WFP and UNICEF to procure and preposition at least 3 months contingency stock of core nutrition supplies to ensure the continuation of life-saving services. * Nutrition cluster and sector partners to advocate to key donors to fund buffer stock through sector partners. * Working through the cluster to identify key supply chain bottlenecks and support nutrition partners to build their capacity at procuring and transporting nutrition supplies.
2	Operational	Devaluation of the local currency and price increase reducing beneficiaries purchasing power and increasing project implementation costs.	5	2	10	* Continuously monitor the situation and harmonize the salaries for health workers and specialists working with the implementing partners in coordination with other agencies to ensure continuity of services in the high-severity areas, and consistency of rates among different agencies. * Weekly market price monitoring to keep track of commodity and service price changes. * Working through the cluster to discuss any changes to transfer value or currency to be distributed to beneficiaries.
3	Operational	Delay in obtaining the required approvals from concerned authorities by Implementing Partners to implement projects.	5	2	10	*UNICEF and WFP to work closely with all potential partners to have the agreement documents ready and shared with relevant authorities in advance in order to get the required approvals on time. * UNICEF has established 2-years agreement, simplification of procedures, contingency budget, and early submission to receive the approvals in time.

4	Strategic / Programmatic	Limited capacity and experience of nutrition partners/programs in delivering assistance via CVA modalities contributing to implementation challenges, compliance and financial risks.	4	3	12	* UNICEF to provide required technical support and capacity building to partners on adherence to humanitarian principles and financial risk management. * All implementing partners to be supported to be Harmonized Approach to Cash Transfers Framework compliant.
5	Strategic / Programmatic	Health workers moving between camps, potential looting of nutrition supplies, attacks on health workers and facilities as well as beneficiaries accessing the facilities, losing follow up of beneficiaries and creating tension when targeting IDPs for distributions in the host community.	5	2	10	*In order to mitigate these risks, and ensuring adherence to humanitarian principles, the sector will continue to adopt a “Do No Harm” strategy while providing nutrition services to vulnerable groups throughout Syria. These mitigation measures include training of nutrition sector partners on the prevention of sexual exploitation and abuse, scaling up community-based approaches to ensure quality access to services. * Carry out community sessions to introduce the different nutrition services provided, beneficiaries targeted, and how to utilize it best. * Set up a community feedback and grievance mechanism to allow the community's feedback on the functionality, safety, and acceptance of the service to avoid risks. * Work closely with local council/camp management to coordinate service delivery and safety of nutrition/health staff and beneficiaries.
6	Strategic / Programmatic	Inclusion errors within the targeted beneficiary population due to fake / wrong identification documents, or incorrect information.	3	4	12	* Strengthen community feedback mechanisms and raise awareness amongst communities to use them to report any inclusion errors. * Streamline beneficiary targeting, registration and verification processes across the sector. * Provide training to implementing partners staff including field monitors and enumerators on

						humanitarian principles and on fraud and corruption awareness. * The initial vulnerability assessment and the verification of the final beneficiary list should be carried out by different teams, with the latter undertaken by third party monitors, partners, or the MEAL department. * Ensure transparency in validation processes and community feedback mechanisms so that potential beneficiaries do not feel compelled to use wrong or fake IDs in order to qualify for assistance. * Provide community awareness sessions on identification requirements and civil registration support. * All sector partners are encourage to have an internal whistleblowing mechanism in place that is routinely promoted among their staff to report any discrepancies. * Initial beneficiary lists to be assessed in coordination with community representatives' committees. * For pregnant women validation: collect information on pregnancy status at the selection level before rolling out the program and informing the community about the intervention. * Work closely with a health partner/department to validate pregnancy and update beneficiary records accordingly. * Partners to regularly review admission data and expected prevalence rates as well as commission rapid nutrition assessments when necessary to confirm emerging trends. * Continuous nutrition surveillance to strengthen preparedness.
7	Strategic / Programmatic	Lack of or inadequate collective information provision, feedback and participation of affected communities due to irregular access to the communities and remote	3	2	6	* Establish/strengthen local partnerships, building the capacity of partners to effectively engage with communities, and strengthen community-based facilitate dialogue with communities. * Promote awareness and systematic and coherent use of community feedback mechanisms so that any feedback/complaints can be reported.

		management of health services.				* Identify remote / digital tools access for communities in harder to reach areas.
8	Strategic / Programmatic	Constrained access to affected population. Barriers to access (especially for children & adults with disability) or exclusion of some vulnerable and minority groups especially in certain areas that have shifted lines of control.	5	3	15	* All programme data collected to be disaggregated by sex, age and disability, with a specific focus on monitoring the needs of vulnerable and minority groups throughout the program cycle to enable programme interventions to be adapted. * The initial beneficiary selection list should be monitored through a vulnerability assessment and/or verification activity carried out directly by the implementing partners before the list of beneficiaries is finalized. * Initial lists can be assessed by community representatives' committees. * Partners to work with service providers to ensure adequate access for all people with disabilities and marginalized groups. * The sector to work closely with OCHA and access working group to advocate for access to affected populations at every level as well as provide necessary documentation and support for increase access; *The Sector to engage with and provide capacity building to local NGOs who can deliver services in challenging contexts. * The nutrition sector to undertake relevant advocacy to ensure that partners have adequate security measures in place, work to increase community acceptance, and ensure adherence to humanitarian principals;

9	Strategic / Programmatic	Breach or leakage of sensitive data and information containing patient names, medical conditions and health care provider names into the wrong hands maybe can put people and communities at risk of targeting, shame, abuse and even death.	5	2	10	* All sector partners to comply with data protection regulations and guidelines. * Partner agreements to have specific clauses on data protection. * Data protection training to be provided to staff for all partners.
10	Operational	COVID-19 cases amongst health workers and partner staff	2	5	10	*Continued training and enforcement of infection prevention and control measures and protocols. *Adopt Covid-19 sensitive nutrition response through development of relevant thematic operational guidance's. * All partners to prepare Business Continuity Plans to ensure that operations have minimal impact.
12	Contextual	Natural disasters and disease outbreaks: While some disease outbreaks are naturally expected and factored into the project planning, outbreak of diseases on and epidemic scale or natural/manmade disaster will affect the Programme implementation.	4	3	12	* Strengthen the surveillance system and also strengthen the Rapid Response Mechanism (RRM) so that potential outbreaks can be detected early and responded to in a timely manner. * Partners prepare Emergency Preparedness Plans and business continuity plans to ensure that programme implementation has limited impact at the onset of a shock.
14	Strategic / Programmatic	Aid diversion	5	2	10	* Clear SOPs to be agreed on with the partners to ensure that the CVA is issued to the targeted beneficiaries. * Community feedback mechanisms, spot checks, and third-party monitoring to provide triangulation of data to ensure close monitoring and report any identified aid diversion.

15	Strategic / Programmatic	Households don't spend assistance on nutritious food commodities/or services (health/nutrition/etc.) (If CVA not at reasonable amount, HH may choose to buy cheaper and less nutritious items that provide bulk to make the money feed more people for longer.)	3	4	12	* All partners to ensure that CVA interventions are complemented with cash plus activities including behavioral change communication. * Explore CVA modalities to add conditionality if desired programme impact not being achieved (although preference is always for unconditional cash). * Conduct regular market monitoring to ensure availability of health and nutrition commodities and services. * Conduct regular post-distribution monitoring to better understand beneficiary expenditure patterns to guide programming.
16	Strategic / Programmatic	Social tensions increase because of the CVA targeting approaches adopted: GBV and negative dynamics at HH & community levels (Where increased cash available to women and girls may lead to targeting for HH violence or where beneficiaries are targeted with violence when they receive the cash distribution or collect food supplies. Also, unable to use the cash as needed - e.g. feed children)	4	3	12	* Partners to conduct awareness sessions with boys, men, girls and women to outline the programme objectives, and importance of preventing/treating malnutrition. * Raise communities awareness on the importance of nutrition conscious decisions for spending cash assistance. * Conduct specific sessions on GBV risks at community and household levels. * Strengthen GBV awareness raising and referral pathways across the catchment areas.

Table 13: Annex 1: Summary of Risk associated with Nutrition sensitive CVA programming

	High Risk
	Moderate Risk
	Low Risk

11.2. Annex 2: Current NWS Survival Minimum Food Basket

Items		Essential Micronutrients						
Food Commodity	Monthly quantity (kg)	Calcium (mg/day)	iron (mg/day)	zinc (mg/day)	Vitamin A (mcg/day)	Vitamin B12(mcg/day)	Vitamin C (mg/day)	Vitamin D (mcg/day)
Bulgur Wheat	2.49	29	2.0418	1.6019	0	0	0	0
Rice, White, Medium Grain	3.18	10	0.848	1.2296	-	0	0	0
Bread, Made From Wheat	6.18	284	7.2512	2.4308	0	0	0.412	0
Lentils	2.49	46	6.2582	3.9674	2	0	3.652	0
Oil, Sunflower, Unfortified	1.17	0	0	0	0	0	0	0
Sugar	0.84	0	0.014	0.0028	0	0	0	0
Leaves, Dark Green, E.G. Spinach	2.01	66	1.8157	0.3551	314	0	18.827	0
Chicken, Meat And Skin, Raw	0.99	4	0.297	0.4323	14	0	0.528	0.066
Egg, Whole, Chicken, Fresh	0.99	18	0.5775	0.4257	53	0	0	0.66
Tomato Paste, Canned	0.99	12	0.9834	0.2079	25	0	7.227	0
Salt, Iodized [WFP]	2.13	-	-	0	0	0	0	0
Total	**23.46**	**470**	**20**	**11**	**407**	**0**	**31**	**1**
Daily PLW requirement		1067	30	15	800	2.6	55	5
Gap after GFD		597	10	4	393	2	24	4
% of Gap covered by voucher		**55.96%**	**33.04%**	**28.98%**	**49.09%**	**84.77%**	**44.28%**	**85.48%**

Table 14: Annex 2: Current NWS Survival Minimum Food Basket

11.2.1.Annex 3: Proposed nutrition sensitive food items to be added to the MFB

Commodity	Monthly quantity (kg)	Monthly quantity (g)	Value (USD/kg	Total price
Carrots, Raw	1.8	1800	0.22	0.40
Sardines, Canned In Oil, Drained	1.65	1650	0.37	0.61
Tuna, Canned In Oil, Drained	0.45	450	0.26	0.12
Yogurt, Whole Milk (Leban)	9	9000	0.36	3.20
Orange, Raw	4.2	4200	0.33	1.40
Lamb, Ground, Raw	2.7	2700	4.85	13.09
Dates, Dried (Deglet Noor)	0.75	750	0.45	0.34
Fortified cereals	1.2	1200	0.52	0.62
Leaves, Dark Green, E.G. Spinach	2.13	2130	0.13	0.28
Total	23.88	23,880	7.49	**20**

Table 15: Proposed nutrition sensitive food items to be added to the Minimum Food Basket

11.2.2. Annex 4: NWS Nutrition Cluster CVA Technical Working Group Members, Jan- Sep 2022

Name	Agency	Designation
Abigael Nyukuri	UNICEF	Whole of Syria Nutrition Cluster Coordinator; NWS Nutrition Cluster Coordinator and NWS Nutrition Cluster CVA TWG Chair (Author)
Rajia Sharhan	UNICEF	Health and Nutrition Specialist
Hashim Zaidi	UNICEF (MENARO)	Programme Specialist, Social policy.
Rewa Al Rass	PAC	NWS Nutrition Cluster Co-Coordinator
Abdulbaset Al Salkini	PAC	NWS Nutrition Cluster Information Management Specialist
Hamza Barhom	Save the Children	Health and Nutrition Programme Manager
Fadi Ibrahim	SHAFAK	Health Programme Supervisor
Ahmed Daif	Mercy USA for Development	Nutrition Manager
Saleem Ahmed	Big Heart	Acting Country Director
Bana Abu Judeh	GOAL	Nutrition Coordinator
Glorious Gragory Das	WV Syrian Response	Technical Manager
Ali KALDIRIM	WFP	Programme Policy Officer
Dr Ismail Alkhatib	AFAQ	Health and Nutrition Technical Manager
Fe Kagahastian	Cash Cap (MENA)	NWS interim CWG Coordinator; CVA Adviser, Whole of Syria
Mohie ALWAHSH	WFP	Whole of Syria Food Security Cluster Coordinator

Table 16: Northwest Syria Nutrition Sector CVA Technical Working Group Members, Jan- December 2022

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