Cash and Voucher Assistance to Improve Maternal and Child Nutrition Outcomes in Emergency Contexts of Nigeria

Operational Guidance

July 2023

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Comments and feedback should be sent to: nigeria.nutrition@humanitarianresponse.info

Acronyms

AAH	Action Against Hunger
ANC	Antenatal Care
BHA	Bureau for Humanitarian Assistance
BMS	Breastmilk Substitutes
CaLP	Cash Learning Partnership
CotD	Cost of the Diet
CRS	Catholic Relief Services
CVA	Cash and Voucher Assistance
CWG	Nigeria Cash Working Group
ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
FAO	Food and Agriculture Organization
FFV	Fresh Food Vouchers
FNG	Fill the Nutrient Gap
GAM	Global Acute Malnutrition
GFA	General Food Assistance
GHIV Africa	Global Village Healthcare Initiative for Africa
HAZ	Height-for-Age Z-score
HRP	Humanitarian Response Plan
IDPs	Internally Displaced Persons
IMAM	Integrated Management of Acute Malnutrition
IMC	International Medical Corps
IPC	Integrated Food Security Phase Classification
IRC	International Rescue Committee
ISCG	Inter-Sector Coordination Group
LGA	Local Government Area
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD	Minimum Dietary Diversity
MDD-W	Minimum Dietary Diversity for Women
MEB	Minimum Expenditure Basket
MIYCN	Maternal, Infant and Young Child Nutrition
MMF	Minimum Meal Frequency
MNCHN	Maternal, Newborn, Child Health and Nutrition
MPCA	Multipurpose Cash Assistance
MUAC	Middle- Upper Arm Circumference
NCVA	National Cash and Voucher Assistance Policy
NGN	Nigerian Naira
OTP	Outpatient Therapeutic Programme
PBWG	Pregnant and Breastfeeding Women and Girls
PNC	Postnatal Care
SAM	Severe Acute Malnutrition
SBC	Social and Behavioral Change
SC	Stabilization Centre
SCI	Save the Children International

SMEB	Survival Minimum Expenditure Basket
SPHCDA	State Primary Health Care Development Agency
TSFP	Targeted Supplementary Feeding. Programme
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WAZ	Weight-for-Age Z-score
WFP	World Food Programme
WHZ	Weight-for-Height Z-score

Terminology[1]

Cash and Voucher Assistance (CVA): Refers to all programs where cash transfers or vouchers for goods or services are directly provided to recipients.

Commodity Voucher: Refers to vouchers exchanged for a fixed quantity and quality of specified goods or services at participating vendors.

Conditionality: Refers to prerequisite activities or obligations that a recipient must fulfil in order to receive assistance. The most common conditionalities in nutrition programming are related to participation in social and behavioral change (SBC) interventions or attendance to health services.

Delivery Mechanism: Means of delivering a cash or voucher transfer (e.g., smart card, mobile money transfer, cash in hand, cheque, ATM card, etc.).

First 1000 days of life: The critical period of opportunity for a child's mental and physical development which is between a woman's conception and her child's second birthday.

Fresh Food Voucher: A voucher (paper, token, or e-voucher) that is redeemed for a set quantity or value of fresh foods at fresh food vendors.

Minimum Expenditure Basket (MEB): Refers to the identification and quantification of goods and services for ensuring that a household's basic needs are addressed.

Multipurpose Cash Assistance (MPCA): Comprises transfers (either periodic or one-off) corresponding to the amount of money required to cover, fully or partially, a household's basic and/or recovery needs that can be monetized and purchased.

Nutrition Outcome: Defined as improvement of the nutritional status typically measured through weight-for-height z-score (WHZ), height-for-age z-score (HAZ), Middle- Upper Arm Circumference (MUAC), weight-for-age z-score (WAZ) and micronutrient status or 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 (MMF) for children.

NutVal: A spreadsheet application for planning and monitoring the nutritional content of food assistance.

Restriction: Refers to limits on the use of assistance by recipients.

Survival Minimum Expenditure Basket (SMEB): Refers to the identification and quantification of goods and services for ensuring that a household's minimum survival needs only are addressed.

Top-up: Refers to the provision of cash transfers or vouchers to complement existing in-kind food assistance or CVA.

[1] Adapted from the Cash Learning Partnership (CaLP) glossary.

Voucher: A paper, token or e-voucher that can be exchanged for a set quantity or value of goods or services, denominated either as a cash value (e.g., 2,500 NGN) or predetermined commodities (e.g., 5 kg maize) or specific services (e.g., milling of 5 kg of maize), or a combination of value and commodities.

Value Voucher: A voucher that has a denominated cash value and can be exchanged with participating vendors for goods or services of an equivalent monetary cost.

1. Introduction

Nutrition Situation

In Nigeria, nearly 12 per cent of children under 5 years are wasted according to the National Food Consumption and Micronutrient Survey (2021).[2] Wasting is largely concentrated in the North with 58 per cent of all cases residing there.[3] In the Northeast and Northwest regions of Nigeria, the prevalence of wasting is 17 per cent and 12 per cent respectively.[2] In 2023, it was projected that nearly 6 million children aged 0-59 months in Northeast and Northwest Nigeria would be acutely malnourished, including 1.6 million severely malnourished. In addition, nearly 512,000 pregnant and lactating women will also likely suffer from acute malnutrition. The nutrition situation in more than half of the local government areas (LGAs) in Northeast and Northwest regions during the lean season (May – September) can be classified as Serious or Critical (IPC Acute Malnutrition Phase 3 and above) as indicated in Figure 1.[4]

The protracted conflict in Northeast, high incidences of insecurity in Northwest, extreme weather events associated with climate change, persistently high levels of inequality, high levels of food insecurity, economic impacts of COVID-19 pandemic and global crises, and very low coverage of preventive interventions have exacerbated the vulnerabilities in these regions, reversing the recent years of progress pertaining to national Maternal, Infant and Young Child Nutrition (MIYCN) targets.

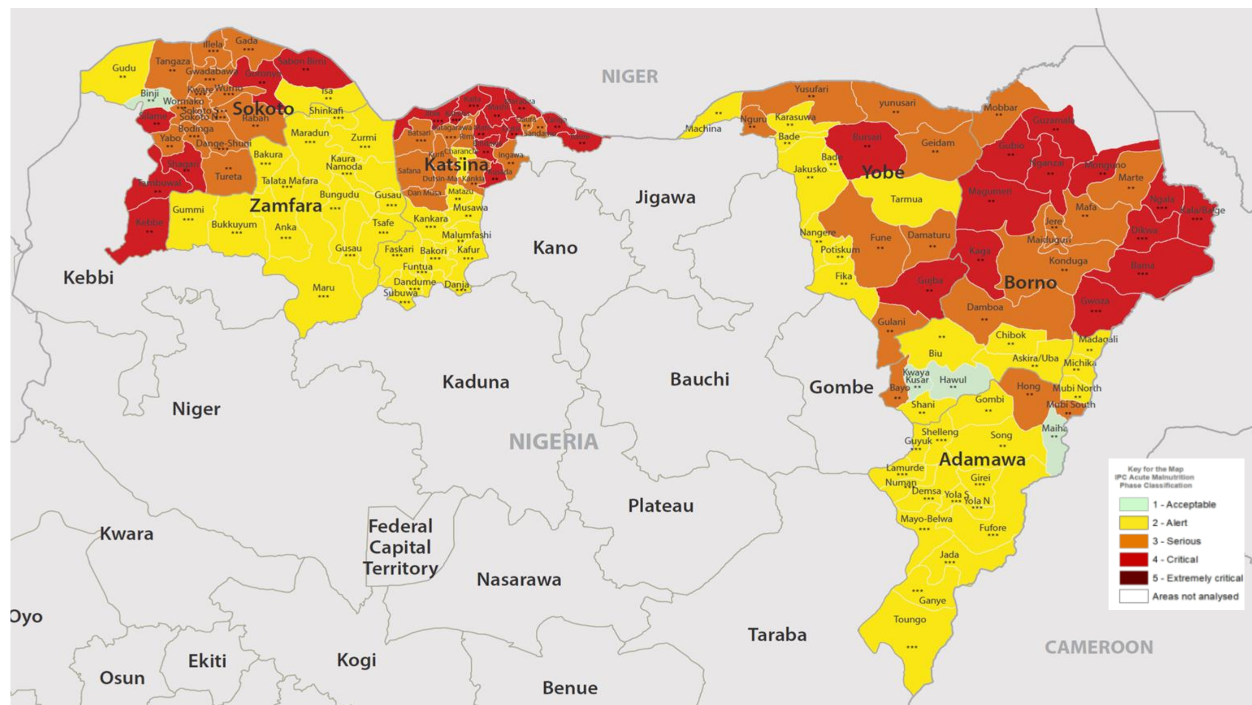

Figure 1: IPC for Acute Malnutrition Map (Current, May – September 2022)

[2] Federal Government of Nigeria (FGN) and the International Institute of Tropical Agriculture (IITA). 2022. National food consumption and micronutrient survey 2021: preliminary report. Abuja and Ibadan, Nigeria: FGN and IITA. 288 pp.

[3] UNICEF, FAO, UNHCR, WFP and WHO. 2021. Global Action Plan on Child Wasting, Nigeria Roadmap: : a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals.

[4] IPC Acute Malnutrition Analysis. 2022. Nigeria (Northeast and Northwest): Acute Malnutrition Situation May - September 2022 and Projections for October - December 2022 and January - April 2023

Cash and Voucher Assistance to Support Nutrition Outcomes

Cash and Voucher Assistance (CVA) to support maternal and child nutrition outcomes is an emerging area of practice globally, particularly in emergencies. The five main approaches for integrating CVA into the nutrition response based on peer-reviewed studies are presented in Table 1.[5]

Table 1: Five main approaches for integrating CVA into the nutrition response

Approach		Main objectives of the CVA component
Prevention	Using cash or vouchers for household assistance and/or individual feeding assistance	**Household CVA:** ● Improve household food security and dietary diversity ● Protect nutritional status **Individual feeding CVA:** ● To prevent deterioration in the nutritional status of at-risk groups ● To reduce the prevalence of moderate acute malnutrition (MAM) in children under five ● Support dietary diversification
Prevention	Combine household CVA with social and behavioral change (SBC) interventions	● Improve household food security and dietary diversity ● Protect nutritional status ● To prevent deterioration in the nutritional status of at-risk groups
Prevention	Provide conditional cash transfers to improve attendance and use of essential health and nutrition services	● Improve attendance to priority health services ● Cover indirect costs and reduce opportunity costs of seeking health services ● Improve household food security and dietary diversity ● Protect nutritional status
Treatment	Provide CVA to facilitate access and adherence to treatment of malnutrition	● Facilitate access and adherence to treatment services by covering indirect and direct costs
Treatment	Provide household CVA to caregivers of children with SAM	● Improve treatment outcomes: reduce defaulting, non-response to treatment and relapse ● Improve household food security and dietary diversity ● Protect nutritional status

CVA for food assistance in Northeast Nigeria has been widely tested and found effective and potential for nutrition outcomes exists, provided the design and implementation ensure specific nutrition features. For example, markets in Northeast Nigeria are functioning in a way that provides opportunities for other purposes of programming to be served by CVA.

The impact of CVA on nutrition is thought to be mainly through the economic pathway as it addresses financial constraints such as unaffordability of healthy diets, access to hygiene items and health services, as well as transport and indirect costs associated to nutrition treatment programs. However, CVA doesn't address other non-financial barriers to nutrition like lack of caregiver knowledge of prenatal and early childhood nutrition best practices and male caregiver involvement in household nutrition decisions and practices. Therefore, it is widely accepted that since CVA alone is in most circumstances not enough to impact nutrition outcomes, this delivery approach should be complemented with other nutrition interventions, e.g., SBC to enhance effectiveness.[5] The case study that documented experiences of using CVA for nutrition outcomes in Nigeria reported that;[6]

[5] GNC. 2020. Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies.
[6] Durr. A. 2020. Case study: Documentation of experiences using CVA for nutrition outcomes in Nigeria

- CVA modalities can be part of preventative and treatment strategies but are generally more suited for preventative approaches.
- CVA can be provided as household assistance (e.g., Household Food Assistance or Multipurpose Cash Assistance) or individualized assistance by addressing the specific nutritional requirements of at-risk groups within households.
- Cash transfers have a much better chance to impact nutrition outcomes of mothers and children if provided alongside context-specific nutrition SBC.
- Conditional cash transfers can increase the attendance to priority health services.
- Targeting CVA based only on the nutritional status of children in a treatment response may tempt caregivers to slow down their children's recovery in order to prolong the treatment period, or in some cases there have been experiences of certain strategies to make children lose weight in order to meet the admission criteria. For this reason, CVA for treatment response should be accompanied by a risk analysis and strong monitoring and accountability system.

Cash and Voucher Assistance in the Nigeria Humanitarian Response

Humanitarian partners in the BAY states have used CVA since 2016 as a response modality to address critical needs for internally displaced persons (IDPs), returnees and host communities. Of the $1.1 billion required for the 2022 Humanitarian Response Plan (HRP), $568M, comprising 68 projects, were for CVA interventions, amounting to 56 per cent of the total financial requirement. The Inter-Sector Coordination Group's (ISCG) Cash Working Group (CWG) provides oversight over CVA implementation.[7] At the national level, the Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development with support from CWG was developing the National Cash and Voucher Assistance (NCVA) Policy at the time of the development of this Operational Guidance. The policy will be aligned with other relevant national policies and strategies, e.g., National Financial Inclusion Strategy (2018), National Policy on IDPs (2022), and the Nigeria Social Protection Policy.

2. Purpose of the Operational Guidance

The use of CVA as a modality to improve maternal and child nutrition outcomes has significantly increased in Northeast Nigeria. A survey conducted in October 2022 by the Cash Working Group (CWG) in collaboration with the Nutrition Sector to assess the proportion of Nutrition Sector partners implementing CVA related activities in Northeast Nigeria found that eight (8) out of the 46 Nutrition Sector partners implemented CVA in 14 out of the 60 accessible LGAs.[8] However, the lack of context-specific operational guidance on how to use CVA in emergency nutrition programming has posed many operational challenges. These include lack of, 1) a harmonized approach for conditionality, targeting, transfer value, duration, and frequency of transfers, and 2) reporting and evaluation. The purpose of this Operational Guidance is to ensure harmonization of the use of CVA to improve Maternal, Infant and Young Child Nutrition (MIYCN) outcomes in Emergency Contexts of Nigeria.

Target audience

The target audience of this Operational Guidance are primarily the partners implementing nutrition activities in Nigeria, members of the Cash Working Group and any other partners who would like to implement nutrition activities in Nigeria. The Guidance however, can be useful to non-members of the Nutrition Sector or Cash Working Group. The Operational Guidance provides the information needed to implement CVA for nutrition programmes at the field level. This Operational Guidance is not exhaustive and therefore may need to be adapted

[7] OCHA. 2023. Nigeria Humanitarian Response Plan 2023
[8] Nigeria CWG. 2022. Northeast Nigeria Cash & Voucher for Nutrition Survey

to each specific context and programming circumstances. The document is intended to be a living document and may be updated yearly and/or whenever significant change of context occurs and/or refined over time to incorporate new evidence and successful best practices on using CVA to improve maternal and child nutrition outcomes. The implementing partners will use this Operational Guidance when making CVA programming decisions related to:

- Feasibility and appropriateness
- Targeting
- Duration of assistance
- Preferred modality
- Conditionality
- Restriction
- Transfer value
- Frequency of transfer
- Delivery mechanism
- Timing of assistance
- Complementary interventions
- Monitoring and evaluation
- Risks and mitigation

3. Operational Guidance Development Process

The Guidance development process involved a review of published and gray literature, and consultations with various stakeholders both at global, national, and subnational levels in Nigeria. The Nigeria Nutrition Sector in collaboration with AAH, CaLP, CRS, CWG, FMoH, Food Security Sector, FAO, GHIV Africa, GNC TA, IMC, IRC, Mercy Corps, SCI, State Primary Health Care Development Agency (SPHCDA), UNICEF, USAID/ BHA, and WFP, conducted a 3-day technical consultation on CVA for nutrition in October 2022. The technical consultation covered the following topics:

1. Evidence on CVA for Nutrition
2. Nigeria Nutrition Situation Analysis
3. CVA Feasibility and Appropriateness
4. Practitioner Experiences
    - Role of Markets and Cost of a Nutritious Diet (Fill the Nutrient Gap)
    - Lessons learnt on CVA for nutrition in Northeast Nigeria
5. Components of Solid Design
6. Minimum Food Baskets for Nutrition Gap Filling
7. Defining Nigeria CVA Use Cases

The following five main approaches were agreed during the technical consultation as the entry points for using CVA to improve maternal and child nutrition outcomes in Nigeria. These approaches are already being used by partners in NE Nigeria, and this Guidance captures learnings and best practices from those existing experiences.

Table 2: Five main approaches for integrating CVA into the nutrition response in Nigeria

Approach		**Main objectives of the CVA component**
Prevention	Individual supplemental nutrition assistance to improve dietary adequacy	● To protect and prevent a deterioration in the nutritional status of the most nutritionally vulnerable groups – children under 5 years and pregnant and breastfeeding women and girls (PBWG) ● To reduce the risk of relapse for children discharged from treatment programmes ● Support dietary diversification ● Narrow the nutritional gaps in HH-level general food distribution baskets for nutritionally vulnerable individuals
	Incentivizing attendance to Maternal, Newborn, Child Health and Nutrition (MNCHN) programmes	● Cover indirect costs and reduce opportunity costs of seeking health services, e.g., antenatal care (ANC), postnatal care (PNC), facility-based delivery, and immunization.

	Approach	Main objectives of the CVA component
		• Improve attendance to MNCHN services • Protect nutritional status
	Provide CVA to support infant nutrition in the absence of breastfeeding options	• Protect nutritional status • Promote growth
Treatment	Provide CVA to facilitate access and adherence to treatment of moderate wasting using locally available nutrient-dense foods	• Provide food inputs and cover milling and transportation costs for a local foods-based MAM treatment program. • Facilitate a platform for caregivers to learn about nutrition and care for sick children • Promote functional options for MAM treatment such as the use of blended floor made from locally available grains, in the event of a supply chain break or other unavailability of treatment products for MAM.
	Provide CVA to caregivers of children having acute malnutrition with medical complications to facilitate access to treatment	• Cover costs associated with access and adherence to inpatient care at stabilization centers (SC) • Improve treatment outcomes: reduce defaulting, non-response to treatment and relapse • Provide meals and complementary services (e.g., out-of-pocket expenditures, admission kits, etc.) for caregivers while at SC.

4. Planning and Implementation Arrangements

Key considerations to implement CVA for nutrition

The following seven steps are recommended when considering using CVA as a modality to improve maternal and child nutrition outcomes:[5,9]

- Step 1: Determine whether CVA can contribute to nutrition outcomes
- Step 2: Determine the feasibility of CVA as part of a nutrition response
- Step 3: Determine and select response options and response modalities
- Step 4: Design the CVA component
- Step 5: Mobilize resources for the response
- Step 6: Implement the CVA component
- Step 7: Monitoring of the CVA component

The above steps should be aligned with the elements of the humanitarian programme cycle and incorporate transversal issues throughout the response, such as preparedness, coordination, information management, and risk analysis and mitigation as illustrated in Figure 2.

[9] USAID. 2021. Modality Decision Tool: Nutrition Addendum

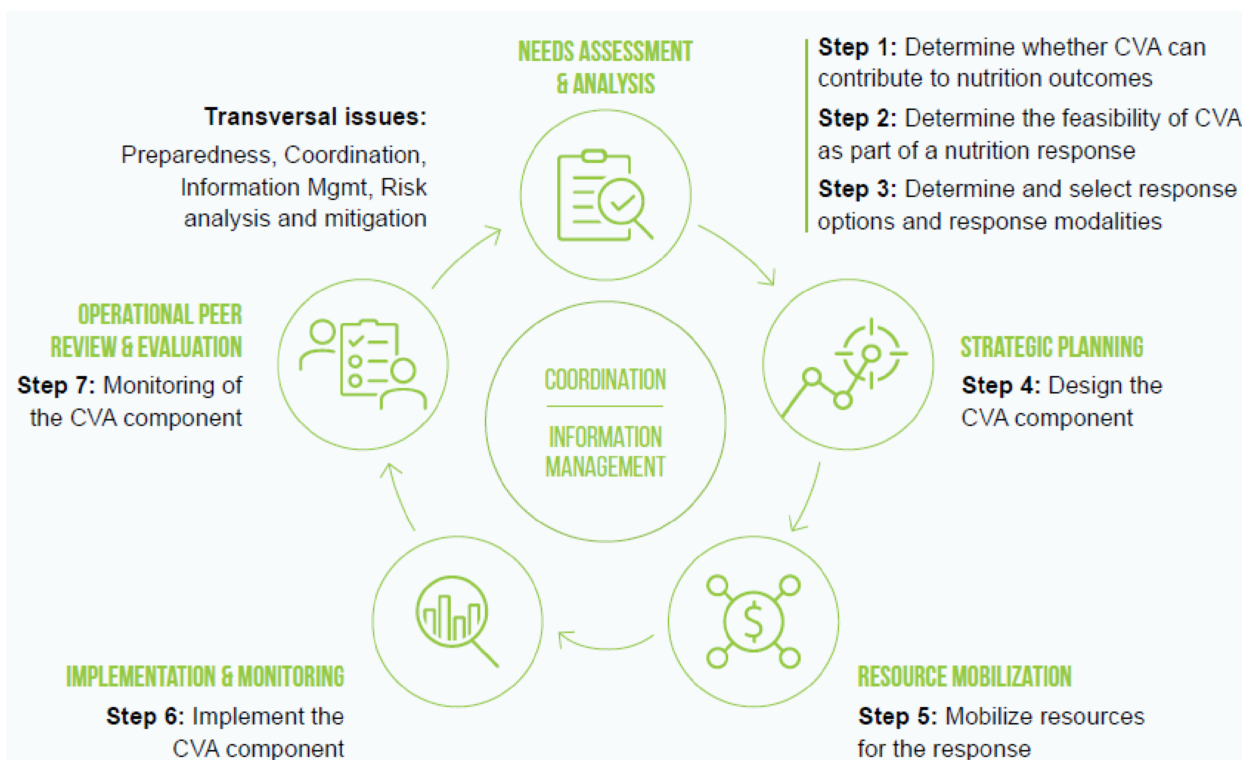

Figure 2: Steps and transversal issues throughout the humanitarian programme cycle[5]

Table 3: Key questions to ask when considering using CVA in the nutrition response[5,9]

Step	Key questions
1) Determine whether CVA can contribute to nutrition outcomes	• **Economic barriers to adequate nutrition:** To what extent is the lack of purchasing power impacting households' abilities to access and prepare nutritious foods, access health services, safe water, and improve hygiene conditions?
2) Determine the feasibility of CVA as part of a nutrition response	• **Market capacity and functionality:** Can a nutritious diet be achieved using locally available foods? Is the local market physically accessible by the target group? Are the main food and hygiene items available in the local market? Are there any seasonal factors that influence market functionality and price volatility? • **Health and transportation services:** Are relevant health and nutrition services for the prevention and treatment of malnutrition available and of acceptable quality? Are transportation services available to access health and nutrition services? • **Delivery mechanisms:** Are there safe and reliable ways to deliver cash or vouchers to targeted recipients? What is their level of coverage? Is it scalable and accessible for the targeted population? • **Community considerations:** How would the targeted group like to be assisted? What delivery mechanism is best suited for the targeted group? Are there protection and safety concerns in relation to providing cash or vouchers? Can they access nutrition-relevant goods and services with additional purchasing power? • **National and local authorities:** Do authorities allow or support the delivery of CVA to affected populations? What is their preferred modality? Do local mechanisms provide social assistance or safety net programs to support vulnerable populations? To what extent do these programs apply a nutrition lens to targeting, complementary programing, program objectives?

Step	Key questions
	• **Additional considerations:** Does the organization and its partners have sufficient capacity to plan and implement the CVA component? If not, what do they need to scale up? How long does it take to set up the CVA component? What is the estimated cost associated to the setup of CVA operations? What type of vendors will most effectively meet the needs of the CVA component proposed?
3) Determine and select response options and response modalities	• **Appropriateness:** Which modality is most appropriate to achieve nutrition outcomes proposed by the objectives? • **Beneficiary and Community preference:** How would the targeted households/individuals and community representatives prefer to be assisted? • **Costs:** Which of the response modalities is most cost-efficient and/or cost-effective? • **Markets:** Which modality is more adapted to local market conditions? • **Risks:** Which modality is likely to be riskier? How can the risks be mitigated? • **Timeliness:** Which modality is faster to implement? • **Organizational capacity:** Which modality/mechanism would the organization be more capable to implement and scale-up?
4) Design the CVA component	• **Targeting:** Which household member(s) is the transfer intended to benefit? What is the justification of needs for the specified group? 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 those considerations related to the modality of transfer and the impact on nutrition? Will the programme apply soft or strict conditionality? • **Transfer value:** How does the transfer value align with a set of in-kind food baskets or minimum expenditure basket (MEB) for food that demonstrate gap-filling for the needs of vulnerable groups targeted? What factors are used to calculate the transfer value, e.g., for transportation/treatment access, and how are they justified? What costs and items need to be monitored regularly in the market to ensure beneficiaries are getting adequate costs and items coverage? What is the tipping point for re-justification of transfer value based on the type of transfer? • **Transfer frequency:** How often will beneficiaries receive their transfers (weekly, biweekly, monthly, etc.)? • **Duration:** How many months of coverage will the program provide? Is coverage for a specific time of year, or rolling? • **Gender:** Has gender analysis and gender sensitive needs assessment been done?[10,11] How will gender roles and implications affect the modality selection 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?
5) Mobilize resources for the response	• **Cost efficiency and cost effectiveness:** Is CVA more cost efficient and/or cost effective relative to other modalities? What are the context specific advantages of CVA in comparison with other modalities? What are the potential positive secondary impacts of CVA on markets and the local economy?
6) Implement the CVA component	• **Roles and responsibilities:** Has the organization defined the roles and responsibilities of the various units/departments (programme, procurement, logistics, finance, etc.) in alignment with existing Standard Operating Procedures? Are internal and external coordination mechanisms established?

[10] Gender Based Violence and Cash and Voucher Assistance: Tools and guidance

[11] Care. 2019. Cash & Voucher Assistance and Gender Based Violence Compendium: Practical Guidance for Humanitarian Practitioners.

Step	Key questions
	• **Beneficiary registration, communication, and accountability systems:** Has the organization set up beneficiary registration, communication, and accountability systems? Where protocols followed in selection and contracting service providers/ vendors to disburse cash transfers and the redemption of vouchers?
7) Monitoring of the CVA component	• **Monitoring, evaluation, learning and quality assurance plan:** What indicators will be used to monitor the process, outputs, and outcomes of CVA?

5. Recommended CVA design considerations for Nigeria

Use-case 1: Individual supplemental nutrition assistance to improve dietary adequacy

The use of CVA under this approach is considered as a preventive measure against malnutrition and an avenue to protect the nutritional status among nutritionally vulnerable individuals, especially during the first 1000 days of life. The approach aims at increasing access to a nutritious diet that enhances growth and prevents deterioration in the nutritional status among target individuals often as a complement to general food assistance transfers. Within this use-case there are three implementation options plus social and behavioral change (SBC) to improve access to nutritious/fortified foods: i) a 6-month lean season CVA coverage, ii) a 3-month CVA coverage following discharge from nutrition treatment programs or iii) continuous programming in conjunction with food security program, targeting the first 1000 days of life, for example, Porridge Mums.[12]

Targeting Criteria

Three nutritionally vulnerable groups are prioritized under this approach:

a) Children aged 6-23 months that reside in households receiving food assistance as top-up to facilitate consumption of nutrient rich complementary foods.
b) All pregnant and breastfeeding women and girls (PBWG), starting from the first trimester (based on evidence of pregnancy) to ensure consumption of nutrient adequate diets.
c) Children aged 0-59 months discharged from IMAM services (SC/Outpatient Therapeutic Programme/Target Supplementary Feeding Programme) to avoid relapse.

Transfer Modality, Restrictions & Conditionality

Cash, vouchers or mixed/hybrid transfer modality can be used for this approach, depending on feasibility, appropriateness, implementer’s capacity, beneficiaries’ preference, and market capacity and functionality in the local context. In some cases, it is possible to apply soft conditionality to the top-up vouchers to maximize impact. For example, encourage and ensure that targeted PBWG attend health services (antenatal and postnatal services) and caregivers of targeted children participate in SBC interventions or care group approaches to nutrition promotion if situational analysis shows that behavioral barriers and attendance to health services are a major aggravating factor to undernutrition in the specific context.

Transfer Value, Frequency, Duration & Delivery Mechanism

It is recommended that cash or vouchers are distributed physically or electronically through already existing financial service providers and platforms (e.g., Banks, NAGIS, RedRose, SCOPE, etc.) on either a bi-weekly basis (preferred) or monthly basis with long redemption period to avoid bulky redemption of perishable food items. A set of sentinel food baskets (Annexes 3 and 4) calibrated to seasonal considerations will be used for establishing transfer values. These were developed using the NutVal tool and incorporating recent price and commodity data

[12] AAH. 2017. Utilizing the Porridge Mum Approach in Rapid Onset Emergency Situations.

collected by the Cost of the Diet exercise. The baskets compare nutritional needs by target group against the GFD ration (in-kind) and illustrative ration basket (CVA) used for food assistance transfers in Northeast Nigeria. Nutritional needs were determined based on the gaps for each group if the food assistance ration is provided at 55 per cent coverage.

Transfer values are not fixed but will need to be determined for each location based on local market prices using the agreed upon sentinel food basket contents by group. For example, a PBWG in Damaturu may receive a different transfer value than a PBWG in Maiduguri because of market conditions and prices for sentinel foods at that specific location. The Nutrition Sector will collaborate with the Cash Working Group to do routine adjustments for inflation and will determine the percentage coverage of cost for each sentinel food basket (PBWG and Child). As such the Nutrition Sector and/or the Ministry of Health, and/or Primary Health Care Development Agency may determine that all implementers will cover at least 60 per cent of the cost of the sentinel food baskets for each group, based on market prices at their location, earlier assessments (Table 3), beneficiaries' ability to meet some of their needs themselves and guidance from CWG.[5,13] Actual transfer values will vary by location, but percent coverage will be harmonized.

Additionally, transfers will be provided on an individual basis based on status. As such there will be one transfer value for children in a given location, whose nutrient needs are less than women, and a separate transfer value for PBWG even where both exist in the same household. This underscores the intention that the top-up ration be focused on the individual with nutrition vulnerabilities and is not just an addition to the family pot. This approach also allows for appropriate coverage of each vulnerable individual in households that may have more than one child between 6-23 months of age. This approach is designed to capture the variability across markets which particularly affect rural and urban locations. Lean season interventions will be distributed for a period not exceeding 6 months (preferably starting a month before the lean season: April to September). Transfers for 1000 days programming will be continuous across the enrollment period. Because transfers are provided to each individual, community and household sensitization will be necessary to ensure clarity about who each transfer is for, and what the purpose is.

The sentinel food baskets were developed through a validation process that relied heavily on the Cost of the Diet (CotD) data gathered by WFP in the 2021 Fill the Nutrient Gap (FNG)[14] process alongside the field expertise of practitioners working in Northeast Nigeria who were able to speak to market availability and dietary preferences in the region.

The FNG CotD exercise found that the limiting nutrients in children's diets were calcium and iron, and the limiting nutrients in women's diets were pantothenic acid (vitamin B_5, iron and calcium. These findings along with the list of commonly consumed nutritionally dense foods and price data from 2021 that were developed for the FNG were used as the database to build sentinel food baskets for children and PBWG. The NutVal tool was used to develop the sentinel food baskets for each target group because it is a free tool that enables current and future users of this Guidance to validate and verify the nutritional value of contents and compositional approach to the basket.

[13] Mercy Corps. 2017. Cash Transfer Implementation Guide: Part of the Cash Transfer Programming Toolkit.

[14] Federal Ministry of Finance, Budget and National Planning Nigeria and World Food Programme. 2022. Fill the Nutrient Gap, Nigeria – Report.

A sentinel basket is essential to continually validate appropriate transfer values because transfer values need to be verified against real time market prices for sentinel foods in order to be reasonable. As future updates to baskets will not be able to rely upon such a detailed data collection and analysis exercise, implementers for CVA for nutrition programming will need to revalidate information periodically based on market monitoring information collected in collaboration with WFP and implementing partners. As is the case for an MEB for food assistance, the sentinel foods basket doesn't represent what people will actually purchase with their transfer but represents the least-cost option that is affordable and reasonable for local diet culture that is possible to purchase with the transfer. The sentinel foods list in Annex 5 represents a full suite of nutritious food options available in Northeast Nigeria and is the preferred market monitoring list for SNA baskets. Estimated transfer value should be costed based on the least cost item in each food group. Transfer values for each sentinel food basket will be reworked in consultation with the CVA for nutrition Technical Working Group (TWG) and CWG if under or above the value by 50 per cent of the nutrition gap for the location where programming is implemented. Sentinel foods should also be emphasized in messaging provided alongside CVA transfers to highlight what locally available foods are nutrient dense and fill notable gaps in current dietary patterns.

The nutritious foods sentinel basket for children focuses on the need to increase consumption of animal-source foods, vitamin A and iron-rich foods. The basket foods are derived from the Northeast Nigeria cooking demonstration guidance recipes.[15,16] Because children's caloric needs are lower than an average family member the amounts needed to fill nutritional gaps in their diets are quite small. The basket provides an egg a day plus small amounts of calcium-rich dried fruits like dates or tamarind, local dark green leafy vegetables, which are commonly consumed and available across Nigeria, a small amount of dairy, flesh foods and dried fish to meet calcium, B_{12} and iron needs, and a small amount of fruits and other vegetables. The basket also includes a small transfer of legumes (such as beans) and cereals (such as millet/sorghum), which are nutrient dense and meant to provide extra protein.

The nutritious foods sentinel basket for pregnant and lactating women was developed using the NutVal setting for lactating women since their caloric and micronutrient needs are the highest of any group. The basket contents were developed and validated by the workshop participants that developed three PBWG-focused baskets to span different times of the year (lean/planting season, harvest season, and post-harvest season). Some foods unique to Nigerian diets were highlighted as preferred for PBWG, including baobab fruit, which is particularly rich in calcium, and okra, which has high levels of folic acid. The PBWG basket contains more items overall and notably adds calories and protein via top-ups of beans and grains and provides for consumption of two eggs per day. The basket also adds iodized salt to meet iodine needs. PBWG have the highest caloric and micronutrient needs of any household member, and the contents of this basket reflect that. While costing for this basket will be high compared to the CU5 basket, this most accurately provides for the actual needs of PBWG and avoids short-changing them in an attempt to average the transfer value.

[15] Federal Ministry of Health, Nigeria. 2022. National guidelines on maternal, infant and young child nutrition.

[16] SPRING. 2016. Nigeria: Complementary Feeding and Food Demonstration Training - Food Demonstration Manual. Arlington, VA: Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project.

Porridge Mum[12] is a 1000-days nutrition promotion program that uses a community kitchen model as a platform for nutrition messaging, supplementation, caregiver empowerment, and connection to essential health and water, sanitation and hygiene (WASH) services. All pregnant women and children up to age 23 months that are beneficiaries of general food assistance are included in Porridge Mums groups. These groups meet weekly to cook a meal together in a community kitchen using the Northeast Nigeria Cooking Demonstration Guidance. During the cooking and eating time, nutrition messages are delivered, and children are screened for acute malnutrition. Participants also receive a voucher for home preparation of complementary feeding recipes learned each month.

The transfer value for each Porridge Mum group should be based on the aggregated transfer value for the individual PBWG and child sentinel food baskets. This should be accompanied by a monthly cash transfer value to cover transport costs (for two group members, to ensure transparency), cooking fuel, grinding services, and water. Each member of the group should as well receive a transfer value equivalent to the PBWG or child sentinel food basket to acquire similar items on the food demonstration recipe list for food preparation at home. Cash or voucher transfers can be done electronically or though selected vendors. The beneficiaries will continue in the porridge mum program for as long as they are pregnant, are caregivers of children aged 6-23 months, and enrolled in food security programs.

Table 4: Summary of recommended CVA design considerations for use-case 1

Approach		**Target Groups**	**CVA Intervention**	**Transfer Modality**	**Conditionality**[17]	**Transfer Value (NGN)**	**Frequency of Transfer**	**Duration**	**Delivery Mechanism**
Prevention	Individual supplemental nutrition assistance to improve dietary adequacy	Children aged 6-23 months	Top-up CVA to improve nutrient adequacy of complementary diets (e.g., micro and macro-nutrients food vouchers)	Cash, Value Vouchers or hybrid	Unconditional	Based on value of items on list provided in Annex 3 in program location.	Bi-weekly (preferred)	6 months (Maximum) during lean season	Paper or Electronic Voucher Mobile Money, Prepaid cards etc.
		PBWG	Top-up CVA to improve nutrient adequacy (e.g., micro and macro-nutrients food vouchers)	Cash, Value Vouchers or hybrid	Conditional	Based on value of items on list provided in Annex 4 in program location.	Bi-weekly (preferred) or monthly with long redemption period	6 months during lean season	Paper or Electronic Voucher (e.g., NAGIS, RedRose etc.) Mobile Money, Prepaid cards etc.
		Children aged 6-59 months	Top-up CVA to prevent relapse (e.g., discharges from OTP, TSFP and SC)	Cash, Value Vouchers or hybrid	Unconditional	Based on value of items on list provided in Annex 3 in program location.	Bi-weekly (preferred) or monthly with long redemption period	3 months (after discharge)	Paper or Electronic Voucher (e.g., RedRose etc.) Mobile Money, Prepaid cards etc.

[17] The most common conditionalities in nutrition programming are related to participation in SBC interventions or attendance to health services.

Approach		Target Groups	CVA Intervention	Transfer Modality	Conditionality[17]	Transfer Value (NGN)	Frequency of Transfer	Duration	Delivery Mechanism
		PBWG or caregiver of a child aged 0-23 months	Porridge mum groups	Value voucher and cash	Conditional	Based on value of items on list provided in Annex 3 and 4 in program location. Preparation transfer value is based on cost of cooking fuel, grinding services, water and transportation in program location.	Monthly	As long as beneficiary is in porridge mum group.	Paper or Electronic Voucher Mobile Money, smart cards, etc.

Use-case 2: Incentivizing attendance to Maternal, Newborn, Child Health and Nutrition programs

The CVA for nutrition modality can be used to address the financial barriers to health seeking behavior and enable mothers to attend MNCHN program sites for services. The mothers can access transport means by getting cash transfer commensurate with the transportation cost to and from the facility per visit.

Targeting Criteria

Pregnant and lactating women attending antenatal care (ANC), postnatal care (PNC), nutrition or immunization services implemented by partners or PBWG referred by implementers for ANC, PNC or delivery services will be targeted in this approach. PBWG who deliver in facilities that are supported by implementers should receive sanitary supplies and delivery items provided by the implementers in-kind and thus will not receive CVA for this purpose. Other targeting criteria can be identified by implementers but should be accepted after review by the Nutrition Sector and/or the Cash Working Group.

Transfer Modality, Restrictions & Conditionality

Cash transfer should be used for this approach. The PBWG should receive the cash transfer as long as she meets the targeting criteria stated above. The CVA to access basic items required for safe delivery and the immediate post-delivery period should be issued only for hospital deliveries or deliveries by skilled birth attendants.

Transfer Value, Frequency, Duration & Delivery Mechanism

It is recommended that cash is transferred electronically through already existing service providers to cover transport costs per visit for the mothers or caregivers to attend MNCHN services (ANC, PNC, Nutrition, Immunization) for as many visits as required for the index PBWG/child, based on the assessment and prescription of the health worker. The same mechanism can be used for cash transfer for the PBWG to purchase items to cover basic needs before and during delivery, and the immediate post-delivery period. It is recommended that the implementer derives the transfer value for transportation, based on the cost per kilometer or based on the actual transport cost from the residence of the beneficiary to and from the health facility.

Table 5: Summary of recommended CVA design considerations for use-case 2

Approach		Target Groups	CVA Intervention	Transfer Modality	Conditionality	Transfer Value (NGN)	Frequency of Transfer	Duration	Delivery Mechanism
Prevention	Incentivizing attendance to Maternal, Newborn, Child Health and Nutrition (MNCHN) programs	Children aged 0-23 months; PBWG	Transportation reimbursement to access MNCHN	Cash	Conditional	Derived based on the cost per kilometer or based on the actual transport cost from the residence of the beneficiary to and from the health facility.	Per visit	For as long as child aged 0-23 months or PBWG requires MNCHN services	Mobile Money, Prepaid cards etc.

Use-case 3: Provide CVA to support infant nutrition in the absence of breastfeeding options

Breastfeeding remains the safest feeding method for effective infant nutrition and should be protected, promoted and supported. But in some situations, Breastmilk Substitutes (BMS) will be essential to ensure infant nutrition, if no other breastfeeding support can be established. The National guidelines on maternal infant and young child nutrition (MIYCN)[15] and National policy on MIYCN detail[18] circumstances in which the mother and/or child will require breastfeeding support including support with BMS. According to the National guidelines and policy on MIYCN, "BMS should be considered only after ALL options for breastfeeding by the mother, caregiver, or through a wet nurse have been exhausted, including increasing the proportion of the diet from locally available complementary solids if the child is over six months, etc." BMS should only be targeted to infants requiring it, as determined from assessment by a qualified health or nutrition worker preferably in a Stabilization Centre; and should be provided for as long as the targeted infants require it. With strict approval and tracking mechanisms in place, such infants' caregivers can be issued vouchers to get BMS supplies from approved local vendors, following National guidelines and policy on MIYCN. An analysis of the vendors and the BMS supply should be conducted in case this approach is used, to ensure the availability and quality of BMS with local vendors, as well as determining the cost of a BMS weekly or bi-weekly ration.

Targeting Criteria

The National guidelines and policy on MIYCN state that BMS prescription is indicated only in the following situations: short-term: i) during re-lactation, ii) transition from mixed feeding to exclusive breastfeeding, iii) short-term separation of infant and mother, iv) short-term waiting period until wet nurse or donor human milk is available; long-term: i) Infant not breastfed pre-crisis, ii) mother not wishing or unable to re-lactate, iii) infant established on replacement feeding in the context of HIV, iv) orphaned infant, v) infant whose mother is absent long-term, vi) specific infant or maternal medical conditions, vii) very ill mother, viii) infant rejected by mother, ix) a survivor of Gender Based Violence not wishing to breastfeed. CVA under this approach should be used exclusively in these situations. Any other situation identified by implementers outside these must undergo scrutiny by the Nutrition Sector and/or the Ministry of Health, and/or Primary Health Care Development Agency before CVA for BMS can be used.

[18] Federal Ministry of Health, Nigeria. 2021. National policy on maternal, infant and young child nutrition (MIYCN) in Nigeria.

Transfer Modality, Restrictions & Conditionality

Commodity voucher is the recommended transfer modality for this approach. The Caregivers can also receive cash transfer to cover the cost of transportation to and from the health facility for prescription and follow up visits, as well as to the vendors' stores to redeem the voucher. This CVA should be delivered only when all the following conditions are met:

- An individual-level full assessment by a trained health worker
- In-depth MIYCN-E counselling has taken place
- All options have been considered including wet-nursing and re-lactation
- Referral to the Stabilization Center in-charge is made
- Non-Breastfed Child Care Action Plan is developed and implemented
- Household availability of clean water and hygiene materials is established, preferably through a home visit.
- Bottles and teats MUST NOT be issued with BMS.
- All the necessary feeding equipment (stainless steel cup, spoon, plate, and kettle) should also be included when prescribing BMS.

Transfer Value, Frequency, Duration & Delivery Mechanism

It is recommended that vouchers are distributed physically or electronically through already existing service providers (e.g., NAGIS, RedRose, etc.) on either a weekly basis (preferred) or bi-weekly basis. A one-week supply of BMS should preferably be given at a time to ensure close follow up and prevent the misuse of the formula such as re-selling the formula. The choice of bi-weekly transfers should be accompanied with justification which must be documented by the health worker. A commodity voucher that covers the prescribed type and amount of the BMS and the necessary feeding equipment (stainless steel cup, spoon, plate, and kettle) should be issued during the first visit and one that covers only the BMS issued in subsequent visits. The supply of BMS should be continued for as long as the targeted infants need it – that is, until breastfeeding is reestablished or until at least 6 months of age after which infants should be supported to transition to complementary feeding which includes some other suitable source of milk and / or animal source food. On an individual basis, the infants should receive a 2-4-week buffer stock of BMS during the transition period.

It is recommended that cash is transferred electronically through already existing service providers to cover caregivers' transportation cost to and from the Stabilization Centre for prescription and follow up visits, as well as to the vendors' stores to redeem the voucher. It is recommended that the implementer derives the transfer value for transportation, based on the cost per kilometer or based on the actual transport cost from the residence of the beneficiary to and from the health facility.

Table 6: Summary of recommended CVA design considerations for use-case 3

Approach		Target Groups	CVA Intervention	Transfer Modality	Conditionality	Transfer Value (NGN)	Frequency of Transfer	Duration	Delivery Mechanism
Prevention	Support infant nutrition in the absence of breastfeeding options.	Infants 0-<12 months old	CVA to access Breastmilk Substitutes (BMS) for feeding of infants in particular circumstances	Commodity Voucher	Conditional	Based on market cost of the type and quantity of BMS prescribed.	Weekly (preferred) or bi-weekly.	Until infant is at least 6 months old.	Paper or Electronic Voucher
			Transportation reimbursement to access BMS	Cash	Conditional	Derived based on the cost per kilometer or based on the actual transport cost from the residence of the	Per visit	For as long as infant is receiving BMS support.	Mobile Money, smart cards, cash in hand

Approach		Target Groups	CVA Intervention	Transfer Modality	Conditionality	Transfer Value (NGN)	Frequency of Transfer	Duration	Delivery Mechanism
						beneficiary to and from the health facility.			

Use-case 4: Provide CVA to facilitate access and adherence to treatment of moderate wasting using locally available nutrient-dense foods

A nutrient-dense blended flour such as Tom Brown, made from locally available grains (cereals, soya beans and groundnut) is reported by implementers to be an effective product for the treatment of moderate acute malnutrition (MAM) in children aged 6-59 months and PBWG. Through the community-based mother-to-mother support group structure, PBWG and caregivers of MAM children collectively process the grains into blended flour which is reconstituted with water to be cooked as porridge. This system also allows time for one-on-one and group counseling on MIYCN. Each support group is composed of 12 members - caregivers of MAM children and PBWG - and 1 lead mother who herself is a member/beneficiary.

The Tom Brown program[19] has two phases; the first of which is for community MUAC screening and enrollment of identified children into the program, and for setting up the support group. The second phase is an 8-12-weeks treatment period during which the lead mother hosts her group members weekly to produce the blended flour from grains provided by the partner and then distribute the blended flour to each caregiver for daily feeding of their children at home. Caregivers are also referred to the nearest health facilities to access routine medications and immunization for their child. The CVA transfer allows each support group to access grains, WASH, and cooking utensils (Annex 6), and petty cash for purchase of cooking fuel, water, and for milling and transportation.

Targeting Criteria:
6-59 months old children and PBWG with MAM and Mother-to-Mother support group lead mothers are the target beneficiaries under this approach.

Transfer Modality, Restrictions & Conditionality
Implementers are recommended to use commodity vouchers to provide the blended flour ingredients to mother-to-mother support groups. Commodity vouchers are necessary for this approach because the recipe requires a set amount of each commodity. Use of a value voucher would subject the purchaser to market price fluctuations and they may not be able to get the correct amount of an ingredient, compromising the nutritional value of the product. A one-off commodity voucher will be issued to the lead mothers to access WASH and cooking utensils that are utilized for the hygienic processing of the grains into the blended flour. 1.5kg (for children aged 6-59 months) and 1.75kg (for PBWG with MAM) of the produced blended flour will be issued in transparent airtight containers (provided in the voucher for cooking utensils) to the beneficiaries for daily feeding at home. The support group lead mothers will receive cash transfers for the procurement of cooking fuel, water, and other miscellaneous items as well as for transportation of items. The conditions attached to this CVA approach are that i) the lead mothers should accept the terms of leading and hosting a mother-to-mother support group for blended flour production on a signed ToR[19], ii) the beneficiaries must be PBWG and 6-59 months old children with MAM, iii) the support group activities must allow sufficient time for social and behavior change communication (SBCC) on MIYCN and hygiene practices.

[19] CRS. 2021. Tom Brown Supplementary Feeding Program: An Implementation Guide

Transfer Value, Frequency, Duration & Delivery Mechanism

The one-off commodity voucher for WASH and cooking utensils should cover the quantity of items in the list provided in Annex 6 and the transfer value should be derived by the implementers based on the local market value of the items at the time of program design/implementation. Similarly, commodity vouchers for the fresh grains should cover the quantity (in Kg) of grains (Annex 7), required for weekly production of the blended flour throughout the 8-12-week treatment period. The transfer value should as well be derived by the implementers based on the local market value of the grains at the time of program design/implementation. Implementers must perform a pre-programming cost survey of their local market to establish a reasonable transfer value. The prices of the commodities covered by the voucher can be negotiated and fixed with participating vendors to ensure a stable value is provided throughout the implementation period. The commodity vouchers can be distributed physically or electronically through already existing service providers (Annex 9).

It is recommended that after each 8-12-week treatment period, new lead mothers should be selected from the group that is closing out. These new lead mothers will host and lead the succeeding support groups and should be issued their own one-off commodity voucher to access the utensils, while the exiting lead mother owns the previously issued utensils. However, if resources are limited, the same lead mothers can lead multiple support groups, using the same utensils. During the 8-12-week treatment period, the lead mothers will receive weekly cash transfer to procure cooking fuel, water and transportation and this transfer can be redeemed through the participating vendors or through mobile money or e-wallet.

Table 7: Summary of recommended CVA design considerations for use-case 4

Approach		Target Groups	CVA Intervention	Transfer Modality	Conditionality	Transfer Value (NGN)	Frequency of Transfer	Duration	Delivery Mechanism
Treatment	Provide CVA to facilitate access to treatment of wasting using locally available nutrient-dense foods	Tom Brown support group (lead mothers)	CVA for lead mothers to procure WASH and cooking utensils for hygienic Tom Brown production in their respective groups.	Voucher	Conditional	Based on value of items on list provided in Annex 6 in program location	One-off transfer	Once	Paper or Electronic Voucher
		Tom Brown support group (lead mothers)	CVA for lead mothers to procure grains for weekly Tom Brown production.	Voucher	Conditional	Based on value of items on list provided in Annex 7 in program location	Weekly	8 – 12 weeks	Paper or Electronic Voucher
		Tom Brown support group (lead mothers)	Cash support to Lead Mothers to procure cooking fuel, water and transportation.	Cash	Conditional	Based on cost of cooking fuel, water and transportation in program location	Weekly	8 – 12 weeks	Mobile Money, Prepaid cards etc.

Use-case 5: Provide CVA to caregivers of children having Acute Malnutrition with medical complications to facilitate access and adherence to treatment

A key component of the integrated management of acute malnutrition (IMAM) is in-patient care also referred to as Stabilization Centre (SC) care for children having acute malnutrition with medical complications. Provision of in-patient care is cost-intensive and is more technically demanding than other malnutrition treatment programs,

hence, stabilization centers are not as widely distributed in communities as other treatment programs (OTP/TSFP). Therefore, children requiring inpatient treatment and their caregivers are often required to move from their communities (including hard-to-reach communities) to SCs situated at state and LGA capitals. In addition, the caregiver will have to stay with the child in the SC facility for a period ranging from a few days to a few weeks, as long as required for completion of the treatment. While at the facility, the caregiver will need a supply of meals, personal hygiene items as well as other out of pocket expenditures like airtime for communication. This CVA approach will enable the caregivers to access safe transportation from their communities to and from the stabilization center, meals, and personal hygiene items, as well as cover out-of-pocket expenditure during hospital stay.

Targeting Criteria

Mothers or caregivers of children aged 0-59 months having acute malnutrition with medical complications admitted in the stabilization center.

Transfer Modality, Restrictions & Conditionality

Cash or vouchers can be used for this approach. Commodity vouchers are to enable the mothers to access wet/dry food rations and a kit containing personal hygiene items (Annex 8) during admission in the SC; whereas, cash is provided to cover the cost of transportation to and/or from the stabilization center (SC) and for out-of-pocket expenditures aimed at catering for other needs during admission in the SC e.g. airtime for communication. It is important to note that the most common practice for provision of food during admission in the SC is through a wet ration (already cooked food) using a certified food vendor. Also, the provision of cash for transportation is recommended only where there are no ambulance services available and in situations of self-referral to the SC.

Transfer Value, Frequency, Duration & Delivery Mechanism

For cash transfer to cover the cost of transportation to and from the stabilization center, the implementer should derive the transfer value based on the cost per kilometer or based on the actual transport cost from the residence of the beneficiary to and from the health facility. It is recommended that cash is transferred electronically through already existing service providers. However, in hard-to-reach locations, a cash in hand approach can be considered. The recommended cash transfer value for out-of-pocket expenditures is 500 NGN/ caregiver/day during admission in the SC which can be delivered through money agents or directly through designated program staff.

The commodity voucher for hygiene kits should cover at least the required items listed in Annex 7. The implementers should derive the transfer value based on the local market value of the hygiene items at the time of program design/implementation. This voucher should be a one-off transfer at the time of admission and can be delivered physically or electronically through existing service providers (Annex 8). In the same vein, the commodity voucher for caregivers' meals should cover at least three meals per day and the transfer value should be based on the types, quality and quantity of food for each meal. The implementer should monitor the nutrient adequacy of the food served, meal frequency, meal hygiene and delivery time. Implementers must perform a pre-programming cost survey of their local market to establish a reasonable transfer value. The prices of the commodities covered by the voucher (for meals and for hygiene kits) can be negotiated and fixed with participating vendors to ensure a stable value is provided throughout the implementation period.

Table 8: Summary of recommended CVA design considerations for use-case 5

Approach		Target Groups	CVA Intervention	Transfer Modality	Conditionality	Transfer Value (NGN)	Frequency of Transfer	Duration	Delivery Mechanism
Treatment	Provide CVA to caregivers of children having acute malnutrition with medical complications to facilitate access to treatment	Caretaker of complicated acute malnutrition 0-59 months	CVA to access SC (e.g., transportation reimbursement)	Cash	Unconditional	Derived based on the cost per kilometer or based on the actual transport cost from the residence of the beneficiary to and from the health facility.	One-off transfer	Once	Mobile Money Or Cash in hand
		Caretaker of complicated acute malnutrition 0-59 months	CVA to purchase Meals during stay at SC	Voucher	Unconditional	Based on type, quality and quantity of meals in program location.	Daily (three meals), during admission at SC	7 to 14 days for as long as child is on admission in the SC	Paper or Electronic Voucher
		Caretaker of complicated acute malnutrition 0-59 months	CVA for out-of-pocket expenditures (e.g., airtime)	Cash	Unconditional	500	Daily during admission at SC	7 to 14 days for as long as child is on admission in the SC.	Cash in hand or Mobile Money
		Caretaker of complicated acute malnutrition 0-59 months	CVA for SC caregivers' admission hygiene kit.	Voucher	Unconditional	Based on value of items on list provided in Annex 8 in program location	One-off transfer	Once	Paper or Electronic Voucher

6. Monitoring, Evaluation and Leaning

Proper monitoring and evaluation of planned CVA for nutrition use cases is essential to create evidence on impact, keep track of progress, identify challenges and document achievements. It is proposed that during implementation, partners monitor the various processes and expected outputs and periodically evaluate expected nutritional outcomes.

Evaluating Outcome: To understand the impact of CVA on maternal and child nutrition, it is recommended that implementing partners consider individual level outcome indicators for example: a) Minimum Dietary Diversity for Women (MDD-W), b) Minimum Acceptable Diet (MAD), c) Minimum Dietary Diversity (MDD) for children 6-23 months and d) Minimum Meal Frequency for children 6-23 months. Individual indicators are preferred as compared to household level indicators such as the Household Dietary Diversity Score or the Food Consumption Score because they help capture intra-household differences in food consumption habits. They also highlight consumption patterns that are deficient in micronutrient-rich foods.

For use cases 2 and 3, indicators that highlight any net improvement in attendance at critical health services, and the total amount of BMS accessed would be good ways to assess program progress against goals. Use case 4 (treatment with local foods) should use the same indicators as a traditional TSFP, marking enrollment, discharge, default, and died numbers for the MAM treatment caseloads. Non attrition at the Stabilization Center should be measured for use case 5.

Monitoring processes and Outputs: It is recommended that partners closely monitor process or output indicators to understand household and individual use of CVA specifically, expenditure on food, the composition of purchased food, expenditure on accessing health services etc., and can be collected at sub-category level (for example what kind of food was purchased? What kind of expenditure to access health services occurred?). The definition of process or output indicator is very much linked to the use case/ assistance modality. The typical indicators include a) number of households or individuals (disaggregated by gender) that have received CVA per distribution, b) number of vouchers redeemed per distribution, c) the total amount transferred per distribution; d) the percentage of payments made according to schedule, etc.

Market Monitoring: Periodic market/ price monitoring is recommended to have up-to-date information on the value of the transfer in terms of what it can buy or provide. In volatile contexts, the transfer amount may need to be adjusted in line with existing market conditions. In case of vouchers for nutritious food, it is important to seasonally adjust the list of food items, to enable promoting nutritious foods that are available and affordable. If this is not done, there is a risk of compromising the intended nutrition outcome. Note: In many humanitarian contexts, systems to assess and monitor markets for food and non-food items are already in place. As such, the Partner does not necessarily have to collect additional market information but rather rely on existing information, if available.

Post distribution monitoring: To mainstream Accountability to Affected Population (AAP), it is recommended that partners periodically conduct regular post-distribution monitoring to better understand beneficiary preference, satisfaction, and feedback to further inform and guide programming.

Information management/ reporting: CVA for nutrition implementing partners are expected to report monthly achievements in the nutrition Sector Monthly 5Ws reporting template.

7. Risks and Mitigation Measures

Risks related to CVA should be identified during the feasibility assessment, considered during response options analysis, and mitigated through programme design and other measures, and monitored during implementation.[5]

S/No	Risks	Mitigation Measures
1	Possible suppression: Targeting CVA based on the nutritional status of children in the treatment response can incentivize caregivers to keep or make children malnourished.	It is important to note that this seems to be the case when nutrition status is the sole targeting criteria. If this is one of many targeting criteria for a CVA for nutrition program the same perverse incentive doesn't seem to be in force. Avoid using the nutritional status as a qualification and entry criteria for CVA support or continuation of participation in the program.
2	Diversion of resources for unintended purposes due to competing needs. Due to high need for basic supplies, the caregivers	Put in place measures and conditions restricting the use of the program to the intended purpose. Monitoring should be done for reinforcement.

S/No	Risks	Mitigation Measures
	can divert resources to meet other pressing obligations.	
3	Value for money: the cost of delivering cash assistance can be greater than its capacity to meet the needs identified by the program objective.	Cost-effectiveness evaluation needs to be done, user friendliness and availability within the target population catchment area.
4	Domestic violence: suspicion by family members about the extra resources and their choice of priority areas of utilization. This might empower one couple financially leading to conflict.	Sensitization, awareness creation, and information sharing on the CVA should be done. This will reduce suspicion and risk of disharmony within the target beneficiaries and their families.
5	Collusion and misappropriation of funds: the vendor, implementing personnel and beneficiaries can be involved in financial misconduct that can lead to loss of funds.	Implementing partners are to set up standard internal control measures to check the issues of fraud that might be associated with all CVA modalities.

8. Accountability to Affected Population

In the implementation of this Guidance, implementing partners will set up strong accountability system with a feedback and complaint response mechanism which aims at improving the quality of CVA in nutrition and promote Accountability to Affected Populations (AAP) in line with the Inter-Agency Standing Committee (IASC) commitment on AAP, and institutionalize the accountability framework (including PSEA) in all functions and operations alongside system level cohesion, coordination and learning.

To ensure accountability to affected population in this framework, humanitarian organizations will ensure that; i) Beneficiary's participation and inclusion, ii) Communication and Transparency iii) Feedback and Response are integrated in all the five approaches of CVA. Partners will provide a range of rapid and accessible channels of communication to the affected populations either through proactive feedback channels (focus group discussions, individual interviews, and community meetings) and reactive feedback channels (suggestion boxes, toll free lines, email addresses and SMS lines) to listen to beneficiary voices and feedback. These channels will facilitate reception of feedback and complaints and to inform affected populations about procedures and processes that affect them so that they are able to make informed decisions and choices.

However, partners will work with the existing systems and structures of complaints referral as well as determine the communities' preference in terms of channels to put in place to enable them provide feedback/complaints relating to the intervention, while maintaining do-no-harm principle. Through the established channels, partners will ensure that all formal and informal communications from persons of concern (both positive and negative) are analyzed to inform protection, assistance and solutions to the programming, and that corrective action is taken as appropriate.

Furthermore, implementing partners will ensure constant sensitization of the affected population on the established channels and how to use them for hearing their views and opinion regarding the intervention. This

sensitization should be done with the aid of Information, Education and Communication (IEC) materials to demonstrate an illustrative approach of the mechanism and how it works, using local languages (Hausa, Kanuri, and Fulani). This sensitization should be done frequently in the health facilities, distribution centers, vendors' trainings, and meeting venues to ensure adequate dissemination of the key AAP messages.

Furthermore, partners will provide all persons of concern with timely, accurate and relevant information on their rights and entitlements, the roles and responsibilities of the organization, its commitment, and processes through community sensitization. While partners will document, analyze, and report on feedback from persons of concern, this in turn will inform future planning, course corrections and evaluation.

Also, partners will establish a meaningful arrangement that will ensure that at any given stage of the implementation of this Guidance, the viewpoints of beneficiaries are taken into consideration, as well as any special needs or concerns and that the framework is aligned to their unmet needs and how they would like to receive assistance. Implementation of this Guidance will also ensure that potentially marginalized groups such as minorities, people with disabilities, and the elderly are included based on the partners' target population. This will ensure a meaningful contribution to the nutrition outcome of the affected population.

9. Protection and Gender mainstreaming

Protection mainstreaming into CVA programming is necessary for positive nutrition outcome. To mainstream protection and gender into CVA, partners should ensure that;

- CVA teams are trained on gender-based violence (GBV) referral pathways and protection issues.
- Ensure that staff and volunteers apply a protection gender inclusion-sensitive lens in their work and can integrate protection in CVA including spotting and reacting to any protection risks.
- Confidentiality is favored by vulnerable recipients over transparency, to protect their identity, dignity and avoid theft.
- Feed results into delivery mechanism procurement, e.g., distribution close to the community if requested.
- Consider standard integrated delivery model with CVA alongside female friendly spaces to capture and manage unreported GBV issues.
- Alongside CVA, provide key messaging on the intention of the CVA, and provide awareness sessions on household financial management strategies, and gender-based violence; - for young people, CVA should be provided within a package of child protection services (e.g., case management, psychosocial support, life skills) and livelihood support.
- Adapt FGD tool for engagement with adolescents and young people.
- Ensure CVA is culturally appropriate for persons of all gender identities, ages, disabilities and backgrounds by amending activities to specific groups as necessary (based on PGI analysis).
- The transfer value is adjusted for people living with disabilities according to extra costs they face.
- The capacities of persons with disabilities in the community have been assessed and taken into consideration in the CVA design, particularly in cash-for-work activities.
- Consider setting-up community-based protection mechanisms to assist persons with specific needs to access CVA.
- Dignity items should ideally always be included in the cash transfer value or distributed as a complementary in-kind contribution.

Annexes

Annex 1: Technical Consultation on CVA for Nutrition in Nigeria

S.n	Participant Name	Designation	Organization
1.	John Yerima	Cash Coordinator	IMC
2.	Odewale Hammed Adesola	Deputy Head of Dep- Nutrition & Health	AAH
3.	Ahmed Abdi Dahir	Nutrition Sector Co-Coordinator	AAH
4.	Eric Ssebunnya	Nutrition Advisor	Mercy Corps
5.	Jamesson Dennish Onekalit	Cash & FS Advisor	Mercy Corps
6.	Andrew Simbwa	Chief of Party	SCI
7.	Samuel Danladi	Nutrition Coordinator	SCI
8.	Dr. Mohamed Kassim	Nutrition Coordinator	IRC
9.	Lucia Jofrice	Programme Specialist	UNICEF
10.	Priscilla Bayo Nicholas Vuni	Nutrition Specialist	UNICEF
11.	Nura Shehu	Surveillance Consultant	UNICEF
12.	Bintu Mustapha	Programme Associate - CBT	WFP
13.	Dorothy Nabiwemba-Bushara	Nutritionist	WFP
14.	Danjuma Garba Saleh	Programme Officer - CBT	WFP
15.	Patience Ajiboye	Nutritionist	WFP
16.	Mulikat Bamidele	Executive Director	GHIV Africa
17.	Geoffery Olwa	Humanitarian Advisor	GHIV Africa
18.	Fati Ali	Director Public Health Care	SPHCDA
19.	Habiba Bukar Kwaya	Assistant SNO	SPHCDA
20.	Dr. Binyerem Ukaire	Director Nutrition	FMoH
21.	Kasim Muheezi Oluwaseun	Dietitian Nutritionist	FMoH
22.	John Uruakpa	Deputy Director Nutrition	FMoH
23.	Eunice C. Kodak	Nutritionist	FMoH
24.	Leslie Parker Odongkara	Food Security Sector Coordinator	FAO
25.	Nsikan Etuk	Project Management Assistant	USAID
26.	Betty Kraus	Humanitarian Assistance Officer	USAID
27.	Gheen Hamed	Regional CVA advisor WCA	SCI
28.	Marina Tripaldi	Global Senior CVA advisor	GNC TA, SCI
29.	Saskia Depee	Chief Analytics & Science for Food & Nutrition	WFP
30.	Geraldine Honton	Nutrition-Sensitive Programme and Policy Officer	WFP
31.	Darline Raphael	Head of Nutrition	WFP
32.	John Mukisa	Nutrition Sector Coordinator	UNICEF
33.	Arnel Limpiada	Co-Lead CWG	CRS
34.	Maggie Holmesheoran	Nutrition Advisor	USAID
35.	William Martin	Cash/Markets Advisor	USAID

Annex 2: Lessons learnt on the use of CVA in Northeast Nigeria

Approach		Financial barriers addressed	Transfer Modality	Delivery Mechanism	Target Group	Frequency of Transfer	Duration	Other Considerations
Prevention	Individual supplemental nutrition assistance to improve dietary adequacy	• Seasonal Commodity price inflation. • Limited HH budget • Empowerment of women to make economic decisions within HH/imbalance of income within the HH.	• Value Vouchers – Unconditional (mostly) • Cash - also tried out.	• Voucher Service providers like Nagis, Redrose • Mobile money, and prepaid card	• Pregnant and Breastfeeding Women or Children 2 or Children U5 • Selected either from Food Assistance caseloads or at Health facility contact points i.e., ANC/PNC, IMAM programs etc.	Vouchers-Duration varies depending on intervention objectives and funding. Mercy Corps – bi-weekly redemption, (with more than a week for redemption to allow small redemption of perishable foodstuffs). SCI- Monthly redemption. Cash: Depends on the objective and resources available. WFP - once a month.	Varies: Mercy Corps: 4-6 months	• Top up recommended during lean season with +1 month before and after, but no more than 6 months of implementation. • Consider a longer window of redemption to allow small redemptions. • Consider a strong SBCC strategy. • Strengthen coordination with other sectors to fulfill unmet needs (such as transportation, fuel). • Gender and protection mainstreaming • Layering of CVA nutrition packages with other Humanitarian Assistance packages. • Need to consider sustainability and exit strategy i.e., link with food security and livelihoods activities, Social Protection etc.
	Incentivizing attendance to Maternal, Newborn, Child Health and Nutrition (MNCHN) programmes	• Low purchasing power to ensure dietary intake and financial access to hygiene and health seeking behaviours. • access to the facilities due to insecurity and limited availability of primary health facility, (average distance to health facility should be 5 km but currently it is more). • Population loss of other sources of income opportunity or temporary labour. • Local wages for temporary labour should be checked (with HEA OA or data from other • Other costs associated to child & maternal health care could be cost of prescriptions, medicines, and primary items if	• Conditional cash as incentive to attend health services • Cash or e-voucher to cover basic needs (food, hygiene).	• Delivery mechanism can be mobile money • Prepaid cards (with options to withdraw over the counter) that can be explored for next programs.	PBWG	Antenatal care are every 2 months; post-natal is after 6 days, after 6 weeks, and until months 9 for immunization. The team should agree on what are the lists of visits that the women should do to determine the number of transfers and agree on frequency (potential of monthly payment). Considering epidemic patterns, seasonality, prevalence of acute malnutrition and other disease, as well as the need to monitor the child growth after birth (VISIT) and we recommend monthly assistance.	• 1000 days of life of the child (from conception to the second year of birth). If fundings are limited, we recommend at least 1 year of duration to cover complete immunization and breastfeeding cycle (last 6 months of pregnancy and first 6 months of the child). • If fundings are even more limited, we recommend a minimum duration of 6 months (the program will target pregnant women during the last	

Approach		Financial barriers addressed	Transfer Modality	Delivery Mechanism	Target Group	Frequency of Transfer	Duration	Other Considerations
		not available in at health facility, such as delivery kits, hygiene items for woman and child. • Lack of Awareness on child and maternal health services in certain areas is also a barrier.					6 months of pregnancy and breastfeeding women during the first 6 months of the child	
Treatment	Provide CVA to facilitate access to treatment of wasting using locally available nutrient-dense foods	• Access to food and affordability • Coverage • Non-sale of commonly used treatment products • Distance to treatment centers because of low coverage. • Need for more kcals for MAM kids- but common model doesn't provide transfers in the case of stock outs • Leakage at the HH level/ sharing • Need for hygiene items, other types of foods (staples), livelihoods implement, productive assets	• Mostly vouchers • Tom Brown: Commodity Vouchers + Cash OR In-Kind + Cash • Porridge Mums: Commodity Vouchers + Cash at the group level + cash to individual participants • Both are 50,000 NGN/Mo voucher- 35,000 commodity vouchers + 15,000 Cash • In this case, use of a commodity voucher is a strong approach because it helps keep costs stable and prevents fraud. • Prices are fixed monthly based on market assessment and posted in the shops (PM) • Tom Brown takes 8-10 weeks- and three days each week are for the prep of the mix, and they receive SBCC messages and MUAC screening. Use enrolment and discharge criteria. • Conditionality: TB: Must be MAM plus show up to get the ration.	• Retailers with existing businesses • Prepaid cards are used by WFP for cash transfers- Access Bank • Mobile money- Airtel & Access Bank • Vendors can also cash out beneficiaries • Tom Brown- hands envelopes of cash	Children 6 to 59 months	• Tom Brown: Weekly distribution- intentional to increase the touches for SBCC messages • Also improves utilization • Adherence days per week (Tom Brown) is too many • Curriculum- Counselling Cards (24 topics) • During festival seasons MUAC readings drop • PM- continual enrolment • TB- could go to biweekly but increases issues of fraud with bulk distribution.		
	Provide CVA to caregivers of children having acute malnutrition with medical complications to facilitate access to treatment	• Transportation to Health facility • Distance • Low income • Treatment cost • Cost of feeding while in the Hospital • Opportunity Cost/loss of income	• In kind such as Nutrition adequate Food, Hygiene kit • Cash transfer for transportation at 2000 naira for to and fro. • Voucher for out-of-pocket money at 500 naira per day for the duration of stay in SC, this is to prevent LAMA	Vendors for wet ration (cooked food) and dry ration (cooking stuff)	Children 0 to 59 months	• Duration for food ration is 3 square meals for the duration of the treatment • Cash at the point of discharge	Throughout their stay in the SC	

Annex 3: Sentinel Foods Basket for Children under 5 years

Food Basket	Ration Contents				
	Food Item/Category	**Existing MEB g/person/day (55% ration coverage)**	**Nutritious Foods Additions to the MEB (grams/person /day)**	**Total in combined GFD and Nutritious Foods Ration (grams/person /day)**	**Nutritious Food Basket: Total per person per month (grams)**
GFD Ration/ Illustrative Food Basket from MEB for Food Assistance	Rice	83	0	83	0
	Maize	138	0	138	0
	Beans	41	19	60	577.6
	Fortified Veg Oil	11	0	11	0
	Groundnuts	8	0	8	0
	Sugar	6	0	6	0
	Palm Oil	6	0	6	0
	Iodized Salt	3	0	3	0
	Onion	5	0	5	0
Nutritious Food Ration Sentinel Foods	Dried Fish	0	5	5	152
	Goat Meat/Dried Beef/Chicken	0	10	10	304
	Vitamin-C and A rich foods: (Oranges/Mangos/Carrots/ Papaya)	0	20	20	608
	Calcium-Rich Fruits: (Dates/Tamarind/Baobab)	0	10	10	304
	Dark Green Leafy Vegetables: (Moringa/Spinach/Zobo/ Cassava/Pumpkin/Baobab/ Okra)	0	100	100	3040
	Goat/Cow Milk/Yogurt	0	50	50	1520
	Egg	0	50	50	1520
	Small grains: Millet/Sorghum	0	20	20	608

Annex 4: Sentinel Foods Basket for PBWG

Food Basket	Ration Contents				
	Food Item/Category	**Existing MEB g/person/day (55% ration coverage)**	**Nutritious Foods Additions to the MEB (grams/person/day)**	**Total in combined GFD and Nutritious Foods Ration (grams/person/day)**	**Nutritious Food Basket: Total per person per month (grams)**
GFD Ration/ Illustrative Food Basket from MEB for Food Assistance	Rice	83	17	100	516.8
	Maize	138	0	138	0
	Dried Beans	41	159	200	4833.6
	Groundnut/Veg Oil	11	14	25	425.6
	Groundnuts	8	22	30	668.8
	Sugar	6	0	6	0
	Palm Oil	6	0	6	0
	Iodized Salt	3	7	10	212.8
	Onion	5	0	5	0
Nutritious Food Ration Sentinel Foods	Dried Fish	0	20	20	608
	Goat Meat/Dried Beef	0	50	50	1520
	Vitamin-C and A rich foods: (Oranges/Mangos/Carrots/Papaya)	0	50	50	1520
	Calcium-Rich Fruits: (Dates/Tamarind/Baobab)	0	20	20	608
	Dark Green Leafy Vegetables: (Moringa/Spinach/Zobo/Cassava/ Pumpkin/Baobab/Okra)	0	200	200	6080
	Goat/Cow Milk/Yogurt	0	100	100	3040
	Egg	0	150	150	4560
	Fruit: (Banana/ Watermelon/ Pineapple/Melon)	0	20	20	608
	Okra (raw or dried)	0	20	20	608
	Small grains: Millet/Sorghum	0	120	120	3648

Annex 5: Northeast Nigeria Sentinel Foods List from FNG CotD Exercise (2021)

Food group (local name)	Average Price/ 100g	Price Range (NGN/100g)
Legumes, nuts and grains		
Groundnut (Gyada)	123	68-176
Soybean, dried (Waken soya)	45	37-54
White bean, dried (Farin Wake)	60	55-67
Red bean, dried (Jan Wake)	63	53-67
Sesame seeds	109	68-229
Eggs		
Chicken egg, raw (Kwai Kaza)	109	84-132
Flesh Foods		
Dried fish	278	178-408
Sardine (in oil)	199	165-253
Chicken (whole)	216	139-348
Goat meat	132	84-166
Beef meat (with bone)	145	80-203
Milk & milk products		
Cow cheese (Chuku)	445	445
Powdered milk (Madara)	264	184-351
Yogurt, plain (Nono)	65	42-90
Fruits		
Pineapple (Abarba)	55	73
Banana (Ayaba)	41	32-61
Baobab fruit (monkey bread) (kuka)	35	26-74
Lemon/lime lemon (tsami)	64	29-101
Dates, raw (Dayan Dabino)	73	22-157
Dates, dried (Dabino)	119	95-172
Guava (Goba)	23	19-28
Mango (Mangoro)	24	14-51
Melon	23	22-25
Orange (Lemon zaki)	17	13-27
Grapefruit	392	188-667
Papaya (Bambus)	78	29-112
Watermelon (Kankana)	32	14-81
Tamarind, dried (Tsamiya)	24	22-27
Tomato (Tumatur)	63	43-102
Vegetables		
Eggplant, African (white) (Yalon bello)	29	17-40
Carrot (Karas)	56	36-93

Food group (local name)	Average Price/ 100g	Price Range (NGN/100g)
Cabbage (Kabeji)	30	14-55
Cucumber (Gurji)	63	16-165
Leaf, baobab, raw (Dayen kuka)	18	18
Leaf, baobab, dried (Kuka)	38	25-58
Leaf, pumpkin, raw		
Leaf, cassava, raw (Doya rogo)		
Leaf, moringa, raw (Zogale)	32	18-42
Leaf, sweet potato, raw (Dankali hausa)		
Leaf, bean, raw (Wake)		
Leaf, roselle, raw (Zobo)	26	26
Okra, raw (Dayen Kubewa)	42	26-56
Spinach	22	10.5-47
Okra, dried (Busheshe n Kubewa)	113	66-177
Green bean, raw	79	53-94
Lettuce	69	28-96
Green onion (Albasa)		
Onion, red (Albasa)	30	26-34
Onion, white (Albasa)	34	24-55
Bell pepper (Tattasai)	168	100-282
Oils & fats		
Vegetable oil, fortified (Mai)	143	127-178
Palm oil, red	81	70-98

Annex 6: Items required per Tom Brown Group

One Off Purchase Per Group			
Line item	Description of Goods	Unit	Qty
1	Mat (size 4)	pieces	1
2	Firewood stove (Murhu Big size)	pieces	1
3	Rubber cups (small)	pieces	13
4	Airtight containers (to fit 1.5 mudu)	pieces	13
5	Pots with cover (Size 10)	pieces	1
6	Frying Pan (Big size)	pieces	1
7	Perforated Big Frying spoons (Aluminium)	pieces	1
8	Medium ladle (Serving Spoon)	pieces	1
9	Big Colander (Stainless)	pieces	1
10	Black plastic bag (Jumbo Size)	pieces	8
11	White Plastic Bag	pieces	8
12	Empty Sack (100kg)	Pieces	8
13	Big Local Tray	Pieces	1
14	Medium Local Tray	Pieces	1
15	Big Rubber Bowl (60 liters)	Pieces	1
16	Liquid Hand Wash (75cl)	Pieces	1
17	Black Rubber with Cover (40 Liters)	Pieces	1
18	Measuring Containers (Mudu)	Pieces	1
19	Light-colored, 3-layer mask	Pieces	13
20	Rubber Bucket (15 liters)	Pieces	1

Annex 7: List of food item (Recipes) for Tom Brown

Weekly Purchase (Food items and stipends) Per Group			
No	**Item**	**Kg/Group/wk**	**Unit Price**
1	Soya beans	8	1000
2	Millet	8	700
3	Sorghum	8	700
4	Ground nut	2.7	1500
5	Cloves	0.5	3,200
6	Preparation cost (grinding, transport, firewood & water)		3500

Annex 8: List of items in SC caregivers' admission hygiene kit

Item description	Units	Qty/kit	Comment
10L plastic bucket with Lid	Pieces	1	Required
160g Bathing soap	Pieces	1	Required
Blankets	Pieces	1	Required
200g Laundry Soap (i.e., Cameroon)	Pieces	1	Required
450g detergent	pieces	1	Required
Plastic Cup (big size, 0.5L)	Pieces	1	Required
Mosquito nets	pieces	1	Optional
Pampers (baby diapers)	Pieces	7	Optional
Toothbrush (Medium size)	Pieces	1	Required
Toothpaste (small size)	Pieces	1	Required
Vaseline (Medium size)	Pieces	1	Required
Disposable sanitary pads	pieces	5	Optional

Annex 9: List of service providers for electronic vouchers

- Nagis NGS Bulgaria
- RedRose
- Aidonic digital platform
- Genius Tag platform
- Vouch Digital
- Squid
- SCOPE