

How cash-based approaches affect nutrition outcomes

Case Studies from World Vision cash programmes in Bangladesh and South Sudan

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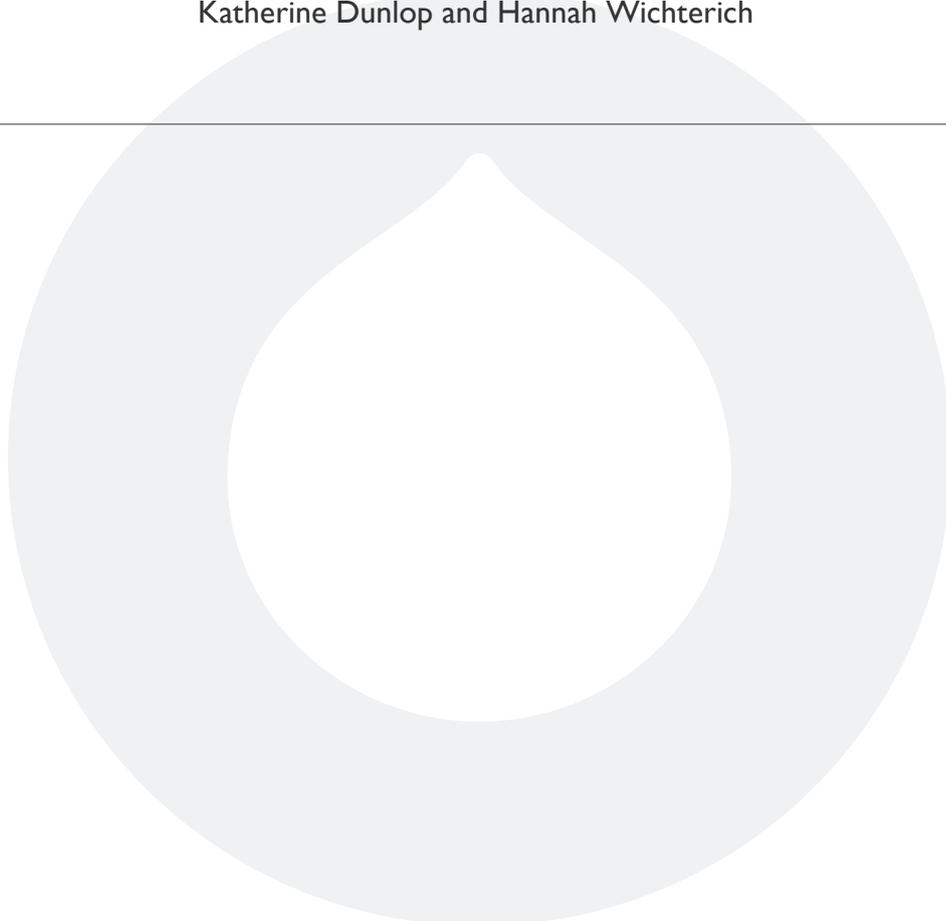


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Acronyms

ANC	Ante-natal care
CCT	Conditional Cash transfer
COEL	Carbon Monoxide Exposure Limiter
CVP	Cash and voucher programming
GAM	Global Acute Malnutrition
GMP	Growth monitoring and promotion
MAM	Moderate acute malnutrition
MAMA	Mobile Alliance for Maternal Action
MEB	Minimum expenditure basket
NFI	Non-food item
NGO	Non-governmental organisation
NID	National Identification Document
PDM	Post-distribution monitoring
PNC	Post-natal care
RUTF	Ready-to-use therapeutic foods
SAM	Severe acute malnutrition
SBCC	Social and behavioural change communication
SIM	Subscriber Identity Module
SMS	Short Message Service
SSP	South Sudanese Pound
TMRI	Transfer Modality Research Initiative
UNICEF	United Nations Children's Fund
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation

Executive Summary

Introduction

Cash and voucher programming (CVP) is a humanitarian intervention method used to help vulnerable populations meet their basic needs with flexibility and dignity. Increasingly, humanitarian actors are using this intervention method to contribute to improving nutrition outcomes for target populations. There is some evidence that CVP has a positive effect on household dietary diversity, health seeking behaviour and hygiene practices, which in turn have a positive impact on nutrition outcomes for mothers and children. However, there is limited evidence about the impact of different types of cash modalities, or how exactly cash works alongside complimentary interventions.

This research case study, commissioned by World Vision, aims to contribute to the evidence and learning around how CVP contributes to nutritional outcomes for mothers and children. It does this by documenting lessons, recommendations and best practices emerging from World Vision cash-based programmes in two contexts: Bangladesh and South Sudan. The case study aims to answer two primary research questions:

1. To what extent is cash-based programming an appropriate programme modality for achieving nutrition outcomes in the given contexts?
2. What is the evidence of impact of the cash-based programming on nutrition outcomes? What factors related to cash-based programming have facilitated or hindered the achievement of nutrition outcomes?

Methodology

This case study took a mixed-methods approach, involving a desk review, key informant interviews, focus group discussions, and an analysis of project post distribution monitoring (PDM) data. In total, 33 interviews were conducted with project staff and partners across both countries, and 11 were conducted with cash recipients. Eight focus group discussions were conducted (four per country) with cash recipients. All participants were pregnant or lactating women, or mothers with children under the age of five. In total, 91 women participated in these focus groups.

Analysis of qualitative data was conducted by coding completed response sheets and using thematic analysis in NVivo, and quantitative analysis of project PDM data was conducted using regression analysis and descriptive statistical techniques in R.

Cash project overviews: Bangladesh and South Sudan

The cash transfer project in Bangladesh is part of a large five-year USAID food security and resilience programme called Nobo Jatra, which began in 2015. The conditional cash transfer element aimed to provide a nutritional safety net to pregnant and lactating women who live below the lower poverty line in Bangladesh, and provided a monthly cash transfer of 2200 taka (27.50 USD) to these “ultra poor” women for 15 months during their pregnancy and after the birth of their child. These cash transfers are conditional upon healthcare check-ups before and after birth, as well as attendance at social and behavioural communication change sessions.

In South Sudan, the Juba Urban Cash Project is a cash transfer and capacity building project that began in 2016 and is implemented by World Vision in partnership with the World Food Programme. The project began as a pilot in 2016 and is currently in its fourth phase. The cash transfers for all phases of the programme have involved six months of monthly transfers, conditional on attendance at monthly training sessions. The cash transfer amount is 45 USD, and this amount varies in South Sudanese Pounds (SSP) depending on fluctuations in the exchange rate. The programme targets various vulnerable households, and a large proportion of beneficiaries are pregnant or lactating women or women with undernourished children.

Key Findings

Cash-based programming design

Design and duration of the programme: In both Bangladesh and South Sudan, the programme design was informed by various assessments and has built on recommendations and experiences from previous programming. In Bangladesh, the programme length was based on the timeframe of child development, while in South Sudan the short duration was due to the programme attempting to maximise reach of vulnerable beneficiaries in an emergency context. Increasing the duration of cash transfer projects that aim to reduce undernutrition may help to support children through crucial periods of their development.

Cash transfer amount: In Bangladesh, the cash transfer amount was based on a previous programme and also on the programme budget. The amount was considered sufficient to meet the needs of the mother and child, but not the rest of the family. In South Sudan, the cash transfer amount aimed to cover just under half the monthly food needs of an average family. The cash amount was considered helpful but not fully sufficient to meet basic nutrition needs of cash recipients, due to large family sizes and high level of need.

Selection of cash recipients: In both Bangladesh and South Sudan, participant selection was based on clear poverty and/or vulnerability criteria designed to target those households most in need. However, in both countries some vulnerable individuals may be ineligible for cash. In Bangladesh, the government restricts cash transfers so that transfers are not given to girls under the age of 18, or women with more than two children. This is to discourage child marriage and large family size, but the result is that some of the most vulnerable women and families may not be supported. In South Sudan, women who are eligible for cash are not identified on a rolling basis. Rather, there is a window of registration, during which all women with malnourished children who attend a clinic are enrolled in the cash programme. Any women attending the clinic after that registration period will not be eligible.

Cash transfer modality: In Bangladesh, where markets are highly functioning, financial institutions are well-established, and cash recipients have access to mobile phones, mobile transfers are an effective and viable modality. They were also considered more efficient and less of a protection risk, although cash recipients had to be sensitised to fraud (PIN theft). In Juba, markets are also functioning (but prices were more volatile). However, financial infrastructure is not in place to allow mobile or direct bank transfers. Cash-in-hand provides a flexible alternative, although it is more time-consuming and can pose protection risks (theft).

Conditions for receiving cash assistance: In both Bangladesh and South Sudan, the conditions for receiving cash assistance were appropriate and worked to enhance the projects objectives to improve nutrition outcomes for cash recipients. Both required beneficiaries to attend health, hygiene and nutrition training, which staff and cash recipients praised in terms of

content and style. Additionally, in Bangladesh, mothers were required to attend health check-ups, and in South Sudan, beneficiaries completed a business skills training.

Project Monitoring: Both projects have an overarching logframe or theory of change that clearly outlines the objectives of the project and links cash to achieving nutrition outcomes. Both rely heavily on PDMs for monitoring. Although output-level and process-level indicators were well tracked by both projects, tracking more indicators related to outcome-level change would allow for better evidence of how cash contributes to nutrition outcomes. For future programmes, a baseline, endline and post-project evaluation is recommended in order to better evidence outcome-level change both during the programme and after it concludes.

How cash-based programmes affect nutrition outcomes

Spending on cash: In Bangladesh, cash recipients spend the cash primarily on food for themselves and children, as well as healthcare. This is in line with project objectives to support the health and nutrition of mothers and children. Due to a successful sensitisation push on the purpose of cash and who should be in charge of it, decisions on how to spend cash were made jointly with wives, husbands and mothers-in-law. In South Sudan, staff advise mothers to spend the money on food and investing in a small business. These are the primary expenses of women, but they also spend money on education and healthcare. An additional stipend for businesses could be considered so that monthly cash can be used more exclusively for immediate health and nutrition outcomes. Two thirds of women decide how to spend the cash themselves, and the rest decide in conjunction with their husbands.

Availability of nutritional foods in markets: In Bangladesh, there have been no changes to food availability in larger markets, but there may have been some increases to food availability and prices in local shops due to the influx of cash and improved purchasing power of women. In South Sudan, there has been no impact on food availability due to the project (since it operates in a large city), although prices of food and availability fluctuate constantly due to external factors, which may have an effect on the purchasing power of cash recipients.

Dietary changes and coping strategies: In both Bangladesh and South Sudan there appears to be an increase in the quality, quantity and frequency of meals, as well as dietary diversity (including increased micronutrient and protein intake). However, dietary diversity is still low in South Sudan. In Bangladesh, coping strategies are moderate and not employed frequently, but in South Sudan, many coping strategies are frequently employed. In both countries, changes to diet are linked to both improved purchasing power, improved access to healthcare, and social and behavioural change communication strategies.

Improved water, sanitation and hygiene (WASH) and health practices: In Bangladesh there was increased expenditure on WASH and health, due to a mix of increased purchasing power, increased knowledge and cash conditions. Health-seeking behaviour improved as a result of growth monitoring and promotion (GMP) sessions being a condition of cash, as well as increased health awareness and increased ability to afford private care. In South Sudan, women reported increased expenditure on health but not WASH. They reported increased practices related to both WASH (due to increased WASH knowledge) and health (due to a mix of increased purchasing power and increased health knowledge). Health-seeking behaviour improved initially due to registration being linked to child enrolment in a malnutrition treatment programme. However, staff indicated that this behaviour declined subsequently (it was not a cash condition).

Improved health and nutrition outcomes: In Bangladesh, health outcomes for children and mothers have increased according to cash recipients and health staff. Anecdotally, rates of global acute malnutrition (GAM) have decreased in target areas. In South Sudan, mothers reported improved health, and nutrition staff explained that cash may have helped to reduce relapse rates of malnutrition among children under five, due to decreased rates of selling and sharing ready-to-use therapeutic food (RUTF) which leads to increased response rates to malnutrition treatment.

Sustainability: In both countries, there is limited evidence to point to the level of sustainability of any health or nutrition outcomes that have resulted because of the projects. However, both countries have taken steps to ensure sustainability. In Bangladesh, the programme is working closely with the government to strengthen their health systems and to ensure that social safety nets are present. In South Sudan, additional income-generating activities are promoted as part of the cash project, with the goal that women should have an additional source of income after the cash transfers stop.

Recommendations and best practices

The following are key overarching best practices that have been highlighted as a result of this study. They should be considered recommendations for future cash-based programmes that aim to improve nutrition outcomes for affected populations.

1. Initial design and beneficiary targeting

1.1 In order to maximise the intended effect on nutrition outcomes, cash transfer amounts should be informed by a minimum expenditure basket (MEB) calculation, which should include an estimate of the basic needs and gaps that the cash transfer intends to cover.

1.2 The duration of a cash-based programme depends on the ultimate objectives of the programme. For programmes seeking to improve nutrition outcomes for mothers and children, a time period of up to the first two years of a child's life may help to better support this crucial period of the child's development.

1.3 The type of cash transfer modality selected should be based on the local context, including functionality of markets, the financial infrastructure available and whether or not preconditions can be met by beneficiaries.

1.4 Beneficiary targeting should ensure that the most vulnerable households are covered, using standard assessment criteria that takes into account income, disability, age, household size and structure, and other factors that influence vulnerability.

2. Conditions for receiving cash transfers

2.1 Conditional cash transfers (as opposed to unconditional transfers) help to encourage nutrition outcomes by making attendance at health or education sessions a requirement for cash recipients.

2.2 Conditions to receive cash assistance should be appropriately tailored to the intended outcomes, and there should be some degree of flexibility for cash recipients to meet these conditions.

3. Integrated programming strategies

- 3.1** Cash-based programmes can contribute to improved nutrition outcomes for mothers and children, but are most effective as part of an integrated approach that includes behaviour-change programming and is linked to social safety nets.
- 3.2** Social and behaviour change communication is a key component of cash projects aimed at improving nutrition outcomes. Multi-pronged messaging strategies should be employed, including community training sessions, messages from health workers, and digital messages where appropriate.
- 3.3** The additional purchasing power provided by cash transfers, combined with clinical treatment programmes for malnutrition and behaviour change sessions, can lead to improved health outcomes among mothers and children.
- 3.4** Continuous sensitisation and counselling for beneficiaries on how to spend their money can encourage spending patterns that are in line with improving nutrition outcomes.
- 3.5** Cash-based projects should include strategies for promoting the sustainability of health and nutrition outcomes, since there is a risk that quantity and quality of beneficiary diets may decrease once cash stops.

4. Monitoring, evaluation and further research

- 4.1** Monitoring and evaluation strategies for cash-based programmes should be set up at the design phase in order to better measure the impact of cash and cash conditions on nutrition outcomes. This should include a longitudinal baseline, endline, and post-project evaluation, if possible.
- 4.2** More research should be conducted into the gender-related aspects of cash programming, including the role of men in improving maternal and child nutrition outcomes, as well as how undernutrition may affect boys and girls differently.

Introduction

Cash and voucher programming

Cash and voucher programming as an intervention model

Globally, cash and voucher programming (CVP) has increasingly become a preferred intervention method by humanitarian organisations. CVP is used by humanitarian actors both as a means to complement traditional in-kind interventions and as a standalone intervention, particularly in contexts where markets are accessible and well-functioning. Unlike in-kind interventions, where food or goods are directly given to target beneficiaries, CVP allows aid recipients to choose how to best spend aid money in order to meet their basic needs. The objective of providing this freedom of choice is to provide greater flexibility and dignity to beneficiaries, as well to promote assistance that is as relevant as possible for individuals and families. Additionally, the relative simplicity of CVP compared to food and non-food item (NFI) distributions can help reduce the associated costs and logistical complexity associated with those types of interventions.

Overview of World Vision's approach to cash and voucher programming

World Vision conceptualises CVP as a way to “connect the affected population to their local markets and traders in order to fulfil their basic needs” by providing them with cash or voucher payments. In this way, interventions must understand and utilise the existing market system in order to deliver goods and services to the affected population (as opposed to in-kind interventions, which may not utilise existing market systems).¹ This helps to avoid disrupting the relationship between affected populations and existing market systems. Some of the benefits of CVP as envisioned by World Vision include:²

- Increasing household purchasing power and enabling households to purchase according to needs
- Simplifying delivery by providing one transfer to meet multiple sector needs
- Supporting local markets and economies
- Supporting traders to restock and restore the supply of goods

Various types of CVP are utilised by World Vision. These strategies depend on the needs and preferences of beneficiaries in the target area, the way that the market system is functioning, and the intended outcome of a particular programme. Types of cash transfer programming include:³

- **Unconditional cash transfers:** These are transfers which do not require beneficiaries to fulfil specific obligations in order to receive cash.
- **Conditional cash transfers:** These types of transfers are given to recipients only on the basis that they meet particular conditions, such as attending a training.

1 Cash-based programming Q and A. World Vision.

2 Cash transfer programming and operations. World Vision, 2017.

3 Ibid.

- **Cash for work:** Cash transfers which require recipients to work on particular public-works programme (for example to improve community services and/or infrastructure).
- **Voucher transfers:** Vouchers may be used by beneficiaries to purchase goods and/or services that are predefined and provided by designated shops.

Additionally, these types of cash transfers may be restricted (cash recipients can only spend the money on specific items) or unrestricted (cash recipients can use the money on items of their choosing). Voucher transfers are more likely to be restricted transfers, since recipients can only spend vouchers on particular goods, or particular quantities of goods, from designated suppliers.

Throughout the following sections of this report, the term cash-based programming will be used (rather than CVP) to refer to interventions that involve cash transfers but not voucher transfers. This is because the two interventions reviewed for this study both involved cash transfers rather than vouchers, and the effect of cash-based programming compared to voucher-based programming on nutrition outcomes is likely to be different given the more restrictive nature of voucher-based programming. The results and recommendations outlined in this report therefore relate specifically to cash-based programming.

Cash-based programming targeting nutrition outcomes

Evidence for the effectiveness of cash-based programming on improving nutrition outcomes

Cash-based programming is used by humanitarian organisations to achieve outcomes related to a number of sectors. Of growing interest is how cash-based programmes can impact the nutrition outcomes for target populations. This is of particular importance because globally, 52 million children worldwide suffer from wasting, 155 million suffer from stunting, and 45% of deaths among children under five are linked to undernutrition.⁴ Cash-based programmes, alongside health and nutrition services, may contribute to helping vulnerable families and children to meet their nutrition-related needs.

The effect of cash transfers on the nutritional status of children (using anthropomorphic indicators such as weight for height) has not been widely studied. One meta-analysis showed promising indications of cash-based programming contributing to improvements in children's nutritional status.⁵ However, another ODI review of six recent studies (mostly conducted in Latin America), found inconclusive evidence of whether cash-based programmes had an impact on child nutritional outcomes, since the pathways of impact are not clearly understood.⁶ Indeed, most existing research has investigated programmes that conduct additional interventions besides cash transfers (such as behaviour change interventions). Therefore, it is difficult to isolate the effect of cash versus other intervention strategies on child nutrition outcomes. One meta-review led by WFP and Action Against Hunger found that complementary programmes are necessary in most contexts in order to tackle the multiple of causes of undernutrition.⁷ There is some evidence for the effectiveness of these multi-pronged interventions. For example,

4 WHO Factsheet on Malnutrition. WHO, 2018.

5 Sarah Bailey and Kerren Hedlund, The impact of cash transfers on nutrition in emergency and transitional contexts: A review of evidence. Humanitarian Policy Group, 2012.

6 Richard de Groot, Tia Palermo, Sudhanshu Handa, Luigi Peter Ragno, Amber Peterman. Cash Transfers and Child Nutrition. Pathways and Impacts. ODI, 2017.

7 Bridget Fenn, Impacts of Cash on Nutrition Outcomes. Research for Action, WFP and Action Against Hunger, 2018.

one recent randomised control trial in Bangladesh found that while cash transfers on their own did not significantly impact the nutritional status of children, cash when complemented with behaviour change interventions did significantly reduce stunting in children under five.⁸

Since understanding the impact of cash interventions can be complicated, due to the difficulty in isolating causal pathways of how cash effects nutrition outcomes, programmes often measure proxy outcomes, such as increases in dietary diversity and food consumption.⁹ Existing evidence points to the positive impact of cash-based programming on these underlying determinants of malnutrition. For example, numerous studies across various countries have pointed to the positive effect of cash (and increased purchasing power) on household food consumption and dietary diversity scores.¹⁰ One meta-review also found that cash is more likely than food transfers to increase dietary diversity and food expenditure on children.¹¹ Similarly, studies have found that cash transfers have improved health-seeking behaviour and improved hygiene practices in target populations.¹²

More research and evidence in this area is clearly necessary in order to fully understand the effect of cash on nutrition, including how different modalities of cash assistance may work in different contexts, and how cash impacts nutrition outcomes when delivered in combination with other nutrition, health and education interventions.

Frameworks for understanding the impact of cash-based programming on nutrition

One way to envision how cash-based programming can impact nutrition outcomes is to illustrate how it may relate to the various levels of World Vision's Global Framework for Nutrition Interventions (see the simplified illustration below).

In terms of the immediate causes of undernutrition outlined in this framework, cash may have the following effects:

1. **Adequate dietary intake:** Cash transfers (increased income) can allow families to purchase sufficient amounts of food.
2. **Health:** Cash can help families to access health services (particularly private or specialised services).

Cash can also help to address the underlying causes of undernutrition:

- **Adequate household food security and livelihoods:** Cash can help families invest in livelihoods and long-term food security strategies.
- **Adequate maternal and childcare practices:** Cash can help families to buy the nutritious food and other items needed to conduct adequate care practices.

8 Which kinds of social safety net transfers work best for the ultra poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative. IFPRI and WFP, 2016.

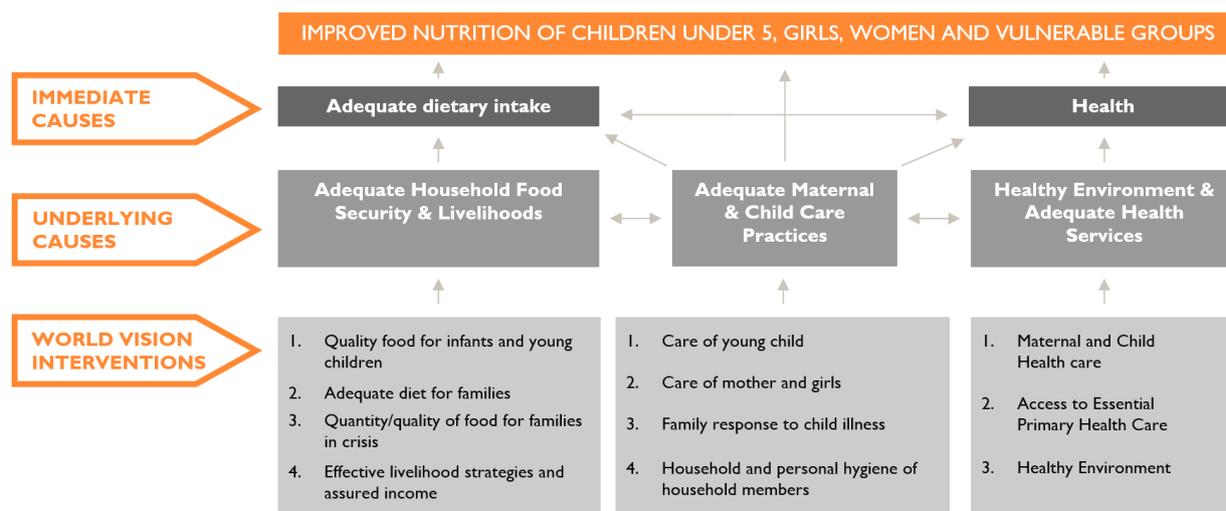
9 Sarah Bailey and Kerren Hedlund, The impact of cash transfers on nutrition in emergency and transitional contexts: A review of evidence. Humanitarian Policy Group, 2012.

10 Richard de Groot, Tia Palermo, Sudhanshu Handa, Luigi Peter Ragno, Amber Peterman. Cash Transfers and Child Nutrition. Pathways and Impacts. ODI, 2017; Sarah Bailey and Kerren Hedlund, The impact of cash transfers on nutrition in emergency and transitional contexts: A review of evidence. Humanitarian Policy Group, 2012.

11 Bridget Fenn, Impacts of Cash on Nutrition Outcomes. Research for Action, WFP and Action Against Hunger, 2018.

12 Richard de Groot, Tia Palermo, Sudhanshu Handa, Luigi Peter Ragno, Amber Peterman. Cash Transfers and Child Nutrition. Pathways and Impacts. ODI, 2017

Figure 1: World Vision's Global Framework for Nutrition Interventions



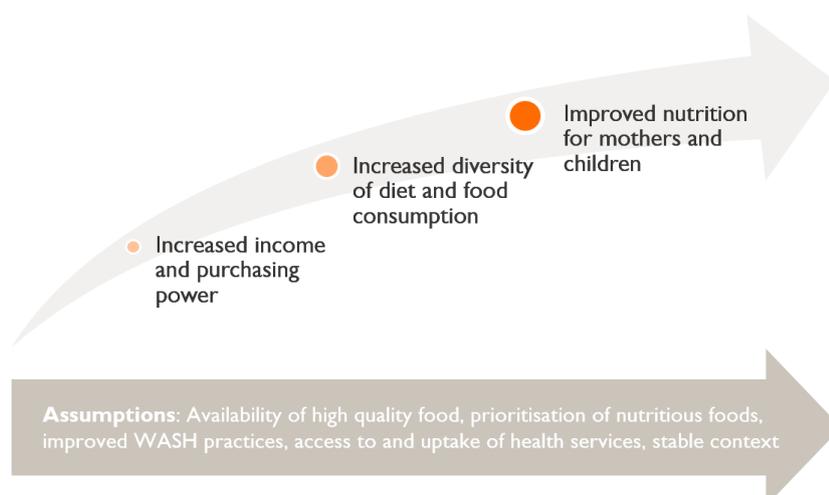
- **Healthy environment and adequate health services:** Cash can help families to buy sanitation and hygiene supplies, as well as access health services.

It is clear that cash alone cannot lead to improved nutrition. For example, improved purchasing power will not necessarily mean that families will prioritise buying nutritious food; however, improved purchasing power alongside nutrition education may help to improve nutrition outcomes. Therefore, in relation to the nutrition framework, cash works in conjunction with other interventions, such as improving health care systems, improving WASH and nutrition practices, and promoting livelihoods strategies.

World Vision's approach to cash-based programmes for nutrition outcomes can also be outlined in a basic theory of change. In this model, cash increases household income and improves purchasing power for food, which leads to increased diversity of diet and increased food consumption, which then leads to improved nutrition for children. This approach should be taken as part of an integrated intervention that involves a variety of components such as WASH, strengthened health and nutrition services, and food security and livelihoods activities.¹³ The assumptions underpinning a cash-based intervention model for nutrition include: the availability of high quality foods in the target intervention area; prioritisation of nutritious food; improved household WASH practices; access to health services; uptake of treatment and prevention services; and stability in terms of the external context. This overarching theory of change is visualised in the diagram below.

13 Cash-based programming: To meet basic needs through sector and multi-purpose programming. World Vision, 2018.

Figure 2: Theory of Change: Cash for Nutrition



Case study objectives and design

Objectives

This study aims to contribute to existing evidence and learning around how cash-based programmes contribute to nutritional outcomes for cash recipients. It does this by documenting lessons, recommendations and best practices on how cash-based programming in South Sudan and Bangladesh has targeted improved nutrition outcomes for mothers and children from two specific World Vision projects. Findings from the research is disaggregated by country, followed by a short section comparing the results from both countries and outlining overarching recommendations for how future cash-based programmes can work to target improved nutrition outcomes.

Key research questions and sub-questions

The two case studies in this report respond to the key questions and sub-questions outlined in Table I below.

Table I: Research Questions

Research Questions	Sub-Questions
1. To what extent is cash-based programming an appropriate programme modality for achieving nutrition outcomes in the given contexts?	1.1 Was the programme design based on context analysis/needs assessments? If not, how is the programme adapted to the context?
	1.2 What key factors were considered when determining the amount of cash transfer in ongoing projects in South Sudan and Bangladesh? How often is this reassessed?
	1.3 What key nutrition services and messaging were integrated into cash-based programming? What key messages can be considered in future cash programming?

	<p>1.4 What nutrition related indicators were used and monitored/evaluated? What key outcome monitoring indicators should cash-based programming consider in future programming?</p>
	<p>1.5 What best practices for cash-based programming implementation have been identified in each country? What hindering factors have been identified?</p>
<p>2. What is the evidence of impact of cash-based programming on nutrition outcomes? What factors related to cash-based programming have facilitated or hindered the achievement of nutrition outcomes?</p>	<p>2.1 For what needs are households primarily using these funds?</p>
	<p>2.2 How are household spending priorities determined? By whom?</p>
	<p>2.3 Has there been a change in quality and quantity of diet, frequency of meals, protein and micronutrient intake, or coping strategies related to food consumption? Are these changes linked to improved purchasing power, and/or nutrition education/behaviour change programming?</p>
	<p>2.4 Has there been change in the availability (quality and quantity) of nutritional food for target populations?</p>
	<p>2.5 Has there been a change in expenditure on: household health and sanitation, access to health services, uptake of treatment and preventative services?</p>
	<p>2.6 Has cash-based programming enabled the improvement of social safety nets to support food security (adequate nutrition) and access to essential services?</p>
	<p>2.7 Has there been a change in the rates of GAM, SAM and MAM in populations receiving cash?</p>
	<p>2.8 What best practices for cash-based programming implementation have been identified in each country? What hindering factors have been identified?</p>

Methodology

This research used a comparative case study design, utilising the same methodology across two countries in order to compare recommendations and best practices for how cash-based programmes can effectively contribute to improved nutrition outcomes. This methodology involved a mixed-methods approach. Primary data collection consisted of exclusively qualitative techniques, including key informant interviews (with staff, partners and cash recipients) and focus group discussions (with cash recipients). The research team also reviewed quantitative data from project post-distribution monitoring (PDM) surveys. Other secondary data reviewed included key project documents such as annual reports and project evaluations. Using multiple methods from various sources allowed for a triangulation of findings, and cross-verification from programme teams ensured consistency and validity of findings.

Desk review

The purpose of the desk review of existing project documentation was to inform the research tools, allow the research team to develop an in-depth contextual understanding of the cash programmes, and to map relevant information related to the research questions. Key documents reviewed included project proposals, narrative reports, PDM reports, evaluations and research reports. A full list of documents reviewed can be found in Annex 1.

Key informant interviews

Semi-structured key informant interviews were conducted with World Vision staff, key project stakeholders and cash recipients. In total, 33 interviews were conducted with project staff and partners across both countries, and 11 were conducted with cash recipients. For a breakdown of the location and demographics of interviewees, see Table 2. It is also important to note that within the scope of this research the interviews with cash recipients were not intended to be a representative sample size, but instead helped to provide illustrative qualitative examples.

The objective of the interviews with staff and partners was to better understand details related to the design and implementation of cash programming, to uncover key lessons learned and to investigate perceived short-term and long-term effects of the projects. The primary objective of interviews with cash recipients was to explore the perceived effect of cash transfers and nutrition messaging on the nutrition and health outcomes for mothers and children. For more details, see the full interview guides in Annex 2.

All interviews were conducted in-country, except for three Skype interviews with Bangladesh staff and partners. In both countries, the cash recipient interviews were conducted with the help of a translator. Interviews with staff and partners were all conducted in English, except for two interviews conducted with health staff in Bangladesh via a translator.

Focus group discussions

Eight focus group discussions were conducted (four per country) with cash recipients. These discussions involved participants of similar demographics, across different implementation sites. In each country, four different project sites were chosen to conduct the focus groups, ensuring a geographic spread of participants. Due to the target population of both programmes, all of the

participants were pregnant or lactating women, or mothers with children under the age of five. In total, 91 women participated in these focus groups across both countries.

These discussions focussed on key questions related to how beneficiaries were spending their cash and why, and explored perceptions related to cash messaging and the effect cash has on recipients nutrition and health outcomes. The benefit of this type of discussion was that it allows participants to agree or disagree with each other, providing insight into a wider range of opinions and ideas related to specific topics.

In each country, experienced translators and facilitators from World Vision assisted with conducting the focus groups. All logistical elements of the focus group discussions, including selection and mobilisation of participants, were conducted by World Vision.

Table 2: Primary Data Collection Overview

Primary Data Collection method	Bangladesh	South Sudan
Focus Group Discussions	Four: Two in each district visited (Dacope and Koyra) 60 women in total (50 mothers and 10 mothers-in-law)	Four: At four different health centres in Juba 31 women in total (mothers of children under five)
Key Informant Interviews (beneficiaries)	Six interviews: Four interviews with female cash recipients Two interviews with female cash recipients and their husbands	Five interviews with female cash recipients
Key Informant Interviews (staff and partners)	12 people (Two women, 10 men). This included: Four with World Vision project staff Two with WFP staff (Three people) Four with government health staff One with the consultant of the TMRI study	11 people (Five women, six men). This included: Three with project staff (five people total) Four with nutrition staff (five people total) One with government health staff

Data analysis

In order to understand the links between cash and nutrition outcomes, the research team analysed both primary qualitative data and pre-existing quantitative data (PDM data). This triangulation of data sources and methods served to produce a deeper analysis of key themes.

Qualitative: The qualitative analysis of key informant interviews and focus group discussions

was categorised by stakeholder group and analysed in order to explore patterns within and between these groups. A coding framework was developed and data from interviews and focus groups was coded by uploading completed 'response sheets' into the NVivo and categorising them according to the coding framework. Developing and using a coding framework ensured consistency and greater cross-comparison of findings.

Quantitative: Quantitative analysis of the PDM datasets provided by the Bangladesh and South Sudan teams was conducted using the statistical software "R". Analysis was based on the data available, which varied by country. Inferential statistical testing was used to determine relationships between variables, and to identify whether certain factors were related to improved health and nutrition indicators. Some descriptive analysis (mean, frequency) was also used to illustrate particular trends.

Limitations

Due to the scope and design of this study, field visits were short (five days in each country) and data collection was limited to qualitative data. Therefore, the study did not involve primary quantitative data collection or household visits to further triangulate findings. To mitigate this limitation, existing quantitative data was analysed and cross-referenced with qualitative data.

Furthermore, due to the scope of the study, only a limited number of implementation sites could be visited, and remote sites could not be visited. Therefore, the findings of these case studies may not represent the experiences of cash recipients in all project locations. This is particularly the case for Bangladesh, where the geographic distribution of cash recipients was much larger.

Due to unforeseen logistical barriers, the number of planned focus groups was reduced from six to four in each country. However, this did not present an issue in terms of data quality, as the original focus group estimate was based on the idea that cash recipients were more demographically distinct. In reality, only pregnant and lactating women and mothers with children under the age of five were interviewed, as these were the target project beneficiaries. Responses were generally consistent across the focus groups, meaning that data saturation was reached quickly. More than four focus groups would not have yielded better quality data, unless they had been conducted in a very distinct geographic location. Finally, the target of at least six interviews was reached in Bangladesh, but in South Sudan as only five interviews were completed due to logistical difficulties.

Case Study: Cash-based Programming in South-Western Bangladesh

Introduction

Overview of the food security and nutrition context in south-western Bangladesh

World Vision has been present in Bangladesh since 1970, and has been operating in south-western Bangladesh for decades.¹⁴ High levels of poverty in this region is a serious issue that leaves women and children particularly vulnerable.¹⁵ Poor nutrition among rural populations in this district has resulted in correspondingly high levels of stunting among children under five (35.5% are moderately stunted and 11.3% are severely stunted) as well as wasting (17.5%).¹⁶ It has also led to nutritional deficiencies in pregnant and lactating women, with adolescent girls most at risk.¹⁷ Some of the major challenges to food security in the region, as described by key informants of this case study, include:

- **Gender and social issues:** Early marriage is common in Bangladesh, and in the region where this study took place the average age of marriage is 15. As a result, adolescent pregnancy is also very common, which can lead to low birth weights in infants.¹⁸
- **High poverty rates:** Poverty and unemployment levels are high. Between 25-35% of the population in the Khulna region are under the lower poverty line, and 51% of the rural populations are landless.¹⁹
- **Environmental issues:** The region faces a range of environmental issues that are exacerbated by climate change, including natural disasters such as floods and cyclones. Agriculture in the area is affected by high water salinity, and there is limited agricultural diversity due to a high reliance on fishing and export crops. This results in limited dietary diversity, and common food staples lack key vitamins and minerals.
- **Health system capacity:** Government systems are overstretched and community clinics have large catchment areas. Health clinics sometimes face stock-outs of key supplements and medicines, and staff are often over capacity or under-trained.
- **WASH issues:** There is poor WASH infrastructure in the area, with limited safe drinking water and water treatment systems. Rates of open defecation are high (22-25%)²⁰ and sanitation systems are not in place. Diarrhoea and water-borne diseases are common.

14 Nobo Jatra Proposal. World Vision, 2015.

15 CCT Learning Brief. World Vision, 2018.

16 Progotir Pathey, Multiple Indicator Cluster Survey 2012-2013, Key Findings. Bangladesh Bureau of Statistics and UNICEF Bangladesh, 2014.

17 CCT Learning Brief, World Vision, 2018.

18 USAID Bangladesh Food Security Country Framework, 2015- 2019. USAID, 2015.

19 Nobo Jatra Proposal. World Vision, 2015.

20 Nobo Jatra briefing PowerPoint, Dacope. World Vision, 2018.

- **Other infrastructure issues:** Roads and electricity infrastructure is poor in rural areas and some communities located on islands have no direct land access. This means that in remote areas, some households face difficulties travelling to health clinics.

Overview of the cash transfer project

The conditional cash transfer project implemented by World Vision in south-western Bangladesh is one intervention under the maternal and child health and nutrition component of a large five-year food security and resilience programme called Nobo Jatra, funded by USAID. This programme began in 2015 with the objective “to improve gender equitable food security, nutrition and resilience of vulnerable people in Bangladesh.”²¹ The programme is implemented across four sub-districts of the Khulna and Satkhira districts in Bangladesh, and includes activities such as: conditional cash transfers to pregnant and lactating women; improving water treatment systems and sanitation facilities; social and behavioural change communication (SBCC) activities; alternate income-generating activity promotion; and establishing disaster risk reduction committees.²² A core cross-cutting theme of these activities is the economic and social empowerment of women.

The focus of this study was on the conditional cash transfer element, which aimed to provide a nutritional safety net to pregnant and lactating women who live below the lower poverty line in Bangladesh.²³ This involves a monthly unrestricted cash transfer of 2200 taka (27.50 USD) to these “ultra-poor²⁴” women across all four sub-districts, for 15 months during their pregnancy and after the birth of their child. These cash transfers are conditional upon three ante-natal care (ANC) check-ups during pregnancy, one post-natal (PNC) check-up, monthly growth promotion and monitoring (GMP) sessions and attendance at SBCC sessions after birth.²⁵ The ANC, PNC, and GMP sessions take place at local community clinics, and the SBCC sessions are held in the community. All cash transfer participants also received mobile phone based health messages and 1,000 women (without mobile phones or those in remote, hard to reach locations) received COEL bangles,²⁶ a low cost audio device that transmits health messages twice a week.



The programme aims to reach 23,600 women by 2020, and as of November 2018 the project had reached 18,309 women.²⁷ Of this total, over 10,000 women have already completed the full 15 month cash transfer cycle. The cash transfer component is led by World Vision and WFP. World Vision is in charge of beneficiary identification, registration, and all SBCC activities and follow up. WFP are in charge of arranging the mobile cash transfers with bKash (a mobile financial service in Bangladesh).²⁸

21 Nobo Jatra Proposal. World Vision, 2015.

22 Annual results report for USAID, Fiscal Year 2018. World Vision, 2018.

23 Nobo Jatra Proposal. World Vision, 2015.

24 Living on less than \$1.90 USD per day.

25 Nobo Jatra CCT Standard Operating Procedures. Nobo Jatra, 2018.

26 COEL stands for Carbon Monoxide Exposer Limiter. In addition to transmitting health messages, COEL bangles will alert mothers when they are exposed to carbon monoxide (for example, from cooking fires).

27 CCT Factsheet. World Vision, 2018.

28 Nobo Jatra CCT Standard Operating Procedures. Nobo Jatra, 2018.

Methodology

This case study involved visits to communities in two sub districts (Dacope and Koyra), where two focus group discussions were conducted in each sub district with women who were or had been part of the cash transfer project. Each discussion lasted approximately an hour, and was conducted with one researcher and one facilitator/translator from World Vision. In total, 60 women participated in the four focus groups, including 10 mothers-in-law of cash recipients. It was considered important to include the mothers-in-law in the discussions, because although they are not direct cash recipients, they are considered influential in household decision making related to health and nutrition. Nobo Jatra intentionally engaged with them during the cash programme, and they were also targeted to receive health and nutrition messaging.

Additionally, six one-on-one structured interviews were conducted.²⁹ Three of these involved women who had also participated in the focus groups. Two interviews involved the joint participation of women and their husbands. See Table 3 for an overview of the demographic characteristics of the interviewees.

In order to consider both the short and long-term effects of cash, the focus groups were designed to include a mix of women who were still receiving cash and who had stopped receiving cash, while four of the six interviewees had stopped receiving cash. During both the focus groups and interviews, the primary focus was on the changes that had occurred while the participants were still receiving cash, compared to before receiving cash. However, where the participants had stopped receiving cash, questions related to how the end of the programme had affected their health and nutrition outcomes were included.

This research also included visits to the World Vision field offices in these sub districts, as well as one community clinic and two regional health facilities. As part of the study, World Vision staff and four government health staff were interviewed.

Table 3: Demographic characteristics of interviewees (Bangladesh)

Characteristic	Number
# of interviews conducted	6 Koyra: 4, Dacope: 2 6 women, 2 men (2 dual interviews)
Average age	30 (approximately)
Average household size	5.8 (3.8 excluding additional adults besides the mother and father)
Average # adults in household	4
Average # children in household	1.8
Average # children under 5	1.3
# of households with someone over age 60	1
# of households with a disabled family member	0

29 See questionnaire in Annex 2.

# of interviewees who had stopped receiving cash transfers	4
Average household income (excluding cash transfers) ³⁰	8000 taka (approximately 95 USD)

Limitations

The main limitation of this methodology is that all four regions where the project was being implemented could not be visited, due to time constraints. More remote communities, which may have faced different nutritional challenges, were also not visited. Finally, the scope of the study meant that a larger survey or household visits could not be conducted to collect additional quantitative data. The interviews conducted do not constitute a representative sample size, but instead provide illustrative examples as per the agreed upon research design.

I. Is a cash-based approach an appropriate programme modality in the given context?

Context analysis and design

As indicated in the programme proposal and confirmed in interviews with World Vision staff, there were several assessments conducted prior to programme implementation in order to understand the economic and food security situation in the region. This was to ensure that any programme activities were appropriately tailored to the context and were also in line with “do no harm” principles. Assessments conducted by World Vision included a household economic analysis, a rapid market assessment and a multi-sector qualitative assessment (including a gender barrier analysis). Staff explained that they took the findings of these assessments into account in order to refine the programme implementation guidelines for Nobo Jatra.

The programme was designed to be multi-sectoral, using multiple different interconnected activities and strategies. World Vision staff, partners and government officials were consistently positive about the holistic nature of the programme, and the integrated activities and approaches used to tackle food security, malnutrition and women’s empowerment. Staff were also very positive about the close working relationships with the government and the programme’s alignment with existing health systems, rather than creating parallel structures.

Cash transfer amount

The cash component of the Nobo Jatra programme was also modelled after the most successful strategy of a randomised controlled trial conducted by the Transfer Modality Research Initiative (TMRI) in 2013. This trial tested various different modalities of improving nutrition outcomes for children under the age of two, including cash transfers, food distribution, a mix of cash and food, cash plus SBCC and food plus SBCC. The study indicated that cash in combination with SBCC had the most significant impact on improving infant and young child feeding practices, and also led to a 7% reduction in stunting when compared to a control

³⁰ The lowest income was 4000 taka, and the highest was 12000, but this was in a household where two adult men earned money. Only one of the women interviewed earned money herself, from tutoring another family’s child. The husbands in these families mostly worked as labourers (for example, transporting goods or working in a brickfield), and explained that the household income was variable and depended on fluctuating demand for work.

group.³¹ In general, cash is a preferred distribution methodology over food distributions, because it provides more flexibility and choice for beneficiaries.³² Cash as a programming modality also works well in Bangladesh, because the economic context is relatively stable and markets are functioning.³³

World Vision adopted this approach, with some adjustments, including an adjustment to the cash transfer amount. The TMRI study originally gave 1500 taka to pregnant and lactating women, an amount that was chosen because it was one quarter of the average household income of poor rural households in Bangladesh. In theory, this amount should have provided approximately 40-45% of calories required by an average household (with 5.8 members) per month. However, it should be noted that these calories were based on “staple” foods such as rice, pulses and oil, and did not take into account the cost of meeting diverse dietary requirements (including protein and micronutrients).³⁴ For the Nobo Jatra project, World Vision increased the cash transfer amount from 1500 to 2200 taka, but only to adjust for inflation. World Vision staff also advised households receiving cash to save a proportion for healthcare costs for the mother and child (approximately 200 per month). The cash transfer amount has remained constant since the beginning of the programme and has not been reviewed.

In relation to why the cash transfer amount was lower than household monthly needs for both the TMRI study and Nobo Jatra, World Vision staff explained that the cash transfer was intended to supplement families’ existing income and livelihoods strategies, and was primarily intended to cover the nutrition and health needs of the mother and children (not the whole household). This was reflected when speaking to cash recipients as well; in general, participants in the focus groups and interviews indicated that the amount they received was enough to meet the nutrition and healthcare needs of the mother and the child, but was not enough for food and healthcare needs for the entire household. However, most families did have additional monthly income to support wider household needs.

Programme staff and government health staff had varying opinions on the cash amount, and several recommended that future programmes should lower the amount to more closely align with a government programme that provides 500-800 taka (potentially to be increased to 1000 taka³⁵) per month for poor pregnant women and children. The rationale for this was that since the programme is ending, a sudden drop in transfer amounts as communities transitioned from receiving Nobo Jatra support to government support may cause tension in these communities. Additionally, there may be tension between women receiving cash support from Nobo Jatra and those being supported by the government, due to the large difference in the cash transfer amount. Staff explained that when determining the cash transfer amount they therefore faced a trade-off between alignment with government services, wider reach of beneficiaries, and level of benefit for individual beneficiaries. If the transfer amount was substantially lowered, it may risk not meeting the needs of cash recipients, and therefore undermining the ultimate objectives of the programme.

31 Which kinds of social safety net transfers work best for the ultra-poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative. IFPRI and WFP, 2016.

32 Cash transfer programming and operations. World Vision, 2017.

33 Nobo Jatra Proposal. World Vision, 2015.

34 Which kinds of social safety net transfers work best for the ultra poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative. IFPRI and WFP, 2016.

35 Reform Plan on Maternity Allowance (MA) and Lactating Mothers Allowance (LMA) Programmes of Ministry of Women and Children Affairs. Maxwell Stamp, 2018.

Cash transfer period

The 15 month time period for the cash transfers, ideally starting in the second trimester of a women's pregnancy, is based on the cash transfer period used in the TMRI study. Based on guidance from USAID, it also considers the UNICEF's 1000 day approach, which emphasises the importance of proper nutrition for a child's development between conception and their second birthday.³⁶ Although this programme does not span this entire 1000 day time period, due to budget limitations, it aims to support several core stages of mother and child nutrition: the second and third trimesters of pregnancy (six months), the recommended period of exclusive breastfeeding for six months, and three months of the crucial transition period from exclusive breastfeeding to complementary feeding. In line with the 1000 day approach, mothers are also encouraged to continue breastfeeding after the cash stops, at least until the child is two years old, and are advised on children's additional health and nutrition needs during this period.

Health staff recommended that any future cash transfers should support children until their second birthday, because this is a critical period of early development for children. They also indicated that this would align better with the government cash programme, which provides two years of cash transfers. Several cash recipients also suggested that cash could be continued for two years, indicating that this support would allow them to better support their children during this time.

Targeting of cash recipients

The programme has clear selection criteria to target pregnant and lactating women from "ultra-poor" families (below the lower threshold of poverty as defined by the government). This involves a household economic analysis at the community level to determine eligible women, which looks primarily at household income but also uses criteria such as land access and number of vulnerable household members.³⁷ Cash recipient lists are validated by committees at three levels: the community, the programme and the government (the government also checks to ensure there is no cross-over with the government cash support programme).

Despite the thorough targeting process, there still may be vulnerable individuals missed, due to restrictions put in place by the Bangladesh government. The government does not want cash transfers to be given to girls under the age of 18, or women with more than two children. The motive for these restrictions is to discourage child marriage and large family sizes, because the government believes that cash grants will encourage early marriage and early pregnancy (although the evidence for this is unclear). The result is that some of the most vulnerable women and families may not be supported through this programme. Adolescent girls particularly need proper nutrition, because they are still growing, and the children of adolescent girls are at higher risk of low birth weight because of this. The Nobo Jatra programme still includes women in these groups in their education sessions,³⁸ but they are not receiving cash.

There may also be tension between those mothers who are not eligible for this cash and those who are eligible. For example, some pregnant and lactating women below the poverty line are supported by the government programme that provides 500-800 taka per month, which is

36 Cusick, Sarah and Georgieff, Michael K. The first 1,000 days of life: the brain's window of opportunity. UNICEF, Retrieved June 4 2019.

37 Nobo Jatra Proposal. World Vision, 2015.

38 SBCC sessions are targeted to the whole community. Pregnant and lactating women in a community can attend regardless of whether they are enrolled in the cash programme, and regardless of their age or family size.

much lower than the 2200 taka per month provided by Nobo Jatra. This topic did not come up during discussions, and it was beyond the scope of this case study to speak to women who had not received cash from World Vision. However, the mid-term evaluation of Nobo Jatra conducted in September 2018 did investigate this topic and found that mothers who were sponsored by the government were unhappy with the discrepancy in cash transfer amounts between the two programmes. Staff also suggested that the lower poverty line was very low, and that even women above that line might have benefited from that programme.

Mobile cash transfers

The programme chose to conduct mobile cash transfers. Upon enrolment, beneficiaries are given a SIM card and a bank account is opened up in their name, and the transfers are made monthly to this account. This is done in partnership with bKash, a mobile financial service provider in Bangladesh, and includes an arrangement to not impose cash-out fees. Cash recipients are also provided with a training on mobile banking. World Vision chose this mobile approach over cash-in-hand or bank transfers for various reasons:

- It is more flexible, and the beneficiaries don't have to travel to collect their cash.
- Cash recipients can keep track of their money easier through the mobile app.
- It decreases protection risks, because beneficiaries don't have to collect and carry around large sums of cash.
- It is less logistically challenging (World Vision did not have to arrange distribution points or make security arrangements with authorities).
- It reduces opportunities for corruption by cutting out middlemen.
- Digital cash transfers allow women to have savings and a bank account. They get to keep the SIM and bank account after the programme, for free. This promotes long-term financial inclusion and increased financial resilience.
- It includes free nutrition SBCC messages and voicemails from the programme. It may also be possible to link cash recipients with other free health messaging services (Nobo Jatra are exploring this possibility).

However, there are also some challenges associated with the mobile registration system. These have included:

- Many women don't have a National Identification Document (NID) which is required to set up a bank account, so they have the option to use the NID of a nominated family member, which is usually the husband, mother or mother-in-law (according to the latest PDM, only 43% of women have set up the account in their name).³⁹ This is not ideal, because part of the goal is to empower women and let them decide how to spend the money. To try to mitigate this obstacle, staff give a lot of counselling to the families so that they know what the money is for and that decisions should be taken jointly. The SBCC activities are also reflective of this, and include strong messaging emphasising the purpose of the cash transfers to support mother and child nutrition and health.
- Cash recipients need a mobile phone in order to register, so this assumes that beneficiaries have access to a mobile phone (although they are provided with a SIM).
- A number of cash recipients had their PINs stolen through a phone scam (they were

39 CCT PDM Report, Round 5. World Vision, September 2018.

contacted by scammers and asked to disclose their PIN), and lost money from their cash accounts. After this incident, World Vision conducted intensive fraud sensitisation sessions with cash recipients to increase their awareness of this issue and to remind them not to disclose their PIN. There have been no new reports of stolen PINs since these fraud sensitisation sessions began.

- The establishment of the mobile cash system has been bureaucratic, and many cash recipients have faced long waits between enrolment and their first payment. For example, many women mentioned only receiving the money when in their third trimester (around seven months), and several women even said that they didn't start receiving cash until after they gave birth.

Conditions for receiving cash assistance

As mentioned previously, receipt of cash transfers are conditional upon attendance at ANC,⁴⁰ PNC,⁴¹ and GMP sessions,⁴² as well as SBCC sessions.⁴³ These conditions were recommended by USAID in order to build on the pilot TMRI study, which found that cash in conjunction with behaviour change activities significantly reduced stunting in targeted populations. However, it should be noted that the SBCC activities employed by Nobo Jatra were less intensive than those conducted by the TMRI study. The level to which differing levels of SBCC activities affect nutrition outcomes has not been studied.

When prompted, none of the women involved in this study mentioned that they found it difficult to meet the conditions for receiving cash assistance. Health centre staff said that since these sessions can be performed in community clinics, and that they also send health workers to communities to conduct these check-ups, travel to clinics and access to these sessions has not been an issue. This was backed up by World Vision staff, who said that very few of the women in the programme were unable to meet the conditions, since clinics are usually within two or three kilometres of people's houses. Staff also explained that there was room for flexibility: if a mother missed sessions for a non-emergency reason they won't be paid that month, but they are still eligible to receive the full fifteen payments if they attend future sessions. The only time a woman is removed from the eligibility list is if she moves out of the region. The drop-out rate of the programme is also very low: as of April 2019 it was only 6.72%.

In addition to the GMP sessions, SBCC initiatives were incorporated into the cash transfer project in a variety of ways, including "courtyard" sessions, household visits, COEL bangles and Mobile Alliance for Maternal Action (MAMA) phone messages. Almost all of the mothers had attended "courtyard" sessions, which were social and behaviour change education sessions delivered by World Vision community nutrition facilitators. These often took place in a communal courtyard, and all women in the community were free to attend. The sessions

40 Antenatal care (ANC), involves maternal visits to a medical health professional prior to the birth of a baby, in order to check the health of the mother and unborn baby, as well as to promote a healthy lifestyle that will benefit both.

41 Postnatal care (PNC), involves healthcare check-ups for both the mother and newborn baby in the first six weeks after birth. The purpose of the visits is to monitor the health of the mother and baby, and to promote practices that will support the health of both (such as exclusive breastfeeding).

42 Growth monitoring and promotion (GMP) is an activity that monitors the growth of a child (for example, their weight and height), and assesses the growth of that child against expected growth for the child's age range. It also involves an element of communication with the caregiver about the results of these measurements, and what they mean in terms of caregiving practices to improve the child's health. GMP sessions are considered a prevention strategy for malnutrition.

43 In general, social and behavioural change communication (SBCC) is the strategic use of communication to promote behaviours and practices that result in positive health outcomes for individuals or communities. SBCC can take multiple different forms, including (but not limited to) classroom-based activities, digital messages, printed materials, and radio messages.

focussed on nutrition advice, cooking demonstrations, hygiene messages and health messages. Some of the women also mentioned attending gender sessions and agricultural sessions. The women were particularly positive about the courtyard sessions as a way to receive health and nutrition information. The mid-term evaluation of the programme praised the courtyard sessions as an effective way to raise awareness on health, hygiene and nutrition, and found them to be engaging and well taught by the community facilitators.⁴⁴ One of the only downsides mentioned by programme staff was that this type of SBCC is resource-intensive and requires well-trained facilitators.

Most of the women had also either received SMS or voicemail messages with nutrition and health advice (MAMA messages) or had received the COEL bangles, which are bracelets that are programmed to deliver audio messages aligned to the gestation cycle on average twice per week. In all of the focus groups, most women agreed that these messages were useful and that they learned from them, although they generally said that the courtyard sessions were the most useful for teaching them health and nutrition messages. Health staff mentioned that it was useful that women could receive messages at home through the SMS messages and COEL bangles. However, some project staff were less positive about their effectiveness in the long term, because it is more difficult to engage with the messages (unlike the courtyard sessions, where topics could be discussed and practical sessions conducted on the concepts taught). Two staff members mentioned that the reason women like these strategies is because they are novelties, and that the interest in the bangles and SMS messages wears off over time.

Focus group participants and interviewees were asked which messages and advice they found the most useful and important. Some of the common responses included:

- Medical/health advice (when to see a doctor, what symptoms to look for)
- The size and frequency/timing of meals for children as it relates to their age
- Breastfeeding practices (when and how to breastfeed)
- The importance of complementary feeding at six months
- What to eat during pregnancy and other guidance for pregnancy
- What foods are nutritious, what foods to buy
- Hygiene practices (handwashing, etc.)
- Tips on how to plant household gardens

None of the interviewees or focus group participants could think of any advice that they did not find useful, and in general wanted the sessions to continue. However, there were some recommendations for the courtyard sessions:

- Use more interactive games/quizzes
- Changes to frequency (some women were happy with the frequency of the sessions at two hours every month, but some wanted it to happen twice a month)
- Using more pictures/visuals/larger screens

World Vision staff also mentioned several best practices related to the SBCC sessions, which included:

- Courtyard sessions and household visits are effective because they involve frontline staff

44 Mid-term Evaluation Report, Nobo Jatra. World Vision and Development Technicians, 2018.

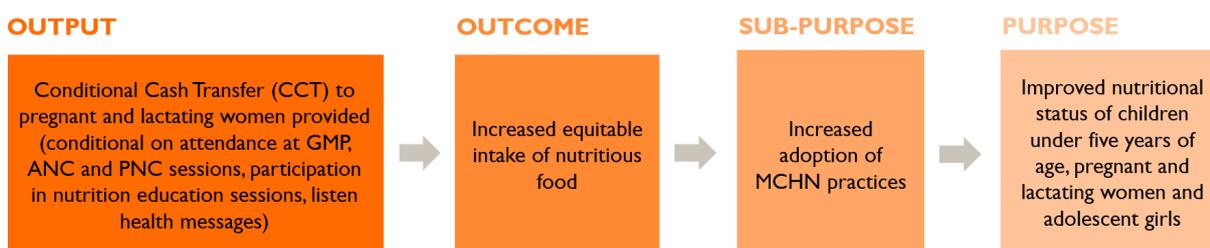
that are familiar with the community and can engage with households on a more regular and deep level. In general, strong communication with the community about project activities enables community acceptance and participation.

- In each session, they try to take a multi-sector approach to messaging (incorporating elements of WASH, nutrition and gender in one session, for example).
- Regular household visits by community nutrition facilitators ensure that hygiene and nutrition messages are being put into practice (for example, checking if latrines are clean or if they are washing vegetables properly).
- Sessions that are hands-on work particularly well, such as cooking sessions. Much of the population is illiterate, so sessions must be very visual and practical.
- COEL bangles and MAMA messaging use audio messages, again because many women are illiterate.

Project monitoring

The programme has a comprehensive and complex theory of change that maps the relationships between outputs, outcomes and impact of the programme. The primary pathway which the conditional cash transfer component contributes to is outlined below.⁴⁵

Figure 3: Nobo Jatra Theory of Change - Cash pathway



Monitoring of the cash transfer component primarily occurs via the PDM survey. In general, the PDM survey is comprehensive at measuring output-level indicators: for example, spending patterns, and attendance at GMP and SBCC sessions. It also tracks necessary process and accountability related information, such as beneficiary satisfaction and knowledge of feedback mechanisms. Although not as highly emphasised, the PDM does include some outcome-related questions. This includes questions related to dietary diversity knowledge and practice during pregnancy, health and maternal care practices, perception of changes to food intake during pregnancy and a 24-hour household dietary diversity score (HDDS).

Some general suggestions about relevant questions to the PDM include:

- **Metrics related to nutrition-related coping strategies:** This could help the project teams to identify needs and gaps that could be addressed through adjustments to programming. Frequency of employing coping mechanisms can later be analysed against other variable (such as length of time receiving cash or the number of SBCC sessions attended).
- **Include WASH items in the expenditure list:** Since WASH practices are correlated

45 Please note that in the original theory of change, there are multiple interconnected outputs and outcomes ultimately leading to the proposed purpose, however, this diagram is simplified for illustrative purposes.

with lower rates of malnutrition, it would be beneficial to track WASH-related expenditure.

- **Household observations and/or questions related to WASH behavioural practices:** With this data the team could measure whether behavioural changes related to WASH are correlated to attendance at SBCC sessions, for example.
- **Information on additional income:** Although this may be a sensitive topic, it would be useful to determine whether the level of income of a family correlates to the effectiveness of cash (for example, increased dietary diversity).
- **Other demographic data:** Information on disability, age, and household size would be useful, as this may have an impact on the effectiveness of cash.

In the future, additional data collection could be conducted, particularly at baseline, in order to better measure whether there have been outcome-level changes that have resulted specifically due to the cash programme. This includes:

- **Collecting key baseline information from a sample of participants** to be enrolled in the cash programme before they start receiving cash or attending the SBCC sessions. Ideally, this can then be collected from the same individuals near the end of their enrolment to determine whether there have been changes for these individuals as a result of receiving cash. These changes can then be measured statistically to determine if cash has led to the desired outcomes. Key metrics that could be collected longitudinally include:
 - » Dietary diversity score for households
 - » Employment of nutrition-related coping mechanisms
 - » WASH behaviour/practices
 - » Maternal health care practices
- **Monitor SAM and MAM rates more systematically** in order to identify whether the cash has had an effect on the nutritional status of children. The project does currently track the nutritional status of children whose mothers are enrolled in the programme, but in order for these numbers to have meaning, they would either have to compare this group to a demographically similar group of households who are not receiving cash, or compare to a baseline figure taken from the targeted communities.
- **Collect follow-up information on former cash recipients** a set period of time after cash ends (preferably the same sample as at baseline). Combined with regular project monitoring as well as baseline information, this data would allow the project to track whether the project has led to longer-term sustainable change. It is recommended to track the metrics outlined above for baseline information, as well as the nutritional status of the child that had been supported through the programme.

2. How does this cash-based approach affect nutrition outcomes for cash recipients?

How is cash spent?

After they are selected to become cash recipients, households with pregnant or lactating women receive counselling from World Vision staff on what the money should be used for, which is to support the health and nutrition needs for the mother and her baby. The responses and attitudes of the women who participated in the focus groups indicated that they largely followed this advice and were well aware of the purpose of the cash transfers. Their spending habits were very much in line with the objectives of the programme. In descending order of how women described using the cash assistance (from categories of items that they spent the most on to those they spent the least on), households primarily used the funds for:



Food and nutrition: Women primarily spent the money on food, and specifically on high-nutrient food that they could not grow themselves. Commonly mentioned foods in focus groups included meat, eggs and milk. In the individual interviews, when asked to list the top five food items that they bought with cash, all interviewees said that they prioritised meat and fish (see Figure 4 for breakdown of top food types mentioned). In two focus groups women also mentioned spending money on iron and calcium supplements (or foods supplemented with these minerals).



Healthcare costs: All of the focus groups mentioned spending money on medical fees and check-ups at private clinics, as well as medication. Although health care at the local community clinics is free, women explained that they were sometimes referred to the private clinics, or preferred to take their children there because the quality of care was higher.



WASH non-food items: Women in all of the focus groups indicated that they spent some cash transfer money on hygiene and sanitation items, such as soap, anti-septic, and sanitary items for their infants. Two out of the six interviewees mentioned hygiene items as one of the main things that they spent the money on. Several women also mentioned buying bottled water for their children, because it was safer to drink.

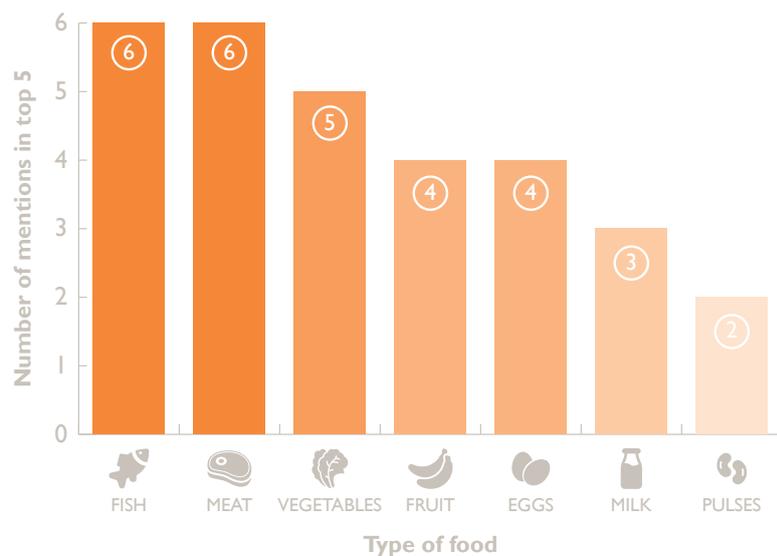


Food security strategies: In one focus group, six out of 15 participants had bought chickens with the cash, and another interviewee mentioned buying ducks as an investment so that they could have eggs at home. Other focus groups mentioned planting home vegetable gardens so that they could have sustainable sources of vegetables after the cash stopped. This strategy did not cost them money (Nobo Jatra provided community members with seeds as part of agricultural trainings), but participants suggested that it would free up cash to spend on food that they could not grow at home.



Other: None of the groups indicated that they spent money on other items, such as other household goods or transport, although one of the interviewees mentioned that she did use some money for transport to the regional health clinic. Education-related costs were also not mentioned, but this could be because many of the women did not have school-aged children, and because education for children in Bangladesh is free.

Figure 4: Top food items bought with cash, as mentioned by interviewees (n=6)



These findings are also in line with previous PDM results, which generally find that cash recipients spend the majority of money on food, followed by medical needs and then “other” expenses. For the September 2018 PDM survey, which covered 357 households who had received 15 months of cash transfers, respondents reported spending 60.7% of the money on food, 30.8% on medical needs, 4.3% on savings and 4.22% on other items.⁴⁶ The mid-term evaluation of the Nobo Jatra programme, which included three focus group discussions and four key informant interviews with cash recipients,⁴⁷ also found that households were using some cash to purchase non-food items, although the evaluation did not specify which items these were. The evaluators extrapolated from this to say that this indicated recipient’s poor understanding of the prime intention of the cash transfers.⁴⁸ However, based on the information gathered for this report, it could be argued that this is not the case, because focus group participants and interviewees consistently highlighted that the most important benefit of cash for them was the ability to support the healthcare and nutrition needs of their children. The flexibility of the cash transfers allowed them to choose how best to support these needs. Although it was also found that some money was spent on hygiene items and medical expenses, this is still very much in line with the overall objective of increasing nutrition and health for the mother and child, since improved sanitation, hygiene and access to health care facilities are crucial in the prevention of malnutrition. As explained by World Vision staff, they tell women to spend approximately 2000 taka a month on food and save 200 taka a month for medical care. Although this is a lower suggested expense than the 30% spent on medical needs indicated by the PDM, it is not necessarily to the detriment of overall programme objectives.

Who decides how to spend the cash?

Household members (including mothers, husbands and in-laws) are counselled by World Vision staff on the fact that decisions on how to spend the cash should be made collectively. Specifically, they are told that the mother should have a say, because the money is ultimately for her and the child’s benefit. All of the interviewees and women who participated in the focus groups indicated that spending decisions were taken jointly as part of a discussion between

46 CCT PDM Report, Round 5. World Vision, September 2018.

47 The mid-term evaluation involved 50 focus groups and 168 interviews across all strands of the programme.

48 Mid-term Evaluation Report, Nobo Jatra. World Vision and Development Technicians, 2018.

themselves, their husbands, and their mothers in law.⁴⁹ When asked if they would change anything about how the cash was spent, all of the respondents answered no. Mothers stated that they were happy that the cash was being spent on food and health-related costs for them and their baby (as opposed to household goods).

Interestingly, when one husband was asked about the most useful educational messages he had learned through this project, his answer was that the most important message was related to how household spending should be decided jointly between the husband and wife. He said that this had helped them to be able to buy the appropriate foods to support their children. Although this single interview is not representative, the mid-term evaluation of the programme also found increased awareness of gender issues and household decision sharing as a result of the programme's gender sensitisation sessions.⁵⁰

Has the availability of nutritional foods changed for target populations?

Although a rapid market assessment was conducted at the beginning of the programme, no market assessment had been conducted during the implementation of the programme to determine whether or not the availability and price of items in markets had changed due to an increase in household purchasing power. It was also difficult to gather informal reflections from beneficiaries on whether or not the prices and availability of foods had changed. In the areas visited, women do not visit the main markets: although they collectively decide how to spend the money, their husbands are responsible for actually purchasing food at the main markets. Only two husbands were spoken with as part of a joint interview with their wives, and they said that they had not noticed any changes in prices or availability of food. Although this is not a representative response, it is unlikely that such a small injection of cash, given to a small proportion of the population, would have an impact on large markets in the area.

However, this study found that women in three of the focus groups had seen changes at the smaller local shops near their houses. These shops held fewer items than the main markets, but women explained that the types of items available had increased since they started receiving cash. Some of the new items they mentioned included: higher-quality fruits and vegetables, bottled oil, iron-enriched salt, and snacks. The focus groups conducted in Dacope also said that prices had increased, but the focus groups conducted in Koyra said that prices had not increased noticeably. Staff suggested that this may be because the women in Koyra lived further away from their nearest local shop, and so did not visit it as often. In one focus group in Koyra, only three of the women reported visiting local shops (because of distance), and they did not record any changes in types or prices of food. Table 4 below illustrates the relative distance of the communities to shops, as well as whether that community has experienced increased food prices or quality.

49 The cash PDM also included questions relating to spending decisions, but the results were extremely varied across the five PDM surveys conducted since the beginning of the programme, and it seems as though not all options were presented during each PDM, meaning that the results are difficult to compare with this study. Joint decision making was also not an option.

50 Mid-term Evaluation Report, Nobo Jatra. World Vision and Development Technicians, 2018.

Table 4: Changes to food availability and price

Focus group	Relative distance to shop	Increased types/ quality of food	Increased food prices
Dacope community 1	Close	Yes	Yes
Dacope community 2	Close	Yes	Yes
Koyra community 1	Medium	Yes	No
Koyra community 2	Far	No	No

It is plausible that the increased purchasing power of women in these communities led to increased spending at local shops, and therefore increased prices and availability of items. However, this cannot be determined for certain, because other factors may also contribute, such as general economic development in the area, inflation and increased overall availability of specific food items in the region.

Have diets or nutrition-related coping strategies changed due to cash-based programming?

Dietary diversity and quality

Many women in the focus groups reported a change in the quality of their diets. Participants reported being able to afford more expensive and high-quality foods, and particularly high-protein foods such as eggs, meat, milk and fish. Health staff also mentioned that they had noticed that women were using the cash to buy better food, and that in general there had been a socio-economic improvement in the community.

The women also described an increase in the diversity of their diet, including more types of dishes that include a wider range of vegetables. This implies that their diets contained a wider range of micronutrients after they enrolled in the cash programme. These changes were largely attributed to the SBCC sessions, where participants learned about nutritious foods and the importance of including foods with a diverse range of nutrients. In one focus group, when asked about dietary diversity, the women began to list the different types of nutrients that they were taught about (vitamin A, iron, protein). They explained that they had learned about these different types of nutrients in the SBCC sessions, and had begun to adapt their diets accordingly. One interviewee described how she used to cook one meal for her family to eat all day, and now she cooks multiple meals with different ingredients in order to increase the nutrients they eat.

The research team also analysed PDM data related to dietary diversity.⁵¹ There was a very slight positive relationship between number of SBCC sessions attended and the respondents' dietary diversity score: however, this relationship was not statistically significant. Likewise, there was no significant relationship between their dietary diversity score and the length of time that they had received cash. Meat consumption scores were also tested (both whether it had been consumed that day and the amount that had been consumed that week, in grams), and there was no significant relationship between this and length of time receiving cash or number of SBCC sessions attended. This may be because changes to dietary diversity occur quite early

⁵¹ The PDM utilised questions modelled on a household dietary diversity survey, which involves recall of household consumption over the past 24 hours. For each respondent, the number of food groups (out of 10 groups) that they mentioning consuming in the past 24 hours was calculated, and attributed a score out of 10.

on when receiving cash (since purchasing power increases immediately), but more research is needed to verify this.

Interestingly, cash recipients' knowledge of which foods were important to eat during pregnancy⁵² was positively associated with the number of SBCC sessions attended, indicating that participants' knowledge of nutritious foods may increase the more sessions they attend. This relationship was statistically significant at a 90% confidence interval. However, when comparing the actual level of dietary diversity during pregnancy, there was no statistically significant relationship between either the length of time receiving cash or the number of SBCC sessions attended, although both of these variables had a slight positive relationship with dietary diversity during pregnancy. The lack of a significant relationship may partly be because many cash recipients are enrolled in the programme quite late into their pregnancy.

Additionally, since no longitudinal data was available to follow one cohort over a period of time, it is difficult to quantitatively determine whether or not attendance at SBCC sessions or receiving cash has led to improved dietary diversity for the individuals targeted. Although the slight positive relationships between these variables are indicative that cash and SBCC may be having an impact on dietary diversity, a further evaluation would be required in order to compare individuals over time (or to compare this cohort to a control group).

Quantity of food and frequency of meals

It was also mentioned that the quantity of food that women and their families consumed had increased because of the cash transfers, although the frequency of meals per day stayed largely the same. Only one of the women interviewed reported increasing the number of meals she and her family ate from two to three meals per day. The rest of the women said their meal frequency stayed the same with three meals per day, but stated that they ate more food at each meal. This was largely attributed to increased purchasing power that allowed them to eat more food, but also to the SBCC cooking sessions, during which women were taught how much they should be feeding their children at different ages, using bowls of different sizes to demonstrate. Several women mentioned increasing the amount of food they gave their children after attending these sessions.

Women also reported that the frequency with which they ate high-protein foods such as meat, milk and eggs increased after receiving cash. When asked how many days per week they ate particular key foods, most interviewees indicated that they ate most foods daily. The least commonly consumed foods were milk and meat, as indicated in Figure 5. However, it should be noted that in one region⁵³ (where four interviews were conducted), milk was not readily available, as there were not as many cows in that area. For meat, in the focus groups and interviews many women explained that they only ate it on one day per week, compared to about once per month when not receiving cash. The results from our small (and not representative) sample show a relatively similar pattern to an analysis of the latest PDM results, which asked respondents to list whether they had eaten particular foods in the past 24 hours (see Figure 6).

52 For both this metric and the actual dietary diversity during pregnancy, a score out of 8 was calculated depending on how many foods a respondent listed.

53 Koyra sub-district.

Figure 5: How many days per week interviewees consumed specific foods (case study interviews, n=6)⁵⁴

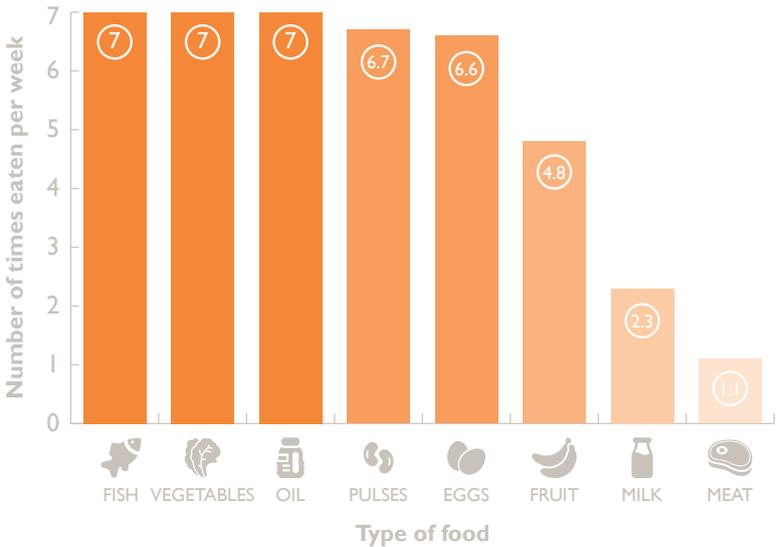
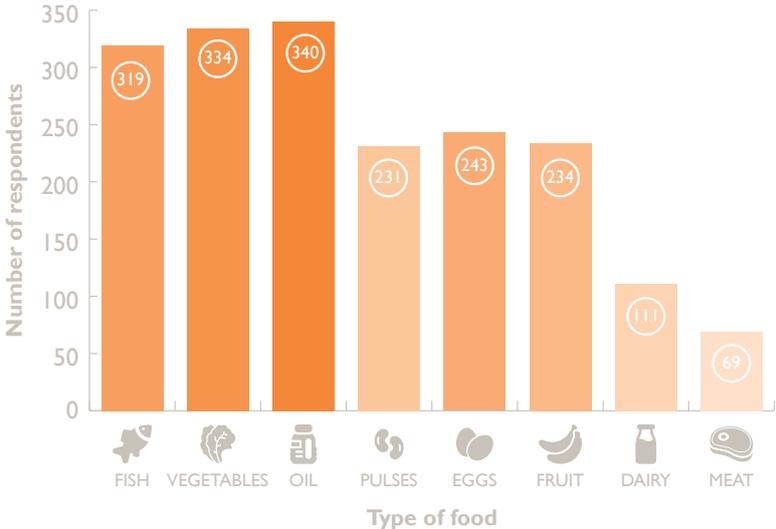


Figure 6: Number of respondents who mentioned consuming specific foods in the past 24 hours (PDM round seven, n=340)



Differences in nutrition between boys and girls

One of the areas of interest for this study was whether boys and girls face different nutritional challenges, and whether differences in feeding practices lead to higher or lower rates of malnutrition for boys or girls. All of the focus group participants and interviewees noted that there was no difference between boys and girls in terms of nutritional challenges, and that they made sure to feed their children in the same way, regardless of sex. They also mentioned that this was not always the case in the past, and that there used to be some discrimination against female children, but that they had received a lot of education on this topic. This finding was corroborated by World Vision staff and government health staff, who explained that

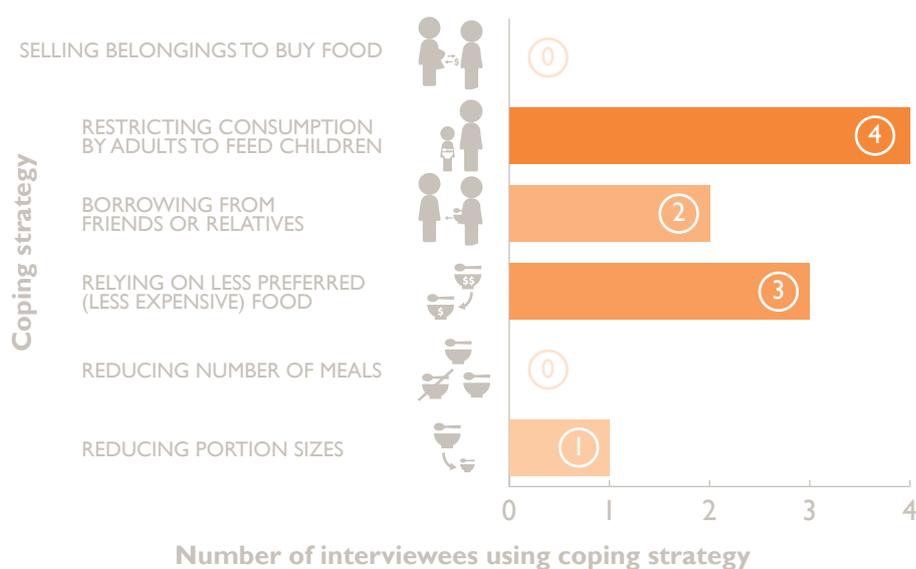
54 Interviewees were asked how many days per week they consumed the food. The number of times it was consumed during one day (for example at one meal or at all three meals) was not factored in. This is aligned with the Nobo Jatra PDM approach.

discrimination against female children may have been an issue 10 years ago, but that thanks to a large sensitisation push from the government and NGOs, it was no longer an issue. One health worker also explained that in her community, the rates of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) among female children used to be higher than among male children approximately 10 years ago, but that now they are about the same.

Coping strategies

One of the most commonly mentioned nutrition-related coping strategies mentioned in the focus groups was taking out loans from friends and neighbours to help to afford their basic needs in the short term. Several women mentioned that without cash they would have had to take out more loans. All interviewees were explicitly asked about whether or not they had employed nutrition-related coping strategies in the past month. All six interviewees mentioned at least one of the coping strategies listed in Figure 7 below. The most common strategy was restricting the food consumption of adults to feed children. As described by one mother, it is common for mothers to not eat in order to feed their kids. “For the sake of my child, why should I eat,” she explained. The next most common coping strategy involved relying on less expensive or preferred foods, which was also mentioned in the focus groups. No interviewees mentioned reducing the number of meals or selling belongings.

Figure 7: Number of interviewees who employed coping strategies in the past month (n=6)



Challenges to sustainability of dietary changes

In one of the focus groups women were asked if they would continue these diet-related changes even once the cash had finished. They said that yes, they would try to continue with these practices, especially the behavioural practices that do not require cash. However, they said that purchasing the same quantity and quality of food would be difficult. Four women who were interviewed had already stopped receiving cash, and they described how the quality and quantity of their diet had decreased since the cash had stopped, because they could no longer afford certain high-quality (and high nutrient) foods, such as meat and milk. In one of the focus groups, where cash had ended for a large proportion of the mothers, they mentioned that some of them were having trouble affording the food that they needed for themselves and their babies.

Has there been a change in expenditure and practices related to WASH and health?

Changes to WASH expenditure and practices

Most (but not all) women in the focus groups and interviews expressed that since receiving cash they had been able to increase their expenditure on hygiene and sanitation items such as laundry soap, household cleaning products, anti-septic, hand soap, sanitary napkins, shampoo, and diapers. This increased expenditure reflected both an increase in quantity and quality of items. As mentioned previously, some of the women also bought more bottled water with the cash, particularly for their children, although they themselves continued to rely on rainwater or filtered ground water.

Interviewees and focus group participants reported changes in their hygiene and sanitation practices as a result of the SBCC initiatives. This included better hygiene when preparing food (washing vegetables, boiling water, better sanitation of cooking areas), as well as improved personal hygiene practices, such as handwashing. The mid-term evaluation of the Nobo Jatra project, which conducted household visits to verify WASH practices, also found that community members had changed their health and hygiene practices (for example, handwashing using soap and water) as a result of the SBCC WASH sessions. However, the mid-term evaluation also found that sanitation and latrine access was limited to project beneficiaries and not the wider community, and that safe drinking water was still an issue. A lack of clean drinking water was highlighted by two of the focus groups, and one group mentioned that no one in their community had access to sanitary latrines, which they considered to be a health issue. Three of the interviewees also mentioned safe water and general sanitation as a challenge, and one woman mentioned that it is the main reason for her children's illnesses.

Changes to health-related expenditure and practices

Focus groups explained that before receiving cash, they would go to the nearest community clinic, which is free. Now they go more frequently to private clinics, because they have a larger range of services (for special requirements or complications). Many women also expressed that they were more willing to pay for medical care for their child than for themselves. They explained that while they were happy to go to the community clinic for their own health issues, they preferred to bring their children to the higher-quality private health clinic (particularly for specialised services). In general, however, all of the interviewees expressed their satisfaction with the government-run community clinics that they attended, saying that they were the most useful service for their children when they were sick.

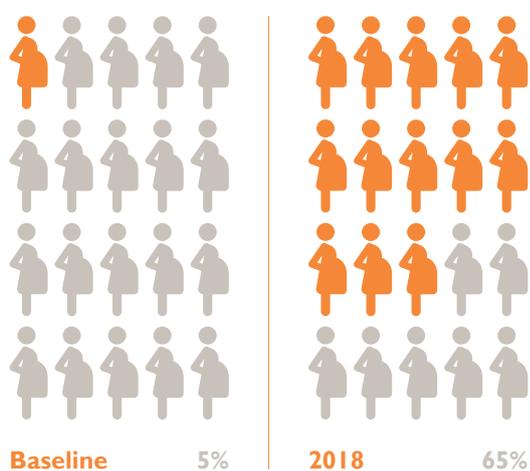
Some said that attendance and spending had actually decreased, because their children were healthier and didn't get sick as often... [others] said that they went more often, because the health education messaged made them aware that they should be visiting the doctor when they had certain symptoms.

In terms of whether or not attendance at health clinics changed since receiving cash, women gave a range of responses. Some said that the amount they went to the clinic or spent on health care hadn't changed much since receiving cash. Some said that attendance and spending had actually decreased, because their children were healthier and didn't get sick as often. Finally, some women said that they went more often, because the health education messages

they received made them aware that they should be visiting the doctor when they had certain symptoms (such as fever). Several mothers mentioned the MAMA messages as particularly useful for helping them to identify sickness symptoms. One mother mentioned that: “It is not possible to go to the doctor all the time for advice, so it is good to get the mobile messages at home.”

In one focus group, women also stated that they attended the GMP sessions because it was a condition of the cash, and that it was not something that they would have done before. However, after attending, they now see the benefit of it in terms of monitoring their child’s health, and would continue to do this even after cash stops. Three of the interviewees expressed the same sentiment, saying that they attended the GMP sessions because it was conditional, but that it turned out to be very useful. For example, one woman described how there was one month where her child did not gain weight, but because she was able to see that during the GMP visit, she was aware of the issue and fed him more. He had gained weight by the next visit. This is a similar finding to the programme’s mid-term evaluation, which found that mothers highly regarded the GMP sessions.⁵⁵

% WOMEN ATTENDING ANC AND PNC SESSIONS



Health staff interviewed in both regions stated that the cash programme had led to an increase in attendance of women at the health centres. One community clinic worker in Dacope mentioned that prior to cash, they used to have to call women five or more times to try to persuade them to attend the clinic when they were pregnant, and now they no longer have to do this. This is confirmed in the Nobo Jatra annual report, which states that the percentage of pregnant women in the targeted regions attending ANC and PNC visits increased from a baseline of 5% seeking these services to 65% attending on a regular basis. For this case study, the change in

attendance was partly attributed by health staff to being a condition of cash, but also attributed to the SBCC and health education sessions. Health staff stated that there had been an increase in attendance even beyond the cash recipients, due to the education sessions. They felt that women were more aware of when they should be attending clinics, when to seek help when they are ill, and what services are available. The mid-term evaluation had similar findings, stating that as a result of the programme, community members were more aware of the services offered by the clinic.⁵⁶

Women in one focus group also mentioned that their husbands were taking a more active role in caring for their children, including buying the right foods from markets because of the nutrition messages that their wives had relayed to them. One of the health staff explained that the increased contribution by men in the health of their children was one of the key changes that they had witnessed as a result of the programme.

55 Mid-term Evaluation Report, Nobo Jatra. World Vision and Development Technicians, 2018.

56 Ibid.

Several variables in the PDM survey were also analysed to determine whether there was a relationship between these variables and the number of SBCC sessions and GMP sessions that participants had attended. In terms of knowledge, there was a statistically significant positive association between women who were aware of their child's growth status and the number of GMP sessions they had attended (with an average of 0.5 GMP sessions for those who didn't know, versus 6.3 sessions for those who did). There was also a positive relationship between number of SBCC sessions attended and knowledge of child growth (3.5 sessions versus 5.8 sessions). However, it is worth noting that only 13 individuals did not know the growth status of their child.

In terms of health behaviours, there was a statistically significant positive association between whether the child had been vaccinated per schedule and the number of SBCC sessions attended by the mother, with an average of 4.8 sessions for those who had not vaccinated their child on schedule, and an average of six sessions for those who had. There was also a statistically significant relationship with the number of GMP sessions attended (three sessions versus 6.8 sessions). This indicates that increased attendance at these sessions was likely to mean that women had vaccinated their child per schedule. Finally, there was no significant relationship between whether a woman took a vitamin A pill and the number of SBCC or GMP sessions that she attended, although those who took the pill did attend more sessions on average. There was, however, a positive association between the number of PNC visits a woman attended and whether they took the vitamin A pill. These relationships indicate that increased exposure to behaviour change interventions and attendance at health check-ups have a positive association with increased health knowledge and practices in cash recipients. Cash itself may facilitate this, primarily because it incentivises women to attend these sessions as part of a condition to receive the cash.

Working closely with existing government services

A positive aspect of the programme is the close relationship and integration of the programme with the government health services. Government health staff were extremely positive about the initiative, saying that they felt as though their work was supported by the programme. They were also committed to continuing aspects of the programme. One health official explained that the government intends to continue some of the health education sessions after the end of the programme, and that over 100 volunteers had been trained as part of a sustainability plan.⁵⁷ The mid-term evaluation of the programme also found that the trainings for health staff and general linkages with the health system were positive.⁵⁸ The one potential improvement mentioned by staff is that they could have aligned the cash amount more closely to the amount that the government is providing, because the amount provided through Nobo Jatra is particularly high and cannot be replicated by the government. However, this may have resulted in a lower impact for those beneficiaries targeted through this programme.

57 World Vision is currently working on a sustainability plan that involves several government departments.

58 Mid-term Evaluation Report, Nobo Jatra. World Vision and Development Technicians, 2018.

Has there been a change to overall health and nutrition status in populations receiving cash?

Changes to the health of children and pregnant and lactating women

The women participating in the focus groups indicated that cash has positively influenced their and their children's health. There are three main reasons for this:



- They are able to afford the quality, nutritious food that is necessary for their growth

- They are able to pay for clinic fees at a private clinic if necessary 



- The SBCC sessions provided by community health workers (and other health and nutrition messaging they received) have enabled them to better understand about their and their children's health and nutrition needs.

All of the women interviewed listed improved health or support to health as one of the main benefits of the cash programme, for the reasons listed above. Several women in both the focus groups and interviews also explained that there was an improvement between the health of their first child and their current newborn, because during their first pregnancy they were not supported by cash and had not received nutrition training. All of the women interviewed who had two children reported changing their feeding practices due to the education sessions, and said that this led to a change in the health of their second child compared to their first (they got sick less often and less severely). One woman, who reported starting to receive cash after her child was born, said that once she started attending the nutrition sessions she began to increase the amount of food that she gave her children, because she had previously been unaware of how much the children needed. She explained that because of this, her children's health significantly improved after receiving cash. Another woman described how her own health had changed as a result of the cash programme. With her first child, she was iron deficient, but with her second pregnancy being supported by cash, she was able to afford supplements and iron-rich foods, and didn't face the same issue.

The health centre staff in both regions believed that the Nobo Jatra programme in general, including the cash component, had contributed a great deal to improving health and nutrition for mothers. One community clinic staff member said that there were now no cases of malnutrition in the local community, and in the whole Union⁵⁹ there were only five cases last month (down from between 15-20 before this programme began). Nobo Jatra staff also described that in the data they track related to child weight, the proportion of underweight children is declining. However, this data was not available for review, so these responses should be considered anecdotal. In both regional clinics in Dacope and Koyra, the head of the facilities also explained that maternal mortality and infant mortality had both lowered, as well as malnutrition rates. They attributed this improvement to the cash subsidy allowing women to access proper nutrition for their babies, as well as the education sessions teaching them how and what to feed their children. Health facility staff believed that even when the cash programme ends, these benefits will remain, because there has been a substantial degree of behaviour change that will continue even without cash. They also attributed the changes in rates of malnutrition to decreasing poverty in the region in general. This is largely due to government initiatives and increased economic opportunities (for example, alternate income-generating activities promoted by Nobo Jatra and other organisations).

59 The local administrative unit, one level below the sub-district. Dacope sub-district consists of 10 Unions.

Key Findings: Bangladesh

I. Is a cash-based approach an appropriate programme modality in the given context?

- 1. The cash-based approach employed by World Vision in south-western Bangladesh was appropriately designed** based on multiple assessments of the context (including household economy analysis, market assessments, and gender analysis) as well as previous research and pilot cash programmes. The holistic, multi-sectoral design of the programme, using multiple different interconnected activities and strategies (including cash), was considered to be an effective approach because it tackles issues of food insecurity from multiple angles. For future projects, it is recommended to consistently monitor the context throughout the life of the project (for example, tracking the effect of cash on local markets).
- 2. The cash was considered enough to meet the needs of the mother and child, but not the whole household. Decisions on future cash transfer amounts will involve trade-offs between coverage, impact and alignment with government benefits systems.** The current cash transfer amount of 2200 taka per month was based on programme budget as well as the amount provided by a previous similar programme. For future programming, World Vision should consider a better informed approach. For maximum impact, cash transfers should ideally be based on a minimum expenditure basket (MEB) approach, where the amount of cash is based on cost of monthly basic needs for an average family. Even if a cash programme is simply intended to supplement family income and not intended to cover all basic needs, the MEB amount should still be calculated (along with average monthly household income) in order to determine how much of a family's basic needs will be supplemented by the cash transfer. However, in Bangladesh there is also a strong argument for better aligning the cash transfer of future programmes to be closer to the government's existing benefits programme for pregnant and lactating women, in order to promote sustainable handover of programmes to the government and also reduce possible tensions between women receiving different benefit amounts. This would likely mean lowering the cash transfer amount.
- 3. The current cash transfer time period of fifteen months covers crucial periods of a child's early development and nutritional needs, but to maximise nutrition outcomes, mothers should be supported for the first two years of a child's life.** World Vision and WFP should also consider streamlining the enrolment and registration system if possible, so that women receive cash earlier on in their pregnancy. Currently many women faced delays in receiving cash.
- 4. The process for targeting cash recipients is highly appropriate, considering poverty levels and other aspects of household vulnerability, but some of the most vulnerable households may be missed due to government restrictions.** World Vision should continue to target/support these vulnerable groups in other ways, such as including them in education sessions.
- 5. Mobile cash transfers are logistically simpler than hard cash transfers, provide opportunities to align mobile SBCC messaging, and present fewer protection risks than hard cash transfers.** However, cash recipients may be

vulnerable to fraud through stolen PINs. World Vision had mitigated this risk after an incident of stolen PINs, through thorough training and sensitisation of cash recipients.

6. **The conditions of the cash, including SBCC sessions and GMP sessions, were appropriately aligned with the goals of the programme, because they encouraged changes to nutrition, hygiene and health-seeking behaviour.** The conditions were also found to be appropriately flexible, and drop-out rates were very low (6.72%). Women did not report difficulties in meeting the conditions of the cash transfer.
7. **Multiple SBCC methods work well, because they reinforce messages for women. “Courtyard” training sessions worked particularly well** because they were interactive, practical, and led by community-based nutrition facilitators who were familiar with the community and could follow up on and reinforce behaviour change through household visits. Women found all of the training topics useful, including hygiene, maternal and child nutrition, home gardening and health.
8. **The programme could collect additional monitoring data in order to better evidence the effect of cash or SBCC on nutrition outcomes.** This could include: adding new outcome-related metrics into the routine PDM in order to conduct better analysis, collecting more longitudinal data to analyse the effect on participants before, during and after the programme, and comparing nutritional status of children to a group who is not receiving cash.

2. How does this cash-based approach affect nutrition outcomes for cash recipients?

1. **Women largely spent their cash on nutritious food and healthcare costs. Staff provided thorough training to households on the purpose of the cash, as well as on who in the household should decide how to spend the cash.** These trainings seem to have been well received. Households decided jointly how to spend the cash (including mothers, husbands and mothers-in-law), and women were happy with how the cash was spent. Women were also happy about the flexibility offered by cash (over food or NFIs), because it allowed them greater choice to address their families’ needs in the most appropriate manner.
2. **There was no effect on price and availability of nutritious food in markets due to increase in spending power,** but there may have been a mild effect on local shops that led to increased availability of items (because of demand) and also increased prices. Regular market assessments would allow the project to more actively monitor this.
3. **Cash mixed with SBCC sessions on nutrition and maternal and child feeding has led to an increase in dietary diversity, quality and quantity of diets.** This was because of increased purchasing power as well as increased knowledge on how best to feed their children to meet their nutritional needs. Women did report moderate nutrition-related coping strategies, however, including asking for loans and restricting the food consumption of adults to feed children.
4. **Boys and girls do not face different nutritional challenges.** This was reported to have been an issue 10 years ago, but that thanks to a large sensitisation push from the government and NGOs, it is no longer an issue.

- 5. Women reported increased expenditure and practices related to WASH and health, due to a mix of increased purchasing power, increased knowledge and cash conditions.** WASH expenditure and practices increased due to both cash and increased knowledge from the SBCC sessions. Health-seeking behaviour improved as a result of GMP sessions being a condition of cash, but women also reported going to clinics more because they were more aware of when to seek help (due to increased health-related knowledge), and had an increased ability to afford private care.
- 6. The cash project has led to better health and nutrition outcomes for mothers and children.** This is largely because they are able to afford nutritious food, they can pay for healthcare costs if necessary, and SBCC sessions have enabled them to better understand about their and their children's health and nutrition needs.
- 7. Working closely with existing government services has allowed alignment with existing health infrastructure, and may help to promote future sustainability.** The programme was closely integrated with government health services. Government health staff were extremely positive about the initiative, and were also committed to continuing aspects of the programme such as the community health and nutrition education sessions.
- 8. The sustainability of outcomes related to the cash project may be an issue due to decreased ability to purchase nutritious foods once cash stops. Although behaviour change related to hygiene and nutrition will likely lead to a degree of sustainability, programming strategies could be adapted to promote alternative sources of income for cash recipients.** Women reported that the quality and quantity of their diet had decreased since the cash had stopped, because they could no longer afford certain high-quality (and high nutrient) foods. However, they also reported that the knowledge they had gained had improved their health, hygiene and nutrition practices in ways that were largely sustainable without cash (for example, handwashing or visiting the local clinic). The programme could consider including an element of training on alternative income-generating activities for cash recipients and their families, which could potentially improve economic outcomes for households after cash stops (alternative income-generating activities were an element of the Nobo Jatra project more widely, but not aimed at cash recipients specifically).

Case Study: Cash-based Programming in Juba, South Sudan

Introduction

As a result of years of armed conflict, population displacement and economic instability, levels of food insecurity and malnutrition in South Sudan are consistently high. Across the country, 6.45 million (57% of the total population) are facing crisis levels of food insecurity.⁶⁰ Global acute malnutrition (GAM) levels across the country are above the WHO emergency threshold of 15%,⁶¹ while 860 000 children are facing malnutrition and two out of five pregnant and lactating women are malnourished.⁶² According to the 2019 Humanitarian Needs Overview, nearly half a million people in the country's capital, Juba, are in need of nutrition-related aid.⁶³ World Vision has been operating in the region since 1989, providing nutrition support to vulnerable populations across the country. Below are some of the major challenges to food security in Juba, as described by World Vision staff:

- **Insecurity and conflict:** The threat of conflict and insecurity is prevalent across the country. Juba has previously been severely affected by conflict, and there has also been a large influx of internally displaced people into the city due to conflict in other areas.
- **High poverty rates:** Large proportions of the population in Juba and South Sudan face unemployment, low wages and high poverty rates. Over 80% of the population of South Sudan lives below the poverty line (less than \$1.99 per day).⁶⁴
- **High prices and volatile exchange rates:** There are high prices in markets that constantly change in response to exchange rates and depreciation of the local currency against the US dollar. Most goods and supplies are also imported from neighbouring countries, with very little produced within South Sudan, meaning that prices are consequently higher for basic goods. Since people living in the city are almost 100% dependent on markets, this leaves them vulnerable to price shocks.
- **Health system infrastructure:** Access to key medicines is sometimes an issue. There are also health staff capacity issues, with too many people in each catchment area for local clinics. Hospital care is not free.
- **WASH infrastructure:** Access to clean water is an issue. Some communities have access to boreholes, but many beneficiaries rely on water trucking, which can be expensive.
- **Lack of land to grow food:** Vulnerable households often do not have plots of land to practice agriculture, and many do not even have space for gardens. Often this is due to displacement: because of the conflict, families left their homes in other regions with better agricultural land in order to settle in the city.

60 Integrated Food Security Phase Classification Snapshot, South Sudan. 2019.

61 Nutrition cluster snapshot, South Sudan. Jan-March 2018.

62 Humanitarian Needs Overview, South Sudan. OCHA, 2019.

63 Ibid.

64 Global Poverty Working Group. World Bank, 2016.

- **Climate:** Seasonal weather patterns have resulted in changes to food availability and food security, with less food available in the dry season.
- **Family structures:** Families are large, with around seven members on average.⁶⁵ Also, a high number of women are widows, meaning that they have to support their families alone.
- **Sharing of RUTF:** Households frequently share or sell ready-to-use therapeutic foods (RUTF), which is meant to treat malnourished children. This may account for why there is not a 100% response rate among children who undergo treatment.⁶⁶

The Juba Urban Cash Project is a cash transfer and capacity building project implemented by World Vision South Sudan in partnership with the World Food Programme.⁶⁷ The project began as a pilot in 2016, and is currently in its fourth phase. The overall objective of the programme is to “strengthen the resilience of the community through creating sustainable knowledge and skills that will improve the livelihood and economic status of vulnerable urban populations in Juba.” It aims to do this through two main activities:

1. Conditional cash transfers to the most vulnerable households to improve their purchasing power for purchasing basic goods and services (particularly food).
2. Capacity building through training programmes that increase the knowledge of vulnerable individuals on health, WASH/hygiene, nutrition, food security and livelihoods, entrepreneurship and marketing skills (in order to build future resilience).⁶⁸

The cash transfers for all phases of the programme have involved six months of monthly unrestricted transfers, conditional on attendance at monthly training sessions. The cash transfer amount is 45 USD, and this amount varies in South Sudanese Pounds (SSP) depending on fluctuations in the exchange rate. The programme targets various vulnerable households, and approximately 30% of the beneficiaries of cash assistance are identified through nutrition services. This means that a large proportion of beneficiaries are women with children under five who have been identified as malnourished.⁶⁹ The focus of this case study is primarily on the effect of the programme’s cash transfers and capacity building activities on the nutritional outcomes for this particular demographic (women with children under five, and their families), although some data relating to the wider programme has also been reviewed and incorporated into the findings.

CASH TRANSFERS



45 USD



6 months



30% of recipients have malnourished children under 5

30 DAYS OF 2-HOUR TRAININGS ON:



Health



Nutrition



Home gardening



Protection



WASH



Business skills

65 The Juba Urban Cash Project PDM listed both the average family size and average household size as approximately seven people. This figure is the same as the ACAPS 2015 country profile for South Sudan, although government estimates place the figure closer to six.

66 The average cure rate is 91% in the therapeutic feeding programme and 88% in the targeted supplementary feeding programme in Juba.

67 Juba Urban Cash Project Proposal. World Vision, 2016.

68 Juba Urban Cash Project Annual Report. World Vision, 2017.

69 The programme also targets pregnant and lactating women identified at community level.

Methodology

For this case study, four health clinics were visited in different neighbourhoods within Juba and one focus group discussion was conducted in each area with women who had been part of the cash transfer project. In total, 31 women participated in the four focus groups. All of these women had been enrolled in the cash project because they had children who were malnourished, and all of them had stopped receiving cash the previous month. Each discussion lasted approximately an hour, and were conducted with one researcher and several facilitators/translators from World Vision.

Five one-on-one structured interviews were also conducted,⁷⁰ three of which involved women who had also participated in the focus groups. The other two interviewees had been enrolled in the 2017 phase of the programme. See Table 5 for an overview of the demographic characteristics of the interviewees.

The research visit also included interviews with one government health staff member and three World Vision nutrition staff members who were based in the clinics. Four other World Vision project staff were also interviewed.

Table 5: Demographic Characteristics of Interviewees (South Sudan)

Characteristic	Number
# of interviews conducted	5 women
Average age	28
Average household size	12.4 (7.2 if excluding additional adults besides the mother and father)
Average # adults in household	7.2
Average # children in household	5.2
Average # children under 5	2.2
# of households with someone over age 60	3
# of households with a disabled family member	4
# of interviewees who had stopped receiving cash transfers	5
Average household income (excluding cash transfers) ⁷¹	10,000 SSP

Limitations

Given the narrow scope, agreed upon methodology and time allocation of this study, visits to all areas covered by the programme was not possible. Conducting household visits was also not part of the intended design. The scope of the study also meant that a larger survey could not be conducted to collect additional quantitative data, although relevant PDM data was reviewed.

⁷⁰ See interview guide in Annex 2.

⁷¹ The women interviewed mentioned that they did not know what their husbands made, and that the amount of money that they shared with them was inconsistent (one said only 500 SSP a month). One of the focus groups mentioned that their husbands were soldiers and were not well paid, and were also not paid regularly. In two of the focus groups, the majority of women who participated did not have husbands or were widows.

I. Is a cash-based approach an appropriate programme modality in the given context?

Context analysis and design

Numerous assessments have been conducted by World Vision and other organisations relating to food security, nutrition and market analyses for Juba. Staff explained that they used these assessments to inform their programming during the pilot. This current phase of the cash programme also builds on the findings and recommendations from the previous phase, for which there was an evaluation conducted in 2017. Other research, such as a case study commissioned by WFP to explore cash programming over the use of food distributions in Juba, were also considered in the design of this project.⁷²

Cash transfer amount

The cash transfer amount for the project is 45 USD per month, although the amount in SSP fluctuates because of the volatile exchange rate. This amount was chosen to cover half of the monthly South Sudanese minimum wage rates (0.5 USD per day) for six people, which is the average household size according to government statistics.⁷³ However, several staff said that the average family size is higher than six amongst cash recipients (7.3 according to the latest PDM survey), so this amount is not enough for all families. According to the project's Phase I evaluation, the project assumes that beneficiaries are earning additional income, which is why it covers less than half the cost of a household's basic food needs.⁷⁴ The project is also considering moving towards an MEB approach, which would likely be more generous. Although it would still only be aimed at addressing "gaps" and not covering all household needs, an MEB approach would be a more informed method of determining the cost of nutrition, health and hygiene needs of an average family.

However, it must be noted that the MEB method likely would not estimate the cost of establishing a small business, which is an activity currently encouraged by the programme. If this continues to be a project goal, an additional stipend to support women to establish businesses should be considered. During the focus groups, several women mentioned that they were expecting to receive a stipend at the end of the cash period to help them to establish their businesses, and were disappointed that this wasn't part of their assistance. This may be partly because World Vision is implementing different types of cash projects in Juba, and beneficiaries might confuse these different programmes. Although World Vision does conduct recurring information sessions about cash entitlement and conditions of the project, staff should be aware about this potential for confusion and make sure to cross-check that participants fully understand all communication regarding the cash entitlement.

Finally, all of the women consulted for this study indicated that the cash was not enough to meet their and their families' basic needs. Many explained that this was because they had large families. Among the women interviewed, the average nuclear family size was 7.2, with an average of 5.2 children. With this family size, the cash transfer was not enough to meet even the

72 Cash-based programming to address hunger in conflict-affected South Sudan: A case study. WV, 2016.

73 Juba Urban Cash Project Proposal. World Vision, 2016.

74 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

monthly food needs of the family. However, many women said that cash was still useful in the short term, and it also allowed them to start businesses so that they could earn income in the longer term. Women recommended that the cash amount be increased, and described some of the needs that they felt were unmet, including:

- Food for whole family and higher-cost foods
- School fees and school uniforms
- Clothes for children
- Medical expenses

Cash transfer period

When asked why the length of six months was chosen for the cash transfer period, staff said that the decision was not based on particular evidence about the efficacy of this length of programme, but rather because they wanted to increase coverage. They decided to give money for a short time period but to more people, rather than to fewer people for a longer time period. Therefore, the project potentially trades off a higher impact for a greater reach. Generally, the cash recipients involved in this study wanted to increase the length of time that they received cash, because they felt that six months is not enough time for their situation to significantly improve. In future projects, also consulting with in-country cash working groups to validate alignment in cash transfer period recommendations would be advisable.

Targeting of cash recipients

The first phase of the Juba Urban Cash Project started in 2016 and targeted 7000 households (with over 42 000 beneficiaries) in urban and peri-urban areas in Juba (excluding refugee camps in the city).⁷⁵ The targeted vulnerable groups for this project are highly appropriate and include:

- Pregnant women and women with malnourished children under 5
- Low income families
- Elderly people
- People with disabilities
- People with chronic illnesses

Some of these beneficiaries were targeted via community assessments and household visits, using a vulnerability assessment tool, and about 30% of the beneficiaries were identified through nutrition services. Since there is a large focus on women with malnourished children, pregnant and lactating women, and female-headed households, the majority of the beneficiaries are women. One staff member said that they target women rather than men because there is a perception that they are more responsible and will spend it on the family. In general, the targeting process is very appropriate, using clear and relevant criteria to target vulnerable community members.

One issue with beneficiary targeting identified by staff was that women who are eligible for cash are not identified on a rolling basis. Rather, there is a window of registration, during which all women with malnourished children who attend a clinic are enrolled in the cash programme.

75 Juba Urban Cash Project Annual Report. World Vision, 2017.

Any women with malnourished children attending the clinic after that registration period will not be eligible. This is due to budget limitations as well as the structure of the project, where once a cohort is registered they have to undergo training in five modules for six months before the next group is enrolled into the project. However, World Vision nutrition staff described that there was tension between women who received cash and women who did not receive it. They suggested that the registration and enrolment period should be ongoing. A number of cash recipients also suggested that the cash programme and training should be expanded to include more women, because there are women who aren't getting cash at the moment. One woman explained that: "Others have not had the same opportunities as us, and they should."

Another related issue was that the mothers selected for the next phase of the programme were registered in October 2018, which is when their children were identified as malnourished and began treatment. However, these women did not start receiving cash until April 2019, six months after registration and long after their children had been discharged from the treatment programme. According to staff, the delay was due to logistical challenges associated with the payment system. However, nutrition staff explained that these women's circumstances may have changed in that period, and in the meantime many more women with malnourished children have needed support. Project staff justified that the cash would still be relevant to the target recipients, because these families have high food insecurity as well as children who are likely to be malnourished again. However, in the future, World Vision and WFP should seek to improve the registration system to increase its timeliness.

Cash-in-hand

The programme decided on cash-in-hand distributions rather than vouchers (a type of cash transfer modality in which vouchers are redeemed for specific quantities/values of pre-determined food items). Staff explained that while vouchers might be appropriate in areas with higher security risks and where markets are less functioning, in Juba the markets are large and highly functioning, so cash-in-hand provides the most flexible option. With direct cash, beneficiaries are ideally able to spend the money in a way that best helps them to meet their needs. For example, women in the focus groups said that they preferred cash over food or NFIs, because it gave them a choice of what to buy and allowed them to invest in their businesses.

The Juba Urban Cash Project uses biometric registration, whereby cash recipient's fingerprints are recorded and registered to an account held by the financial service provider supporting the cash transfers. When cash recipients come to collect their cash at a distribution point set up once a month, cash project staff check their fingerprints and release the cash to them.

This cash-in-hand modality may sometimes lead to protection issues, however, because cash recipients are more vulnerable to pickpocketing or robbery. Women in one of the focus groups in Juba reported being robbed outside of the cash distribution centre, and 4.2% of respondents to the latest PDM survey indicated that they did not feel safe leaving distribution points because of this.⁷⁶ Staff noted they were aware of this issue and have been taking mitigating measures to address this protection concern, such as reminding women to hide their money, not to walk alone and not to tell anyone about the time/place of the cash distribution.

Despite some of the limitations of cash-in-hand, mobile cash transfers and bank transfers are unlikely to be appropriate modalities in Juba at the moment, as they require a level of financial

76 Juba Urban Cash Project PDM Report, Phase III. World Vision, February 2019.

infrastructure in the country as well as for beneficiaries to meet certain preconditions (such as owning a phone or having a bank account). The high poverty rates and lack of necessary infrastructure means that these methods of transferring cash are not currently viable.

Conditions for receiving cash assistance

The condition for receiving cash is that recipients attend monthly training sessions, conducted by specialised trainers and World Vision staff in designated local training centres, usually a school, church or health centre building. Cash recipients or a designated member of their household must attend five days of two-hour trainings in a month, every month. By the end of the programme the cash recipient will have attended a minimum of 30 days of training.⁷⁷ The trainings focus on a variety of topics, including:

- Home gardening
- Hygiene/health
- Nutrition
- Protection
- Business Skills

All of the women who participated in the focus groups had attended these training sessions, and none of the women mentioned having difficulties getting to or attending the training; many of them lived close to the training centre, although a few had to use transport to attend. According to staff, women usually lived near the training centres (within a 5-10 minute walk), and did not generally face any challenges attending the trainings. However, an analysis of the project PDM revealed a positive association between the length of time it took to travel to the distribution centres and the amount of money spent on travel costs. It is therefore important for the project to keep trainings as close as possible to where people live, because this will minimise the amount that the cash transfer is spent on transportation.

Two interviewees mentioned missing sessions due to illness or other emergencies, and mentioned that they missed the month's pay because of that. Also, the evaluation of the first phase of the project found that some women did have challenges travelling to the training centres,⁷⁸ and the PDM report of the third phase of the project reported that a high proportion of the cash recipients (28.9% out of over 700 respondents) had missed a payment.⁷⁹ World Vision staff did indicate that they conducted a "mop-up" training targeted at cash recipients who had missed sessions, so that they were able to receive the missed payment. They also indicated that part of the reason for missed payments was the unstable nature of life in Juba, where beneficiaries frequently move locations.

All of the women were positive about the trainings, a finding that is aligned with evaluation findings from the first phase of the project.⁸⁰ When asked about which advice and messages they found most important, the focus groups mentioned the following:

- **Hygiene:** Handwashing, cleaning the house, washing food, washing hands and breasts

77 Juba Urban Cash Project Proposal. World Vision, 2016.

78 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

79 Juba Urban Cash Project PDM Report, Phase III. World Vision, February 2019.

80 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

before breastfeeding, making sure toilets were not near a water source, burying waste.

- **Nutrition:** Nutritious foods, how to cook diverse meals, what to feed their child.
- **Business skills:** How to establish a small business, basic marketing skills.
- **Household gardening:** How to plant small things in their yard/kitchen.

MOST USEFUL TYPES OF MESSAGES

-  **WASH/hygiene**
-  **Nutrition**
-  **Home gardening**
-  **Business skills**

Hygiene-related messages were mentioned the most as being useful, followed by nutrition and business skills. Interestingly, none of the women mentioned the protection module, which covers topics such as child marriage and gender-based violence, as among the most important trainings, and none mentioned any examples of how this training was applicable to them. However, these are also sensitive topics. None of the women had criticisms about the training content, and many women stated that everything that they had learned had been useful.

Both cash recipients and staff mentioned several best practices that worked well when conducting the trainings. These included:

- Best practices mentioned by cash recipients:
 - » Face-to-face training works well.
 - » The teaching style is good, trainers explained things slowly and clearly and gave the opportunity to ask questions.
 - » The training content includes practical things that they can easily apply at home.
 - » It was all new information, and therefore engaging.
 - » Trainings were not held far from where the participants lived.
- Best practices mentioned by World Vision staff members:
 - » The topics are relevant and appropriate to the context. Topics were chosen based on a needs assessment in the targeted communities to understand the most relevant content for these communities.
 - » Since the population is largely illiterate, they rely on interactive practices, including techniques like singing and dancing.
 - » Synergies between the health centres and the project has been important. There is a convergence in key nutrition and hygiene messaging, for example, and women hear the same messaging from different sources.
 - » A mother-to-mother support group has been established. Individuals selected are trained on hygiene and malnutrition, and then train other women within their community. Staff explained that for some women, messages are better received when they come from other women they know.

In addition, cash recipients and World Vision staff mentioned several recommendations for conducting trainings. These included:

- Recommendations from cash recipients:
 - » More women-led trainings (one group mentioned none of their instructors were women, and that they would like more female trainers).

- » They would like more trainings, for at least another two months.
- » Five days of training is not enough, particularly for the business skills training. There should be more training, for longer.
- » Some people learn faster than others, so the trainings could be tailored for different abilities.
- Recommendations from staff:
 - » Most staff said that the core subjects were well-covered, but some suggested additional topics such as money management and peacebuilding.
 - » The type of Arabic spoken in Juba doesn't have a written form, so it can be challenging when preparing materials.
 - » Juba is a multicultural city, and women speak different languages. There is sometimes a need for interpreters, which can make facilitation challenging.
 - » In the protection module, some of the practices that they are trying to change (relating to child protection and early marriage) go against ingrained cultural norms. Although there have been no issues to date, this module is particularly sensitive and should be treated sensitively.

Project monitoring

The programme has a well-structured and relevant logframe that outlines clear outcomes, outputs and indicators. The overarching goal of the current phase of the programme is “to contribute to improved food security and nutrition status of 15 000 households in Juba by Dec, 2019.” Two outcomes under this goal are related to the two main cash project activities (cash transfers and training sessions), while the third is related to overall project accountability to beneficiaries. These outcomes are:

1. Improved access to food through provision of conditional cash transfer for vulnerable households.
2. Enhanced beneficiary household capacities through behaviour change, communications and skills development.
3. Improved capacity for humanitarian accountability and protection.

Project monitoring is primarily conducted through the PDM survey, which is comprehensive in process-related questions focussed on beneficiary safety, satisfaction with services and knowledge of feedback mechanisms. Questions related to project effect on nutrition outcomes include measuring dietary diversity through a seven-day food consumption score (FCS), perceived nutrition impact, number of meals consumed, and questions about coping strategies. Some questions that the South Sudan team may wish to consider including are:

1. **Tracking attendance at training sessions:** It would be useful for the PDM to track how many and which type of training sessions respondents have attended, or if someone from their household attended in their place. This would enable analysis of whether attendance at training sessions influenced dietary diversity and other indicators related to improved nutrition. Although this information is likely recorded separately (training attendance sheets), tracking it in the PDM would improve ease of analysis.

2. **Including questions related to behavioural practices (for nutrition, health and WASH):** In order to draw links between cash and/or training sessions and improved behaviours associated with nutrition outcomes, the PDM should include questions related to nutrition knowledge/behaviours, health practices, and WASH practices.
3. Track the number and type of businesses started by participants enrolled in the programme: This would enable a deeper understanding of whether the project leads to improved livelihoods for cash recipients, and ultimately more sustainable food security.
4. Information on additional income: Although the PDM does ask about the primary source of income, it does not ask about the amount of monthly income, which would be useful to determine whether household income levels relates to cash effectiveness.
5. Other demographic data: The current PDM includes a good level of detail about demographic data. However, it is recommended to add questions on disability of household members and gender of the respondent.

In future phases, additional data collection could be conducted to better measure whether there have been outcome-level changes as a result of the cash programme. This could include:

- **Collecting key baseline information from a sample of participants** to be enrolled in the cash programme before they start receiving cash or attending training sessions. Ideally, this can then be collected from the same individuals near the end of the six months to determine whether there have been changes. Key metrics that could be collected longitudinally include:
 - » Dietary diversity score for households
 - » Employment of nutrition-related coping mechanisms
 - » WASH behaviour/practices
 - » Maternal health care practices
 - » The nutritional status of children
- **Compare SAM and MAM rates of children whose mothers are/were enrolled in the programme and those who are/were not:** This would allow the project to better identify whether cash has had an effect on the nutritional status of children. World Vision does currently track the nutritional status of children who attend their clinics, so this information could already be available. Two metrics that could be used are the nutritional status of children and the relapse rate of children who have gone through the therapeutic feeding programme (comparing a sample of children whose mothers are enrolled in the programme and those who aren't).
- **Collect follow-up information on former cash recipients:** This would occur after cash ends, using the same sample as at baseline. Combined with regular project monitoring as well as baseline information, this data would allow the project to track whether the project has led to longer-term change. Tracking the baseline metrics outlined above, as well as information about the businesses they started as a result of the business skills training (what income this provides, for example) is recommended.

2. How does this cash-based approach affect nutrition outcomes for cash recipients?

How is cash spent?

Women described a wide variety of items on which they spent their cash assistance. Although these women were targeted to receive cash because they had children who were malnourished, staff counselled women to not only spend money on food for their children, but to also invest some of the money into establishing small businesses or alternative income-generating activities, so that they could continue earning an income after cash stopped. This strategy was reflected in the focus groups, where many women explained that they spent most of their money on food and on their business. The main needs that women were using this money for included the following (in order of most to least mentioned):



Food and nutrition: All of the focus groups mentioned spending cash on food for their children. Two most commonly mentioned items in the focus groups were milk and flour. The most commonly mentioned “top five” type of items among interviewees were cereals/grains and vegetables (see Figure 8 for a breakdown of the top mentioned types of food bought with cash).



Business costs: Almost all of the women said that they spent money to establish their small business. This included buying materials and goods to sell, such as: charcoal, wheat flour for cakes, onions, oil and stones for making concrete. It also included buying infrastructure, such as cabinets to sell their wares.



Education and school fees: Almost all of the women who had children of school age mentioned that they had spent money on school fees. School is only free for children between the ages of six and 13 in South Sudan. Staff mentioned that households began receiving cash around the start of the school year, so this cost coincided with the start of the latest round of the cash programme. This was not planned as part of the project design, but rather was an unintentional result of the project.



Healthcare costs: Healthcare costs were brought up in three focus groups, and many women mentioned spending money on medicine, clinic fees and transport to clinics.



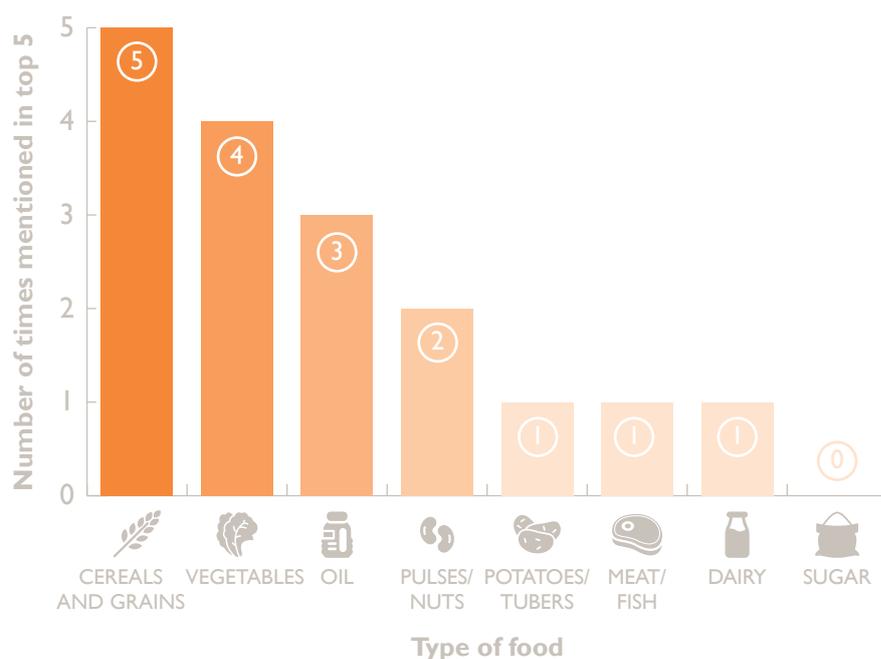
Hygiene items: In two of the groups, women mentioned buying soap with cash. However, generally hygiene items did not seem to be a high priority purchase. Nutrition staff who worked at the local health centres also explained that they distributed WASH NFIs to women whose children were undergoing treatment at their clinics, so there may have been a lower need for additional NFIs.



Other: Several women mentioned that they used the cash to buy clothing. A few women mentioned using the money to buy other household goods, such as furniture.

The diverse range of needs women addressed with this cash indicates the high general rate of poverty and unmet needs among this demographic in South Sudan. Positively, it seemed that with some exceptions, women followed the advice of project staff to spend money on food, healthcare costs and the costs of establishing a business. However, there is a risk that children’s

Figure 8: Top food items bought with cash, as mentioned by interviewees (n=5)



nutrition needs will not be met in the short term, because the money is spread quite thinly. One interviewee, for example, mentioned that she did not have enough money for food because she had to spend it on her business. This is a concern, especially since these women were chosen as beneficiaries because their children were malnourished. Several staff and cash recipients mentioned that it would be a good idea to establish a one-off fund or stipend (in addition to monthly cash payments) to be used exclusively to fund the establishment of income-generating activities. In this way, the monthly cash could be used more exclusively to address nutrition needs. In another stand of the cash programme in Juba, people are trained on vocational skills and are given a “grad kit” (for example, tailoring materials), as a way to initiate their business. According to staff, this method works well, so it could be something to be considered for this project. The project’s Phase I evaluation also highlighted that the cash amount was insufficient for women to fully establish their businesses.⁸¹

Community Adaptation and Initiative: Pooling money

Some of the women in the focus groups described about an informal strategy that they used to pool their money, which is a common practice in South Sudan. Four or five women will decide to pool most of their money every month and give the total amount to one of the group, so that she can have a larger amount that month. The next month, another woman will get the same amount. The women employed this strategy so that they had the opportunity to purchase more expensive items. This is a good strategy to allow women to invest in what they need to establish their small businesses, since the monthly cash transfer amount might not be enough for this. However, this may also mean that women won’t have as much money during other months to cover basic needs for their families, such as food and healthcare costs.

81 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

Who decides how to spend the cash?

In the focus groups, the majority of women (71%, or 22 out of 31), said that they were solely responsible for deciding how to spend their cash. Seven participants (22%) said that they made these decisions in consultation with their husbands, and two said that their mother or mother-in-law were responsible. Even for an unrepresentative sample, this is fairly similar to the results of the latest PDM survey, which indicated that 63% of women made spending decisions on their own, and 29% made decisions jointly with their husbands.⁸²

All of the women explained that they were happy with how the money was spent, because they had control over the major decisions on how to spend the cash (primarily food for their families, investing in business, and school fees). Even the one woman whose mother-in-law decided how to spend the cash said that she was happy, because her mother-in-law had convinced her that the money was to be used entirely on proper nutrition for her sick child. Individual interviewees also provided similar feedback on who decided how to spend the cash.

Has the availability of nutritional foods changed for target populations?

None of the women mentioned changes in food prices or the availability of food as a result of their increased spending power. Staff explained that since they live in a large city with a very active and functioning market, the amount of cash that women receive would not have any impact on prices or food availability in the markets. Prices and food availability do fluctuate, but this is due to other factors such as seasonal availability, inflation, volatility of the local currency, the security context in South Sudan and price fluctuations in countries from which they import food (primarily Uganda). However, these fluctuating prices were mentioned as an issue by women. Since food prices are constantly changing, women often cannot afford items that they may have been able to afford previously. This was also an issue highlighted in the Phase I evaluation, which stated that inflation and exchange rates were hindering the purchasing power of the cash transfer.⁸³

Have diets or nutrition-related coping strategies changed due to cash-based programming?

Dietary diversity and quality

All of the focus groups and interviewees mentioned a change in their diet as a result of the cash. This included an increase in quality and diversity of foods consumed, which implies an increase in the range of micronutrients that women and children are consuming. Women mentioned that since receiving cash, they started buying more expensive foods, such as meat, fish, pulses, milk, more vegetables and fruit. They also mentioned eating more food that contained protein and fat. Participants mentioned that the diversification of food was due to increased spending power, but they also said that the cooking sessions and nutrition sessions had taught them how to diversify their diets. One woman described how her health improved after she started to eat more types of food. She explained that she thought that her original poor health was because she had only been relying on one staple food.

82 Juba Urban Cash Project PDM Report, Phase III. World Vision, February 2019.

83 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

Staff members had mixed views on whether or not the trainings had led to increased dietary diversity. Several said that they thought it had, but one nutrition staff member explained that although the diversification of diets may have improved slightly, it is also difficult to get people to change their diets, and it depends on the attitudes of individual women. The PDM for the third phase of the programme indicates that 60% of respondents feel that they are eating more diverse food than before.⁸⁴ The Phase I evaluation quantitative survey also demonstrated that there had been a significant increase in dietary diversity among cash recipients, with 23% of households eating a sufficiently diverse diet, compared to only 1% at baseline. There was also an increase in “borderline” households from 17% to 51%. Poor food consumption scores declined from 78% to 27% by the end of the first phase.⁸⁵

When asked how often they eat particular types of foods per week,⁸⁶ most interviewees indicated that they only ate cereals and sugar daily. The project PDM also indicated that cash recipients ate cereals and sugar most often, although on fewer days. The least commonly consumed foods in this small sample (which is also reflected in the PDM) were potatoes/tubers, meat, and dairy. The PDM survey results indicate a relatively low dietary diversity, particularly around protein and micronutrients from vegetables. Among the women interviewed, the two who reported the least dietary diversity were those who lived in the most rural area. These women had also stopped receiving cash much earlier than the others, because they had been part of the first phase of the programme.

Women in one of the focus groups also mentioned that as a result of the training advice, they started to do complementary feeding when their child was six months old (something that they hadn't done before). Health and nutrition staff also reported an increase in the breastfeeding rates among women, due to the training sessions and advice from health clinics.

Quantity of food and frequency of meals

The focus groups also described an increase in the quantity of food and frequency of meals consumed. This aligned with the results from the PDM of the third phase of the programme, in which 81% of respondents indicated that they had acquired more food to eat, and 55.7% indicated that they were eating more often than previously.⁸⁷

In the focus groups, many women reported eating more meals per day and feeding their children more in general. For example, one woman mentioned that before receiving cash, she and her family would just drink tea in the morning and have one meal in the evening. Interviewees reported similar changes, and reported that after receiving cash the number of meals that they ate increased from an average of 1.6 per day to an average of 2.8 per day. This was not a representative sample, however. The evaluation of the first phase of the programme in 2017 also recorded increases to meal frequency, and found that people ate an average of 1.3 meals per day before cash, 1.8 during the cash transfers, and 1.6 after cash stopped.⁸⁸

Based on analysis of the PDM, no statistically significant relationship was found between food consumption scores and family size, or whether the household was female-headed. However, there was a statistically significant relationship between family size and respondents'

84 Juba Urban Cash Project PDM Report, Phase III. World Vision, February 2019.

85 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

86 The categories chosen match the categories in the PDM survey.

87 Juba Urban Cash Project PDM Report, Phase III. World Vision, February 2019.

88 Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.

perceptions of whether or not cash had allowed them to acquire more food to eat, with a larger family size decreasing the likelihood that respondents believed this. As mentioned previously, the cash amount is currently designed for a family size of six, but since most families are larger, this means that many families may not have enough. An MED approach may help to address this issue.

Finally, there was a strong negative association between respondents' age and their food consumption scores, indicating that the elderly may be more vulnerable to low dietary quantity and quality. This may be because elderly individuals are less likely to be employed or earning additional income.

Figure 9: How many days per week interviewees consumed specific foods (Case study, n=5)

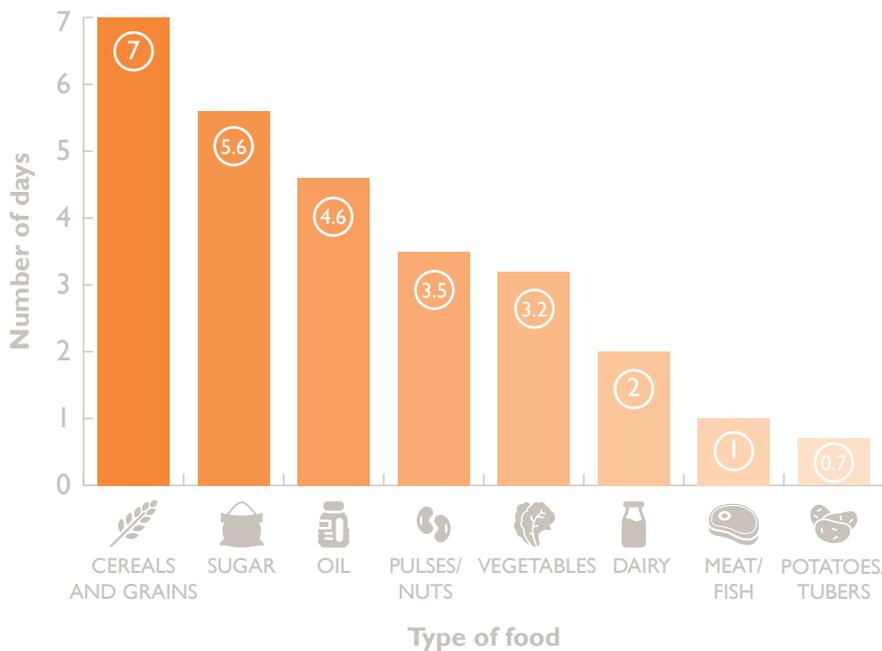
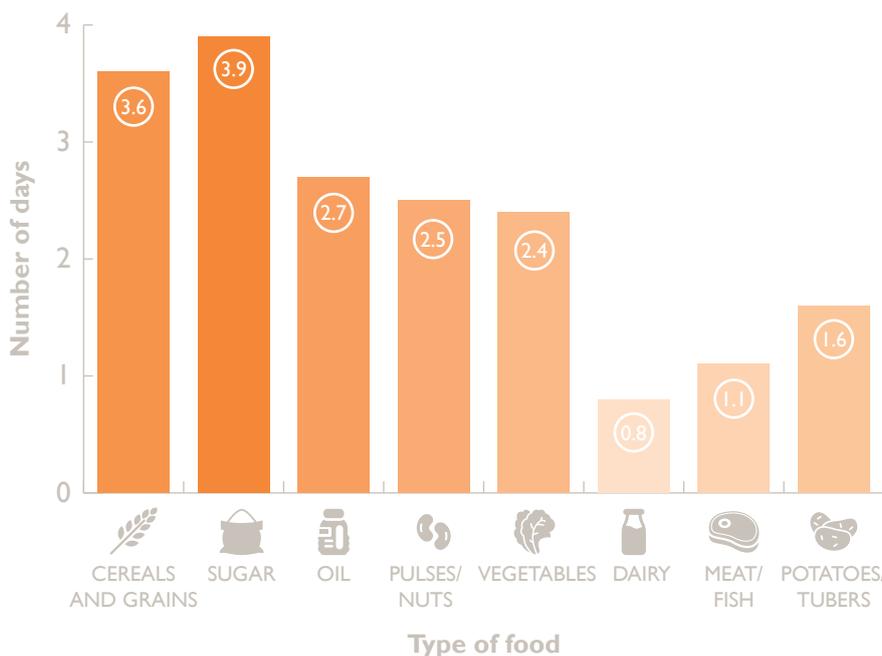


Figure 10: How many days per week interviewees consumed specific foods (PDM, n=705)



Differences in nutrition between boys and girls

Findings from this study relating to the different nutritional challenges faced by boys and girls were inconclusive and contradictory. It is clear that female children suffer higher rates of SAM and MAM in South Sudan, as explained by the nutrition programme manager, but it is unclear why exactly this is, and what household behavioural practices result in this difference. World Vision staff either stated that the reason for this discrepancy was unclear, or offered various theories for why this might be. These theories included:

- That boys and girls ate separately (although other staff members said the opposite).
- That actually the rate of malnutrition was similar between girls and boys, but women tend to bring girls to the clinic more often, because boys are considered the responsibility of their fathers.
- That more girls are born than boys, so the actual number of malnourished girls is higher, but is proportionally the same as malnourished boys.

In the focus groups and interviews, women had differing opinions over whether girls or boys faced more nutritional challenges. Most women believed that boys were more likely to get sick and were more vulnerable to malnutrition, but some believed that girls were more prone to ill-health. Two of the interviewees said that out of their children, the girls benefited more from cash because they were more in need. One woman said that her son had benefitted more because he was smaller. However, the women also stated that they did not feed boys and girls different food or in a different way.

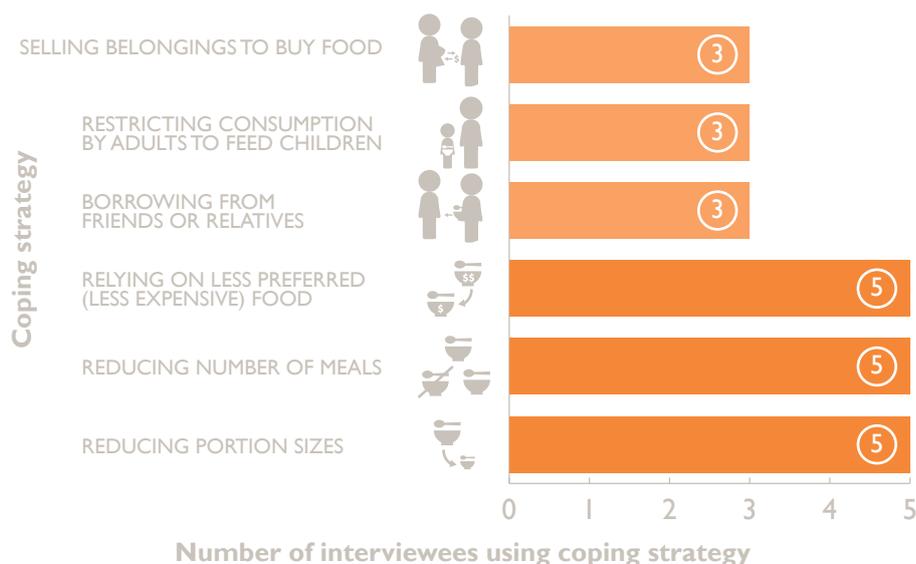
More research is needed to fully understand the gender-related issues related to malnutrition in Juba. Conducting a gender analysis focussing on understanding the differences in attitudes and feeding practices of boys and girls is recommended. Results from any study should be shared with staff, and trainings should be conducted so that staff have similar and consistent knowledge on this topic.

Coping mechanisms

In terms of coping mechanisms, many of the women in the focus groups reported relying on less expensive foods and also asking for loans from friends and neighbours. Several women also said that the cash transfers had made borrowing money easier, because lenders knew that they had the means to repay the loans.

Interviewees were also asked explicitly about coping strategies related to nutrition. All five interviewees mentioned at least three of the coping strategies listed in the graph below, and two women mentioned employing all of these strategies. The most common coping strategies related to reducing the quality and quantity of food. Three interviewees mentioned asking for loans from neighbours, but one woman said she would rather go hungry than ask for help from others. Three described selling belongings, including a water container, a bed, and bedsheets. The woman who sold her bedsheets said that she did it to get milk for her baby, because she was having trouble breastfeeding (she also reported only eating one meal per day). Overall, the coping strategies described in the interviews reveal that women are struggling post-cash to feed their families more than two meals per day.

Figure 11: Number of interviewees who employed coping strategies in the past month



The number of coping mechanisms employed in the past month was also statistically significantly associated with age, with the elderly employing more coping strategies. Additionally, participants who spent more money on transport costs were significantly more likely to employ more coping strategies, implying that paying more for transport may lessen cash recipients' ability to meet their basic needs and therefore increase the use of negative coping mechanisms. There was no association between family size and coping mechanisms.

Unsurprisingly, respondents who indicated that cash has allowed their family to have more access to medical care, more types of food, and allow their children to eat more often employed statistically significantly fewer coping mechanisms. This implies that those who are better able to meet their needs do not need to employ as many coping strategies, while those are less likely to be able to meet their needs (such as the elderly and those with additional monthly expenses) are more likely to need to resort to coping strategies.

Challenges related to sustainability

Despite some positive changes, many women mentioned that food they needed in the markets was expensive, and the money was not enough to cover food for their families for the whole month. Also, at the time of this study the cash had recently stopped for many of the women, and they explained that they were now unable to buy the same kinds of foods, or the same quantity of food. For example, the women interviewed ate 2.8 meals on average per day when they were receiving cash, but now that cash had stopped they reported having on average 1.8 meals per day. Almost all of the women said that when the cash stopped, the number of meals they had per day had dropped back to the original number.

Interestingly, several of the women from the first phase of the programme said that when cash stopped, some of their children became more picky with food. They explained that this was because they had become used to the more expensive and diverse food that they were able to afford when they were receiving cash, and now the children were not eating as much because they did not like the food they were given post-cash.

Staff suggested that in terms of sustainability, behaviour change (due to the training sessions), was the most sustainable aspect of the programme. They also mentioned that the businesses set up by women were an effort to promote sustainable sources of income (see section below).

Have food security / livelihoods strategies changed?

Small businesses / alternate income activities

Starting a business was one of the main benefits that women attributed to the cash programme. The majority of women in the focus groups (26 out of 31), had their own small businesses. The vast majority of these had been started after receiving cash, and women said they started them because of the cash and business skills training module. Previously, they had not been able to afford to start their own business. Project staff confirmed that a high percentage of the women who received cash had started businesses, although the exact number was not tracked.

Some of the common small businesses that women started included:

- Selling charcoal or firewood 
- Cement making 
- Baking cakes 
- Owning kiosks to sell basic food items 

In one of the more rural areas that was visited, one of the women mentioned that there was nowhere to do business in their area, and that they had to travel into the centre of Juba to sell items. The women in this focus group also stated that the money that they were making from their businesses was less than the cash transfer amount from World Vision. In the other focus groups, some women said that the amount that they made from their new businesses was more than or equal to the amount that they made from the cash transfers, but other women reported that it was not as much. According to the five women that interviewed (which is not a representative sample), their average monthly income from their business was 10,000 SSP (70 USD). The large majority of women said that what they were earning was not enough to meet their family's needs. Programme staff also described how price fluctuations in the markets in Juba can affect these businesses. Several women asked for continued support for their livelihoods. One woman summarised that if they received additional support it would help them to be able maintain their standard of living on their own, "without depending on others."

Household gardens

Several women in the focus groups had begun household gardens as a result of the training they had received, and two interviewees mentioned that their home gardens had been useful for supplementing their diet with vegetables when they were hungry. Several nutrition staff also mentioned the increase in home gardens as a change that had occurred because of the training sessions, during which they also distributed seeds. One of the field staff explained that in the area where he worked, which was close to the river and had more land, people had even begun selling produce that they started to grow after receiving agricultural trainings.

However, some women faced challenges establishing these gardens, including: a lack of space, animals or insects eating their vegetables, and a lack of rain. Women from the latest cash phase explained that they had not started their home gardens yet because it was still the dry season, but that they intended to plant them when the rainy season began.

Has there been a change in expenditure and practices related to WASH and health?

Nutrition staff who worked at the clinic, as well as other World Vision staff, were clear that they believed that the training sessions were the most important component in promoting behaviour change among women, complemented by the mother and child nutrition messaging they themselves do at the clinic. They said that the training had more of an impact than the cash, but that the money incentivised attendance at the training. Women, on the other hand, attributed the changes to both the cash and the training sessions.

Changes to WASH expenditure and practices

Women in the focus groups did not report an increase in the amount they spent on hygiene items, although a few mentioned using the cash to buy soap and bottled water. No other hygiene items were mentioned. Staff also mentioned that WASH NFIs were supplied to women at health centres, so this may explain the low expenditure on hygiene and sanitation items.

However, women did report changing their hygiene practices as a result of the training and awareness sessions. Hygiene practices that they changed included washing their food and dishes, washing their hands, keeping their homes cleaner, and treating their water to kill bacteria. In two focus groups women directly stated that they thought that this was why they were not getting sick as much. They said that this was because of the training, more than the cash. Two interviewees also expressed this view.

Nutrition staff who worked at the clinics, as well as the field staff, also reported general improvements in hygiene practices. This included increased handwashing at the clinics: staff explained that previously they had to remind the women to wash their hands, and now they rarely have to. They attributed this to the various messaging provided to women, including the training sessions linked to the cash project.

Changes to health-related expenditure and practices

All of the women in the interviews and many of the women in the focus groups said that they spent more money on healthcare for themselves and their children since receiving cash (including as medicine, transport and hospital fees). All interviewees specifically mentioned being able to afford this only because of the cash transfer. In two focus groups women discussed how prior to cash, when their children were sick, they wouldn't take their children to the hospital because of the associated costs, but now they do. One woman stated: "Everything is easier when you have money, you can buy medicine and pay for hospital fees." Another woman described about an incident where her child fell into a fire and was badly burned. She said that it was only because of the cash grant that she was able to afford his hospital care.

Women described the local health clinics, which are government-run and supported by NGOs, as being useful in supporting their and their child's health. Several explained that since receiving cash, they had increased their attendance at these clinics. Nutrition staff were also asked if the cash had helped to improve health-seeking behaviour among these women, and they said yes, but only initially. They said that women were motivated to come to the clinics when they were made aware that the cash project was accepting registrations, and were incentivised by the possibility of receiving cash. Staff said that this increased attendance was helpful for the team to identify malnourished children. However, they also mentioned that once the cash transfer registration period had ended, the number of women attending the clinic lowered again. They

believed that follow-up visits from the women enrolled in the project did increase slightly, but not much. One staff member recommended that the cash distribution process should be more integrated into the health system, so that every time a mother came to collect cash, for example, they could also go for a check-up at a nearby clinic.

Changes to education-related expenses

Findings from the Phase III PDM indicated that 35% of households felt they had more money for education-related expenses. The women that consulted for this case study who had school-aged children also mentioned spending more money on education and school clothing for their children. This was primarily because the start of their cash grants had coincided with the start of the new school year in South Sudan. Many women explained that they would not have been able to afford their children's school fees without this cash. They explained that supporting their children's schooling was one of the most important things that they had been able to do with the cash. "We want to invest in their education," one woman explained.

Has there been a change to overall health and nutrition status in populations receiving cash?

Changes to health of women and children under five

Generally, it appears that the additional purchasing power of cash for food and medical fees, combined with clinical treatment programmes for malnutrition and behaviour change sessions related to hygiene and nutrition, has led to improved health among mothers and children, and has helped to reduce malnutrition relapse rates among children under five.

Many women in the focus groups and all of the women that were interviewed indicated that, as a result of increased food intake and dietary diversity, their health and their children's health had improved. They explained that since they had been able to afford to feed their children properly and pay medical fees, they were no longer malnourished or sick. They also attributed some of these changes to the trainings and knowledge that they had received, especially the hygiene and nutrition trainings. Since these women had been chosen as cash recipients specifically because their children were malnourished, they noticed a drastic change in their children's health. Three of the focus groups mentioned changes in their children's behaviour as well, saying that now they were less lethargic and could play. Several women said that some of their previously malnourished children were now attending school.

However, this improvement to health cannot be fully attributed to cash, because it is also strongly linked to the care that children receive from the health clinics, which is part of World Vision's ongoing programming. When a child is admitted to a clinic with SAM or MAM, they generally spend approximately eight weeks in treatment, followed by follow-up check-ups. Outpatient treatment involves health clinics providing RUTF for mothers to feed their children at home. When nutrition and health staff at the clinics were asked whether they thought that the cash project had affected malnutrition rates in children, almost all of the staff said yes, it had resulted in lower rates of malnourishment and reduced the nutrition issues that children were facing, because mothers could buy additional food for themselves and their children. One interviewee also mentioned that the rate of relapse had decreased at his clinic among those women who received cash. However, two staff members explained that it was always hard to attribute changes in malnutrition rates to any one project, especially since malnutrition rates also varied with the season (in the dry season, for example, less food is grown or available for

households). However, these staff members noted that the cash programme had reduced the rates of food and RUTF sharing (verified through household visits), which in turn has increased the rate of responsiveness to treatment amongst children of those mothers who received cash.

Staff also attributed changes to children's health and reduced admission rates to the training and behavioural change initiatives. They described how better hygiene practices among these women led to decreased malnutrition from diarrhoea and disease, and they also said that changes to feeding practices such as increased breastfeeding and increased dietary diversity, promoted by nutrition and health trainings, had led to better overall nutrition and health.

Challenges and sustainability of health and nutrition outcomes

However, most of the women mentioned that since the cash had stopped, they were worried about having enough money to properly feed their children. They explained that now that they were not receiving money, many of the challenges they had faced before were starting again. One woman, who had been part of the first phase of the programme and whose cash had stopped a year and a half ago, had noticed her children losing weight again.

Several women stated that after starting their businesses, they were able to support their children's health through this additional income. However, many women explained that this money was not enough to afford nutritious food or pay for healthcare costs for all of their children. World Vision staff also mentioned that the time that women invest in their businesses means that they sometimes cannot be at home to feed their children. Two women described this issue as well, saying they were unable to feed their children in the middle of the day, because they had to be out at work collecting firewood or charcoal.

Key Findings: South Sudan

1. Is a cash-based approach an appropriate programme modality in the given context?

- 1. The programme design was informed by numerous assessments relating to food security, nutrition and market analyses.** This current phase of the cash programme also builds on the findings and recommendations from the previous phase.
- 2. The cash transfer amount was not considered enough to meet the basic of needs of beneficiaries, although beneficiaries noted that it helped significantly.** The cash transfer amount was based on an estimate of covering just under half of the monthly food needs of the average family size in South Sudan (based on minimum wage rates). However, the average family size of cash recipients varies, meaning not all families benefit equally. It also assumes some level of pre-existing income of cash recipients, which is not necessarily the case. The project should consider a minimum expenditure basket approach to calculate the true cost of needs related to improved nutrition outcomes. World Vision should also consider a stipend for women to establish businesses.
- 3. The six-month length of the programme is short and not based on evidence of the effectiveness of that length, but rather a desire to reach more beneficiaries.** Due to funding limitations and the high numbers of vulnerable people in Juba, decisions on the length and amount of cash provided requires a trade-off between

coverage and impact on individuals.

4. **The targeting process is appropriate, using clear and relevant criteria to target vulnerable community members. However, due to the registration process, many women are left out of the programme.** Women should ideally be identified on a rolling basis, rather than during a specific registration window. This would help to maximise reach and reduce tensions. Also, World Vision and WFP should seek to improve the registration system to increase its timeliness, as the time between registration and the start of the programme for the latest phase was over half a year.
5. **Cash-in-hand was chosen over other methods: in Juba the markets are large and highly functioning, so cash-in-hand provides the most flexible option for beneficiaries.** This may not be the case in other areas of South Sudan, where vouchers or food distributions might be more appropriate in areas with higher security risks and where markets are less functioning. Mobile cash transfers and bank transfers are unlikely to be appropriate modalities in Juba at the moment, as these require beneficiaries to meet certain preconditions (such as owning a phone or having a bank account). Cash-in-hand may sometimes lead to protection issues, however, because cash recipients are more vulnerable to pickpocketing or robbery. Staff should continue to take steps to minimise these risks and encourage cash recipients to do the same.
6. **The conditions of the cash transfer (attending behaviour change and skills training on a variety of topics) are appropriate in relation to the programme objective, and World Vision should continue to explore flexible/alternative options so that those who miss sessions can still receive payments.** Although some staff and cash recipients say that they have no issues in meeting the conditions of cash, almost a third of cash recipients have missed trainings. World Vision should continue to provide options for cash recipients to make-up missed sessions, as well as continue to allow nominated household members to attend the trainings.
7. **Training content and style were praised, especially the practical, clear and interactive nature of instruction, which is tailored for a largely illiterate audience.** Participants were open to more trainings, and staff suggested that modules on money management (savings) and peacebuilding could be included. Having more female instructors was also a key recommendation for a group largely consisting of women.
8. **The project could collect additional monitoring data in order to better evidence the effect of cash or training on nutrition outcomes.** This could include adding new outcome-related metrics into the PDM in order to conduct better analysis, collecting longitudinal data to analyse the effect on participants before, during and after the project, and comparing nutritional status of children to a group not receiving cash.

2. How does this cash-based approach affect nutrition outcomes for cash recipients?

1. **Based on advice from World Vision staff, women largely spent their cash on food and the costs of establishing a business, but they also spent a significant amount on other needs. These other needs included education and health care.** Approximately two thirds of cash recipients (women) decided how to spend the cash on their own, while approximately one third decided in conjunction with their

husbands. Women were happy with how the cash was spent, and were also happy about the flexibility offered by cash (over food or NFIs), because it allowed them greater choice.

- 2. There is a risk that children's nutrition needs will not be met in the short term, because the money is spread thinly. World Vision should consider establishing a one-off fund or stipend (in addition to monthly cash payments) to be used exclusively to fund the establishment of small businesses.** This would allow women to invest more of the monthly payments in other basic needs, such as food.
- 3. There were no changes to food prices or the availability of food at markets as a result of increased spending power.** Since cash recipients live in a large city with a very active and functioning market, the amount of cash that women receive would not have any impact on prices or food availability in the markets. Prices and food availability do fluctuate, but this is due to other factors. However, these fluctuations may hinder the purchasing power of the cash transfer.
- 4. Cash mixed with training sessions on nutrition and maternal and child feeding has led to an increase in dietary diversity, quality and quantity of diets.** This was likely because of increased purchasing power as well as increased knowledge on how best to feed their children to meet their nutritional needs. However, rates of dietary diversity are still quite low, and women reported frequent use of nutrition-related coping strategies.
- 5. Girls have higher malnutrition rates than boys in Juba, but it is unclear why this is. More research is needed to fully understand the gender-related issues related to malnutrition in South Sudan.** Conducting a further study focussing on understanding the differences in attitudes and feeding practices of boys and girls is recommended. Results from any study should be shared with staff, and trainings should be conducted so that staff have consistent knowledge on this topic.
- 6. Business skills training may increase long-term sustainability of nutrition outcomes.** The business skills training was well received by women, with the majority of women starting a small business after receiving cash. However, many women reported that the amount that they earned was still not enough to meet their families' basic needs.
- 7. Women reported increased expenditure on health and education, and improved practices related to WASH and health. This was due to a mix of increased purchasing power and increased knowledge from training sessions.** WASH practices such as handwashing increased due to increased knowledge from the training sessions, but not many women spent money on WASH items. Health-seeking behaviour improved initially due to the registration being linked to child enrolment in a treatment programme for malnutrition. However, it may have declined subsequently, although women reported increased expenditure on health. Many women reported increased spending on school fees for children.
- 8. As reported by staff, the additional purchasing power provided by cash for food and medical fees, combined with clinical treatment programmes for malnutrition and behaviour change sessions related to hygiene and nutrition, has led to improved health among mothers and children,** and has helped to reduce relapse rates of malnutrition among children under five. Cash has decreased the rates of selling and sharing RUTF, and therefore has helped to increase response rates to treatment. More research is needed on the extent and sustainability of this improvement.

Summary

Comparison of findings

The table below compares the context, the programme characteristics, and the case study findings in both countries:

Context		
Feature	Bangladesh	South Sudan
Nutrition and food security situation	High poverty and poor nutrition among rural populations has resulted in correspondingly high levels of stunting among children under five (35.5% are moderately stunted and 11.3% are severely stunted) as well as wasting (17.5%).	57% of total population facing crisis levels of food insecurity (or worse). GAM levels across the country are above the WHO emergency threshold of 15%. Nearly half a million people in the country's capital, Juba, are in need of nutrition-related aid.
Challenges for malnutrition	<ul style="list-style-type: none"> Early marriage Early birth rates High poverty rates Fragile climate Health system capacity WASH issues Infrastructure issues 	<ul style="list-style-type: none"> Insecurity and conflict High poverty rates High prices and volatile exchange rates Health system capacity Lack of WASH infrastructure Lack of land and climate issues Large family sizes Sharing/selling of RUTF
Average household size	4.5 nationally (3.8 among the women interviewed)	7 nationally (7.2 among the women interviewed)
Are markets functioning?	Yes, only a few items not available	Yes, although prices fluctuate unpredictably

Programme Characteristics		
Feature	Bangladesh	South Sudan
Type of programming	Development/resilience	The context is humanitarian, but this programme has a strong resilience/development focus
Target cash recipients	Pregnant and lactating women who are from "ultra poor" families	Women with malnourished children under five, other vulnerable individuals (chronic disease, disabled)
Monthly cash amount	\$27.50 USD (2200 taka)	\$45 USD (varying rates in SSP)
Duration	15 months	Six months
Cash modality	Mobile cash	Cash-in-hand

Conditions of cash	Attendance of GMP,ANC and PNC visits (including SBCC sessions)	Attendance at monthly training modules on health/hygiene, nutrition, WASH, protection, home gardening, business
Purpose of cash (as advised by staff)	Nutritious food and health care costs	Food and investment in small businesses

Case Study Findings

Research Question: To what extent is cash-based programming an appropriate programme modality for achieving nutrition outcomes in the given contexts?

Sub-question	Bangladesh	South Sudan
1.1 Was the programme design based on context analysis/needs assessments? If not, how is the programme adapted to the context?	<p>Yes, the programme conducted several analyses of the context (household economy analysis, market assessment, sectoral analysis, gender analysis). It was also based on findings of a previous randomised control trial which found that cash mixed with SBCC is an effective modality to improve nutrition outcomes.</p> <p>Programme length was based on the timeframe of child development, and targeting was based on household poverty levels. Mobile transfers are an effective and viable modality in the region.</p>	<p>Yes, the programme design was informed by numerous assessments relating to food security, nutrition and market analyses. This current phase of the cash programme also builds on the findings and recommendations from the previous phase.</p> <p>Programme length was decided in order to increase reach (by providing more people with fewer payments, due to the high number of people with acute needs). Targeting was based on a range of vulnerability criteria. Cash-in-hand is generally appropriate for the context.</p>
1.2 What key factors were considered when determining the amount of cash transfer in ongoing projects in South Sudan and Bangladesh? How often is this reassessed?	<p>The cash amount was based on the amount provided by the previous randomised control trial (adjusted for inflation) and also on the programme budget. Coverage versus impact were considered. The amount was not reassessed during the programme (2016-2020).</p>	<p>The cash transfer amount was based on an estimate of covering just under half of the monthly food needs of the average family size in South Sudan (based on minimum wage rates). The amount of cash assistance had increased in the most recent phases.</p>
1.3 What key nutrition services and messaging were integrated into cash-based programming? What key messages can be considered in future cash programming?	<p>Cash conditions (SBCC, growth monitoring, ANC and PNC sessions) were aligned with project goals to improve nutrition and health outcomes. Effective messages centred on health, hygiene and sanitation, nutrition (feeding practices and dietary diversity), home gardening and gender.</p>	<p>Cash conditions (training on health, hygiene, protection, business, and gardening) were aligned with project goals to increase food security and resilience. Effective messages centred on hygiene, nutrition, home gardening, and business skills.</p>

<p>1.4 What nutrition related indicators were used and monitored/evaluated? What key outcome monitoring indicators should cash-based programming consider in future programming?</p>	<p>The PDM measures output-level indicators such as spending patterns and attendance at GMP / SBCC sessions. It also includes some outcome-related indicators related to dietary diversity and health and maternal care practices. In order to further evidence impact on nutrition outcomes, the project could track longitudinal data related to:</p> <ul style="list-style-type: none"> Dietary diversity scores Coping mechanisms WASH behaviour/ practices Maternal health care practices Child nutrition status 	<p>The PDM is mostly process-related and does not track spending patterns or training attendance. However, it does track dietary diversity and coping mechanisms. In order to further evidence impact on nutrition outcomes, the project could track longitudinal data related to:</p> <ul style="list-style-type: none"> Dietary diversity scores Coping mechanisms WASH behaviour/ practices Maternal health care practices Child nutrition status Sustainability of businesses
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Research Question: What is the evidence of impact of the cash-based programming on nutrition outcomes? What factors related to cash-based programming have facilitated or hindered the achievement of nutrition outcomes?

Sub-question	Bangladesh	South Sudan
<p>2.1 For what needs are households primarily using these funds?</p>	<p>Food for themselves and children, as well as healthcare and WASH NFIs.</p>	<p>Mostly food and materials to start up a business. Also education and healthcare for children.</p>
<p>2.2 How are household spending priorities determined? By whom?</p>	<p>Money is largely spent to support the health and nutrition of the mother and child. Women and men together decide how to spend the cash.</p>	<p>Money is spent as needed on household needs (food, school fees and healthcare), but also used as an investment in establishing a business. Two thirds of women decide how to spend the cash themselves, and the rest largely decide in conjunction with their husbands.</p>
<p>2.3 Has there been a change in quality and quantity of diet, frequency of meals, protein and micronutrient intake, or coping strategies related to food consumption? Are these changes linked to improved purchasing power, and/or nutrition education/behaviour change programming?</p>	<p>Yes, there has been an increase in the quality, quantity and frequency of meals, as well as dietary diversity (including increased micronutrient and protein intake). Coping strategies are moderate and not employed frequently.</p> <p>Changes to diet are linked to both improved purchasing power as well as social and behavioural change communication strategies.</p>	<p>Yes, there has been an increase in the quality, quantity and frequency of meals, as well as dietary diversity. However, dietary diversity is still low, and protein and micronutrient intake may not be sufficient. Many coping strategies related to nutrition are frequently employed.</p> <p>Changes to diet are linked to both improved purchasing power as well as nutrition education.</p>

<p>2.4 Has there been change in the availability (quality and quantity) of nutritional food for target populations?</p>	<p>There have been no changes to availability in larger markets, but there may have been some increases to food availability and prices in local shops.</p>	<p>No, there has been no impact on food availability due to the programme, although prices of food and availability fluctuate constantly due to external factors.</p>
<p>2.5 Has there been a change in expenditure on: household health and sanitation, access to health services, uptake of treatment and preventative services?</p>	<p>Yes, there was increased expenditure related to WASH and health, due to a mix of increased purchasing power, increased knowledge and cash conditions. Health-seeking behaviour improved as a result of GMP sessions being a condition of cash, but women also reported going to clinics more because they were more aware of when to seek help and had an increased ability to afford private care.</p>	<p>Women reported increased expenditure on health but not WASH. The reported increased practices related to both WASH and health. This was due to a mix of increased purchasing power and increased knowledge from training sessions. Health-seeking behaviour improved initially due to the registration being linked to child enrolment in a treatment programme for malnutrition. However, it may have declined subsequently.</p>
<p>2.6 Has cash-based programming enabled the improvement of social safety nets to support food security (adequate nutrition) and access to essential services?</p>	<p>Yes, it has increased attendance at government maternal health services, and the government also is planning to incorporate elements of this cash programme (such as the education sessions), into their own work. Government staff felt supported by this programme, and felt it largely aligned with their own objectives.</p>	<p>This is unclear. It did increase attendance initially at clinics and lead to an increase in enrolment. However, some staff felt that aspects of the programme could be more integrated (for example, cash distributions could be linked to health check-ups).</p>
<p>2.7 Has there been a change in the rates of GAM, SAM and MAM in populations receiving cash?</p>	<p>Health outcomes for children and mothers has increased, and anecdotally the rates of GAM, SAM and MAM have decreased in target areas.</p>	<p>Cash may have helped to reduce relapse rates of malnutrition among children under five. This has been particularly because the cash has decreased the rates of selling and sharing RUTF, and therefore has helped to increase response rates to treatment.</p>
<p>2.8 What best practices for cash-based programming implementation have been identified in each country? What hindering factors have been identified?</p>	<p>See summary of overall best practices below (and summary of Bangladesh best practices and recommendations).</p>	<p>See summary of overall best practices below (and summary of South Sudan best practices and recommendations).</p>

Best Practices and Recommendations

The following global-level best practices and recommendations are based on the findings of the two case studies from Bangladesh and South Sudan. These recommendations should be considered as general guidance when designing and implementing cash-based approaches for improving nutrition outcomes for mothers and children.

I. Initial design and beneficiary targeting

I.1 In order to maximise the intended effect on nutrition outcomes, cash transfer amounts should be informed by a minimum expenditure basket (MEB) calculation, which should include an estimate of the basic needs and gaps that the cash transfer intends to cover. In order to ensure that the cash transfers are achieving the programme's intended outcomes, it is recommended to use a minimum expenditure basket (MEB) approach to inform cash transfer amounts. Even if a cash programme is simply intended to supplement household income and not intended to cover all basic needs, the MEB amount should still be calculated (along with average monthly household income) in order to determine how much of a family's basic needs will be supplemented by the cash transfer. Food security, health and hygiene needs should all be considered, as all can impact the nutritional status of women and children.

I.2 The duration of a cash-based programme depends on the ultimate objectives of the programme. For programmes seeking to improve nutrition outcomes for mothers and children, a duration of up to the first two years of a child's life may help to better support this crucial period of the child's development. Adequate nutrition for the mother during pregnancy and both the mother and child during the first two years of a child's life can substantially improve a child's nutritional status. Cash-based programmes should therefore aim to supplement nutritional needs throughout this period. However, it is common for funding limitations to require organisations to compromise between project reach, transfer amount and duration of the cash transfer period. Therefore, decisions related to these factors will depend on available funding as well as contextual factors. Additionally, more research should be conducted into whether cash programmes of varying lengths affect nutrition outcomes differently.

I.3 The type of cash transfer modality selected should be based on the local context, including functionality of markets, the financial infrastructure available and whether or not preconditions can be met by beneficiaries. In some contexts where markets are unreliable, redeemable vouchers may be appropriate. However, where markets are functioning, direct cash provides a more flexible and appropriate way for beneficiaries to meet their needs. Cash-in-hand has the benefit of being easier to use in contexts where financial infrastructure is not in place, but it may pose specific protection risks. Bank and mobile transfers can be more efficient and less risky in areas where financial infrastructure is available and beneficiaries can access bank accounts and/or phones. However, cash recipients should be sensitised to potential fraud risks. Mobile phone transfers have the added value of potentially being linked to educational messages that can be transmitted via SMS or voicemail.

I.4 Beneficiary targeting should ensure that the most vulnerable households are covered, using standard assessment criteria that takes into account income, disability, age, household size and structure, and other factors that influence

vulnerability. When there is a risk that certain vulnerable individuals will be ineligible to receive cash, or are left out of the programme for any other reason, programmes should attempt to ensure that alternate strategies of targeting these individuals are in place, such as including them in behaviour change sessions or working to strengthen local social safety nets. Beneficiary selection should also be conducted on a rolling basis in order to avoid missing segments of the target population.

2. Conditions for receiving cash transfers

2.1 Conditional cash transfers (as opposed to unconditional transfers) help to encourage nutrition outcomes by making attendance at health or education sessions a requirement for cash recipients. Cash and cash conditions may have a compounding effect on nutrition outcomes when employed in conjunction. Receiving cash can incentivise cash recipients to attend health check-ups or nutrition/WASH trainings if they are conditions of the cash transfer. In turn, these conditions encourage nutrition and hygiene-related behaviour change and improved health-seeking behaviour. Cash also allows participants to afford to put nutrition advice into practice and buy nutritious food.

2.2 Conditions to receive cash assistance should be appropriately tailored to the intended outcomes, and there should be some degree of flexibility for cash recipients to meet these conditions. For programmes intending to improve nutrition outcomes, appropriate conditions may include: nutrition, hygiene and health education sessions; health check-ups such as growth monitoring and promotion sessions; and livelihoods or alternate income-generating activities. In order to increase the likelihood that recipients can meet these conditions, an element of flexibility should be incorporated, such as make-up sessions, nominating a family member to meet the condition or delaying (but not cancelling) payments when possible. Staff should also ensure that cash recipients are appropriately consulted and briefed about the conditions, and that feedback mechanisms are in place.

3. Integrated programming strategies

3.1 Cash-based programmes can contribute to improved nutrition outcomes for mothers and children, but are most effective as part of an integrated approach that includes behaviour-change programming and is linked to social safety nets. Cash can lead to improved purchasing power, which can allow cash recipients to increase their spending on WASH items, healthcare and nutritious food. However, it is education and behaviour change communication that will enable cash recipients to improve their knowledge and practices related to WASH, health and nutrition, and make informed decisions on how to spend the cash. In addition, the access to and awareness of social safety nets and health systems is key to ensuring mother and child health. Programmes should aim to align with or strengthen these systems.

3.2 Social and behaviour change communication is a key component of cash projects aimed at improving nutrition outcomes. Multi-pronged messaging strategies should be employed, including community training sessions, messages from health workers, and digital messages where appropriate. Key education topics include: infant and child feeding, dietary diversity, WASH practices, maternal and child health, household gardening and livelihoods skills. Face-to-face community-based education works particularly well, because it allows cash recipients to engage and practice the skills that they are being trained. Facilitators should have appropriate training in leading these education sessions,

and should ideally be based in the community. This would allow them to better conduct follow-up visits to reinforce messaging and verify if the targeted knowledge and practices are being employed.

3.3 The additional purchasing power provided by cash transfers, combined with clinical treatment programmes for malnutrition and behaviour change sessions can lead to improved health outcomes among mothers and children. Cash can not only incentivise recipients to attend health sessions and allow recipients to better afford medical care, but it may also directly help to reduce negative coping mechanisms and issues such as food or RUTF sharing. In turn, this can contribute to increased child response rates to malnutrition treatment programmes. Greater attendance at growth monitoring sessions can also increase caregiver awareness of their child's nutritional status. In addition, increased spending on WASH NFIs, along with improved WASH practices, and lead to improved health due to lower rates of communicable diseases.

3.4 Continuous sensitisation and counselling for beneficiaries on how to spend their money can encourage spending patterns that are in line with improving nutrition outcomes. Strong messaging from programme staff about how to spend the cash (this may depend on the context, but should include a focus on nutritious food and healthcare) can encourage cash recipients to see cash as a means to improve their children's nutrition. If the programme has a livelihoods component, counselling on how to invest in livelihoods and alternative income-generating activities should be a focus. Spending patterns should also be systematically tracked to ensure that they are in line with programme objectives. If cash recipients have clear needs that fall outside of the project objectives, the amount of cash provided or the objectives of the project may have to be adjusted to account for this.

3.5 Cash-based projects should include strategies for promoting the sustainability of health and nutrition outcomes, since there is a risk that quantity and quality of beneficiary diets may decrease once cash stops. Although behaviour change related to hygiene and nutrition will likely lead to a degree of sustainability, additional programming strategies should be included to promote sustainability. Encouraging and supporting in improved livelihoods and income-generating activities could enable more sustainable income generation after cash ends. An additional stipend should be considered to support these activities. Additionally, local health systems and social safety nets could be strengthened in order to promote sustainability. Working closely with existing government services throughout the project can increase alignment with existing health infrastructure.

4. Monitoring, evaluation and further research

4.1 Monitoring and evaluation strategies for cash-based programmes should be set up at the design phase in order to better measure the impact of cash and cash conditions on nutrition outcomes. This should include a longitudinal baseline, endline, and post-project evaluation, if possible. PDM surveys should include questions related to the targeted output and outcome indicators, so that this may be easily analysed throughout the life of the project. A baseline, endline, and post-project evaluation should be conducted in order to determine the effect of cash during the life of the project as well as after the project is completed (to measure long-term outcomes). Indicators that should be tracked include dietary diversity, employment of nutrition-related coping mechanisms, WASH behaviour/practices, maternal health care and young child feeding practices, and child nutritional status (including SAM recovery and relapse rates). In addition, ongoing market analyses should be

conducted in order to track the purchasing power of cash recipients and make programmatic adjustments accordingly.

4.2 More research should be conducted into the gender-related aspects of cash programming, including the role of men in improving maternal and child nutrition outcomes, as well as how undernutrition may affect boys and girls differently. In programmes that tackle undernutrition, mothers and women are highly targeted since they are often the primary caregivers. However, there is some evidence that including men in gender, health and nutrition sensitisation sessions may be an enabling factor for improving overall nutrition incomes for children. More research is needed on this topic. Also, in order for cash-based projects and nutrition sensitisation sessions to maximise their effectiveness, the causes of gender differences in malnutrition among target populations need to be fully understood.

Annexes

Annex I: Sources Referenced

#	Country	Document Reviewed
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6	General	Richard de Groot, Tia Palermo, Sudhanshu Handa, Luigi Peter Ragno, Amber Peterman. Cash Transfers and Child Nutrition. Pathways and Impacts. ODI, 2017.
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9	Bangladesh	Annual results report for USAID, Fiscal Year 2018. World Vision, 2018.
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23	South Sudan	Global Poverty Working Group. World Bank, 2016.
24	South Sudan	Humanitarian Needs Overview, South Sudan. OCHA, 2019.
25	South Sudan	Integrated Food Security Phase Classification Snapshot, South Sudan. 2019.
26	South Sudan	Juba Emergency Food Security Project, Phase I: End of Project Evaluation. World Vision and Primson Management Services, 2017.
27	South Sudan	Juba Urban Cash Project Annual Report. World Vision, 2017.
28	South Sudan	Juba Urban Cash Project Annual Report. World Vision, 2017.

29	South Sudan	Juba Urban Cash Project PDM Report, Phase III. World Vision, February 2019.
30	South Sudan	Juba Urban Cash Project Proposal. World Vision, 2016.
31	South Sudan	Nutrition cluster snapshot, South Sudan. Jan-March 2018.
32	South Sudan	South Sudan Country Profile. ACAPS, 2015.

Annex 2: Data Collection Tools

Key Informant Interview Guide: Staff and partners

Length: 30-45 minutes

Target interviewees: Project leads/staff (including cash, nutrition, MEAL staff), external cash partners (if appropriate).

Guiding Research Sub-Question	Interview Question
General	Please describe your role and involvement in the cash project.
I.1 Was the programme design based on context analysis/needs assessments? If not, how is the programme adapted the context?	<p>Was a context analysis, market analysis or a needs assessment conducted to help inform this programme?</p> <p>If not, how was the programme adapted to the context? What elements of the programme design reflect this particular context?</p> <p><i>If applicable:</i> What are the pros and cons of using vouchers versus cash-in-hand versus digital cash transfers? Why was (X method) chosen for this programme?</p> <p>Can you describe the benefits and/or challenges of conditional cash transfers? <i>For example, beneficiaries must attend education sessions in order to receive cash</i></p>
I.2 What key factors were considered when determining the amount of cash transfer in ongoing projects in South Sudan, Somalia and Bangladesh? How often is this reassessed?	<p>How was the cash transfer amount determined? What factors were considered when determining this amount? <i>For example, do market assessments impact the transfer amount?</i></p> <p>How often is this amount reassessed?</p> <p>Has there been a change in food availability in markets since cash implementation (quantity, quality, type of food)?</p>

<p>I.3 What key nutrition services and messaging were integrated into cash-based programming? What key messages can be considered in future cash programming?</p>	<p>What key nutrition messages were integrated into the cash-based programme?</p> <p>What nutrition services were integrated with this programme?</p> <p>What messages/services do you think have worked well? What have not worked as well? Why?</p> <p>What messages/services do you think should be integrated into future programming?</p>
<p>I.5 What best practices for cash-based programming implementation have been identified in each country? What hindering factors have been identified?</p>	<p>In what ways do you think that cash has affected nutrition outcomes for children in the target population? Can you provide examples?</p> <p>What particular aspects of the programme do you think have worked well in helping to improve nutrition outcomes for children? Can you provide examples?</p> <p>What are some of the hindering factors that have affected the programme's ability to improve nutrition outcomes for children?</p> <p>What aspects of the programme could be improved?</p> <p>Has cash assistance had an effect on the following for beneficiaries? Why or why not? Can you provide examples?</p> <p>Household sanitation/WASH</p> <p>Access to health services</p> <p>Access to any other essential services</p>

Key Informant Interview Guide: Cash Recipients

Length: 30-45 minutes

Target demographic: Pregnant women, women with children under the age of five.

Guiding Research Sub-Question	Interview Question
Introduction	<p>Introductions (names)</p> <p>Describe purpose of the focus group/research</p> <p>Informed consent to participate</p>

Demographic questions	<ul style="list-style-type: none"> i. Gender ii. Household size/composition: How many people live in your household (adults and children)? iii. Age: How old are you? How old are the members of your household? iv. Disability: Does anyone in your household have a physical or mental disability? v. Pregnancy: Are you currently pregnant?
2.1 For what needs are households primarily using these funds?	<ul style="list-style-type: none"> 1. What is the amount of cash assistance that you receive every month? 2. Do you or your family have additional income? If so, how much? 3. In general, what kinds of things do you buy with cash assistance? 4. Please list the top five food items that you buy with cash assistance.
2.2 How are household spending priorities determined? By whom?	<ul style="list-style-type: none"> 5. Who in your household decides how the cash is spent? 6. Are you happy with how these decisions are made? Is there anything you would change about how the cash is spent?
<p>2.3a Has there been a change in quality and quantity of diet, frequency of meals, protein and micronutrient intake, or coping strategies related to food consumption?</p> <p>2.3b Are these changes linked to improved purchasing power, and/or nutrition education/behaviour change programming?</p>	<ul style="list-style-type: none"> 7. Do you think that cash assistance has led to better nutrition for your child/children? 8. How has the quality of the food you and your children eat changed since receiving cash assistance? 9. How has the quantity (amount) of the food you and your children eat changed since receiving cash assistance? 10. How many meals do you eat per day? How many did you eat before receiving cash? 11. How many days per week do you eat the following foods? <p>Bangladesh:</p> <ul style="list-style-type: none"> Meat Fish Egg Vegetables Milk Pulses Fruits Oil

South Sudan:

Cereals and grains
Potatoes/tubers
Pulses/nuts
Vegetables
Meat/fish
Dairy
Sugar
Oil

12. Do you feel that you are able to buy enough food for you and your family with this cash assistance?

13. Do you feel that you are able to meet your and your family's other basic needs with cash assistance?

Define basic needs as: The essential things you and your family use or need on a day to day basis (food, water, health care, shelter, hygiene items)

14. What challenges do you face in meeting the nutrition needs of you and your family?

15. In the past month, has your household done any of the following things because you do not have enough money for food?

- » Reducing portion sizes
- » Reducing number of meals
- » Relying on less preferred (less expensive) food
- » Borrowing from friends or relatives
- » Restricting consumption by adults to feed children
- » Selling belongings to buy food
- » Other (please elaborate)

16. Which services (in addition to cash assistance), have you found the most useful in helping you and your child to be healthy? *Give examples of types of services available in that particular region.*

17. What health/nutritional information or advice (from NGOs, other organisations) have you found the most useful? Is there any information or advice that you have not found useful? Why?

<p>2.5 Has there been a change in expenditure on: household health and sanitation, access to health services, uptake of treatment and preventative services?</p>	<p>18. Since receiving cash assistance, have you spent more, less, or the same amount of money on things related to your family's health and/or sanitation? <i>For example, household cleaning items, hygiene items, medication, travel to health clinics.</i></p> <p>19. Since receiving cash assistance, have you spent more, less, or the same amount of money on other items (other than food or health/sanitation items)? Which items?</p>
<p>2.6 Has cash-based programming enabled the improvement of social safety nets to support food security (adequate nutrition) and access to essential services?</p>	<p>20. Since receiving cash assistance, have you found it easier or harder to access government or NGO health services (or other services)? Why?</p>
<p>Overarching</p>	<p>21. Can you describe the main benefits you have seen for your children and family since receiving cash assistance?</p> <p>22. To what extent do you feel that the cash assistance has helped to improve the health of your child? How?</p> <p>23. Are you satisfied with the assistance you received? What aspects of this cash assistance would you improve?</p>

Focus Group Discussion Guide: Cash Recipients

Length: 90 minutes

Target demographic: Pregnant women, women with children under the age of five.

Guiding Research Sub-Question	Interview Question
Introduction	<p>Introductions (names)</p> <p>Describe purpose of the focus group/research</p> <p>Informed consent to participate</p>

<p>2.1 For what needs are households primarily using these funds?</p>	<ol style="list-style-type: none"> 1. What are the main items that you buy with the cash assistance from this project? For example: <ul style="list-style-type: none"> » Food » Medical/health care » Sanitation/hygiene products » Other household items » Transport » Other
<p>2.2 How are household spending priorities determined? By whom?</p>	<ol style="list-style-type: none"> 2. Who in your family decides what to buy with the cash assistance? 3. Are you happy with how these decisions are made? Is there anything you would change about how the cash is spent?
<p>2.3a Has there been a change in quality and quantity of diet, frequency of meals, protein and micronutrient intake, or coping strategies related to food consumption?</p> <p>2.3b Are these changes linked to improved purchasing power, and/or nutrition education/behaviour change programming?</p>	<ol style="list-style-type: none"> 4. How has your diet and the diet of your family changed because of the cash assistance? For example: <ul style="list-style-type: none"> » Amount of food » Quality and type of food » Frequency of meals 5. Have you attended any nutrition, health or agricultural education sessions? <ul style="list-style-type: none"> » What nutrition or health advice did you think was the most important? » Have you changed your diet or agricultural practices as a result of this advice, if so how? If no why not? 6. Have you noticed changes in your children's health or behaviour since receiving cash assistance? 7. What challenges do you face (if any) in meeting your children's nutrition needs? How do you deal with these challenges?
<p>2.4 Has there been change in the availability (quality and quantity) of nutritional food for target populations?</p>	<ol style="list-style-type: none"> 8. Has the food available in markets changed at all since you started receiving cash (amount and type of food)? 9. Has the price of food changed at all?

<p>2.5 Has there been a change in expenditure on: household health and sanitation, access to health services, uptake of treatment and preventative services?</p>	<p>10. Since receiving cash, how has your spending on household health/sanitation items changed? For example, soap, cleaning supplies, personal hygiene items.</p> <p>11. Since receiving cash, how has your spending on health services or medical treatment changed? For example, travel to the clinic, or spending money on medication.</p>
<p>2.6 Has cash-based programming enabled the improvement of social safety nets to support food security (adequate nutrition) and access to essential services?</p>	<p>12. Has the cash assistance helped you or your children to be able to access health services or other government services? How?</p>
<p>Overarching</p>	<p>13. Is the cash provided enough to help meet your family's basic needs?</p> <p>14. What basic needs have you not been able to meet through cash assistance?</p> <p><i>Define basic needs as: The essential things you and your family use or need on a day to day basis (food, water, health care, shelter, hygiene items)</i></p>
<p>Suggestions</p>	<p>15. Do you have any suggestions on how to improve cash assistance in the future?</p>

Annex 3: Terms of Reference

Case Study Title: Cash-based Programming and the implication on nutrition intervention in the Bangladesh, Somalia⁸⁹ and South Sudan Emergency Responses

Background:

Globally, malnutrition is an underlying contributor to 45% of child mortality and is a leading contributor to morbidity, which has a negative impact on the national economy and increases the burden on the health system. Cash programming provides targeted communities with resources to meet their needs, access services, and the dignity to decide how to prioritize their specific needs. Cash-based Programming (is increasingly popular in emergency projects across sectors to support social protection interventions. The assumption is that direct cash input increases household income and improves effectiveness of purchasing power; which increases food diversity and household food consumption that directly translates into nutrition

89 Somalia was dropped as a sample country during the design phase of this research.

improvement for children.

Purpose:

Learning from cash-based nutrition programming in different country contexts and systematic reviews of cash transfers in humanitarian crises reveal there is little evidence as to how cash-based approaches affect nutrition and health outcomes in emergencies. There is limited and sometimes confusing evidence about the impact of different combinations of modalities on nutritional status and on the importance of the design and implementation. This study will contribute to addressing these information gaps and contribute to the quality of cash-based programs for nutritional outcomes.

Objectives:

The objective of this work is to develop a three-country study, documenting lessons and new learning that will enhance effectiveness and efficiency of cash-based programming to address nutritional outcomes. Specifically, the case study will respond to the following key questions;

1. What **key factors were considered when determining the amount of cash transfer** in ongoing projects in South Sudan, Somalia and Bangladesh. What has worked well? What has not worked well?
2. For **what needs are households primarily using these funds?**
3. How are **household spending priorities determined? By whom?**
4. **What nutrition services and messaging were integrated as part of the projects** and what **key messages can be considered in future cash programming?**
5. What was the **proposed pathway by which the cash-based assistance project sought to address or contribute to addressing nutrition outcomes?** (Either through increasing access to nutrition specific or nutrition sensitive services)
6. What is the **evidence of impact of the cash-based programming on nutrition outcomes?** What **nutrition related indicators were used and monitored/evaluated** and what **key outcome monitoring indicators should cash-based programming projects consider in future programming**

The findings will identify learnings and recommendations for nutrition- sensitive cash-based assistance with a focus on the following outcomes;

- Increased quality and quantity of diet, frequency of meals, protein and micronutrient intake, through improved purchasing power, and nutrition education/behaviour change programming
- Increased availability of nutritional food production
- Increased expenditure on household health and sanitation, access to health services, uptake of treatment and preventative services
- Links and opportunities to work on social safety nets to support food security and adequate nutrition and access to essential services.

The learnings and recommendations of this case study will be used to develop field guidance on cash-based programming for nutrition outcomes. The learnings of this study will be shared externally through relevant working groups and publications.

Country Focus:

The study information gathering will be conducted in World Vision's South Sudan, Somalia and Bangladesh programs.

Methodology:

Desk review of project documentation – project proposals, monitoring, evaluation and monthly reports and other relevant documents.

Interviews and focus group discussion with beneficiaries and project teams as part of the field visit data collection. Where appropriate, questionnaires could be used.

A one-day workshop with relevant WV staff from Bangladesh, South Sudan, Somalia as well as WV's regional or Global Centre nutrition experts, and other partner agencies, where the consultant will present the findings of the assessment and final report.

The consultant will develop a detailed plan including methodology, timeline and other study details including time for a) secondary document reviews b) field data collection and analysis, including discussions with WV and other partners (nutrition clusters, WFP etc) c) workshop presentation plan

Deliverable:

Upon completion of the consultancy period, the following deliverables will be provided:

1. Final report including:
 1. Study overview and methodology used
 2. Summary of findings for each country, taking primary data collected and secondary data reviewed into consideration for each country
 3. Detailed findings and analysis for each country
 4. Best practices already being used by World Vision in each country, in relation to cash-based nutrition programming
 5. Recommendations for improvements to cash-based nutrition programming -country specific and overall
 6. Conclusions from the study – country specific and overall
 7. Any study tools and all raw data collected or analysed to reach the findings and recommendations. List of references / resources used in the study
 8. Recommendations for further research / study aligned with nutrition focused cash programming work.
2. Summary guidance note
 1. 2-3 page guidance note with key recommendations from the study final report
 2. Key points for consideration for field offices implementing nutrition focused cash programming work
3. Facilitate workshop / presentations to share and validate the findings with participants
 1. Presentation of findings to WV representatives from each country, along with WV Regional and Global nutrition and cash programming technical experts (in person –

location TBD, potentially Nairobi).

A preliminary report is to be prepared and shared with World Vision for comments and clarifications prior to finalization or presentation. All deliverables will be produced by the consultant, and approved by World Vision, within the time frame of the consultancy. Final report with four copies of materials and raw data in CD-ROM will be provided.

Source and information:

World Vision country program offices will share datasets and reports with the consultant. This includes:

Cash transfer project/program proposals and reports, market survey, baseline and endline data, and a summary policy brief. Nutrition specific information such as survey reports, database information, baseline documents, including a WVI CMAM dataset based information, project monitoring and evaluation reports and any household survey and a background report as available. Beneficiaries who have participated in World Vision cash-based nutrition projects will also be sources of information for this study.

Additional information provided through Inter-Clusters Working Group (ICWG) and collaboration between Global Food Security Cluster and Global Nutrition Cluster, will be collected with support from WV. Other partners, such as WFP, will also be expected to provide information.

All information shared remains the property of World Vision (or the agency providing the information) and cannot be used by the consultant for any other purposes outside of this study without explicit written consent from World Vision or agencies providing the information.

Timeframe and Deadline:

A minimum of one week, up to a maximum of two weeks per country field work will be required for each of the three countries during the proposed timeline. Specific timing of travel will depend on consultant's location and logistical arrangements. Travel may be broken up into several shorter trips or may be combined into a longer period of travel to two or three of the countries on the same trip.

Consultant will be required to provide a detailed work plan on how they propose to manage the data collection schedule and travel during the allotted study timeline. Exact length of travel to be agreed upon by World Vision Canada and the consultant prior to finalizing a contract.

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