


**GLOBAL
NUTRITION
CLUSTER**

Technical Alliance

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

Operational Guidance

VERSION 1

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Acronyms

AAP	- Accountability to Affected Population
ANC	- Antenatal Care
BMS	- Breastmilk substitute
CaLP	- Cash Learning Partnership
CE	- Community Empowerment
CFM	- Complaints and Feedbacks Mechanism
CotD	- Cost of the Diet
CVA	- Cash and voucher Assistance
CWG	- Cash working Group
FNG	- Fill the Nutrient Gaps
FSC	- Food Security Cluster
FSP	- Financial Service Provider
GBV	- Gender Based Violence
GAM	- Global Acute Malnutrition
HH	- Household
HRP	- Humanitarian Response Plan
IDPs	- Internally Displaced Persons
ICCG	- Inter-Cluster Coordination Group
INGO	- International Non-Government Organizations
IMAM	- Integrated Management of Acute Malnutrition
ITP	- Inpatient Treatment Programme
IYCF	- Infant and Young Child Feeding
MAM	- Moderate Acute Malnutrition
MCCT	- Maternal and Child Cash Transfer
MEB	- Minimum Expenditure basket
MFB	- Minimum Food Basket
MIYCN	- Maternal Infant and Young Child Nutrition
MNCH	- Maternal, Newborn and Child Health

MOHS	- Ministry of Health and Sports
MPCA	- Multi-Purpose Cash Grant
NC	- Nutrition Cluster
NGO	- Non-Government Organizations
OTP	- Outpatient Therapeutic Programmes
PBW/G	- Pregnant and Breastfeeding Women and Girls
PNC	- Postnatal Care
RCT	- Randomized Control Trial
RUSF	- Ready to Use Supplementary Food
RUTF	- Ready to Use Therapeutic Food
SAG+	- Strategic Advisory Group Plus
SAM	- Severe Acute malnutrition
SBC	- Social and Behavior Change
SBCC	- Social and Behavior Change Communication
SCI	- Save the Children International
SMEB	- Survival Minimum Expenditure Basket
SNF	- Specialized Nutritious Food
SOPs	- Standard operating procedures
TSFP	- Targeted Supplementary Feeding Programme
TWG	- Technical Working Group
UNICEF	- United Nations Children's Fund
WFP	- World Food Programme

Terminology¹

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

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

Conditionality: Refers to prerequisite activities or obligations that a recipient must fulfil in order to receive assistance.

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

Inpatient therapeutic programme (ITP)

Inpatient therapeutic programme (ITP) is one of the approaches of integrated management of acute malnutrition (IMAM), which includes community engagement and mobilization for outpatient management of complicated severe acute malnutrition (SAM) children 6–59 months at Hospital.

Minimum Acceptable Diet (MAD)

Minimum acceptable diet (MAD) is a composite indicator formulated from minimum dietary diversity (MDD) and minimum meal frequency (MMF), designed to measure dietary intake for breastfeeding children and MDD and MMF along with minimum milk feeding frequency (MMFF) for non-breastfeeding children. The indicator assesses the acceptability of a child's diet based on its micronutrient adequacy and meal frequency.

Minimum Dietary Diversity (MDD) for children 6-23 months

Minimum dietary diversity indicator assesses the proportion of children 6-23 months of age who have consumed at least five out of eight pre-defined food groups the previous day or night. It is an indicator of a diet's micronutrient adequacy, an important dimension of its quality.

Minimum Dietary Diversity for Women (MDD-W)

The Minimum Dietary Diversity for Women (MDD-W) is a population-level indicator of diet diversity validated for women aged 15-49 years old. The MDD-W is a dichotomous indicator based on 10 food groups and is considered the standard for measuring population-level dietary diversity in women of reproductive age. The MDD-W was preceded by the Women's Dietary Diversity Score (WDDS), which was a validated continuous measure based on reported intake of 9 food groups.

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

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

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

Minimum Meal Frequency for children 6-23 months

The minimum daily meal frequency is defined as: twice for breastfed infants aged 6-8 months, three times for breastfed children aged 9-23 months. four times for non-breastfed children aged 6-23 months.

Nutrition Outcome: Defined as improvement of the nutritional status typically measured through weight-for-height score (WHZ), height-for-age score (HAZ), Middle- Upper Arm Circumference (MUAC), weight-for-age score (WAZ) and micronutrient status or improvement in the dietary intake of individuals, typically measured through Minimum Dietary Diversity for Women (MDD-W), Minimum Acceptable Diet (MAD), Minimum Dietary Diversity (MDD) and Minimum Meal Frequency for children.

Outpatient therapeutic programme (OTP)

Outpatient therapeutic programme (OTP) is one of the approaches of integrated management of acute malnutrition (IMAM), which includes community engagement and mobilization for outpatient management of uncomplicated severe acute malnutrition (SAM) children 6-59 months.

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

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

Targeted Supplementary Feeding programme (TSFP)

Targeted Supplementary Feeding programme (TSFP) is one of the approaches of integrated management of acute malnutrition (IMAM), which includes community engagement and mobilization for supplementary feeding of moderate acute malnutrition (MAM) children 6-59 months.

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

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

Soft conditionality is a form of conditionality whereby conditions are set to increase accountability and encourage households to fulfill certain conditions (attendance of Social Behavior Change) with no major consequence in case conditions are not met.

Market monitoring: refers to the regular collection of data from marketplaces and market vendors to better understand the prices of key goods and services, the functionality and accessibility of markets, and any dynamics preventing the market system from working smoothly.

Mobile money: use of mobile phones to access financial services such as payments, transfers, insurance, savings, and credit. It is a paperless version of a national currency that can be used to provide humanitarian *e-cash* payments.

Unconditional transfers: are provided without the recipient having to do anything to receive assistance, other than meet the intervention's targeting criteria (targeting is separate from conditionality).

Social Behavior Change (SBC): are a set of interventions that systematically combines elements of interpersonal communication, social change and community mobilization activities, mass media, and advocacy to support individuals, families, communities, institutions, and countries in adopting and maintaining high impact nutrition-specific and nutrition sensitive behaviors or practices.

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

1. Introduction

1.1. Overview of Nutrition Situation

Myanmar has the highest maternal mortality rate in the world 250 deaths per 100,000 live births which is almost twice as the regional 137 deaths per 100,000 live births². The rate is higher in rural areas at 310 deaths per 100,000 live births compared to urban communities at 193 deaths per 100,000 live births.³ Myanmar is also facing a triple burden of malnutrition.⁴

1. Prevalence of anemia is of public health concern (>40%) throughout the country
2. High prevalence of undernutrition (stunting 30% and wasting 7% with aggravating factors)
3. Increasing trend of overweight

Inadequate nutrient diets are linked with increases in malnutrition including stunting. A Phone Survey conducted by UNICEF in June 2023 findings reveal that:

- Only 1 out of 2 children are exclusively breastfed.
- Too many children (63%) are fed unhealthy foods and almost 1/3 of children are not consuming any fruits and vegetables.
- Less than 1 out of 2 children are consuming diversified nutrient rich foods needed for their optimal growth and development.

The state of food security and nutrition has deteriorated in Myanmar mainly due to the widespread conflict that has caused a protracted humanitarian crisis. It is reported that currently there are around 1,703,900 internally displaced persons (IDPs). Among them, 328,000 were displaced prior to the February 2021 coup, while the remaining 1,375,900 were displaced afterward⁵ as shown in Figure 1.

In addition to these issues, Myanmar faces a considerable risk of recurrent and frequent natural disasters, such as floods, cyclones, and earthquakes. On May 14, 2023, Myanmar experienced the devastating impact of Cyclone Mocha, one of the most powerful cyclones ever documented, as it made landfall in Rakhine State⁶ causing extensive damage to residences, shelters for internally displaced individuals, and public infrastructure⁷ affecting an estimated 3.4 million people.

Soaring inflation, COVID-19 related job losses, unstable macro-economic landscape, rising food prices, reduced incomes, and a struggling public health system, restrictions on mobility due to curfews and checkpoints, and increasing transport costs as well as increasing feelings of insecurity and reports of crime all of which has further worsened household nutrition.

² World Health Organization (WHO). Trends in Maternal Mortality: 2000–2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division; WHO: Geneva, Switzerland, 2019. Available online: https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf

³ Int. J. Environ. Res. Public Health 2020, 17, 1464; doi:10.3390/ijerph17051464

⁴ Myanmar DHS 2015-2016

⁵ UNHCR – Myanmar Emergency Overview Map and Statistics – March 2023

⁶ Cyclone Mocha made landfall on 14 May 2023, with maximum sustained winds of around 250 km/hour and causing sea storm surges of up to 3.5 meters. Humanitarian Action for Children, UNICEF May 2023

⁷ Reports noted significant damage to people's homes, IDP shelters and public infrastructure – including hospitals, health centers, banks, schools, roads and bridges, religious buildings, and water and sanitation systems – in all affected areas. This disaster comes on top of a continuing humanitarian crisis.

Overall food consumption declined, with 24% of households reporting insufficient food intake in August-September 2022, up from 19% in 2021, and particularly impacting rural areas (26%) and urban areas (19%), with urban areas showing a steeper decline from the previous year.⁸ Diets also deteriorated, with fewer protein-rich foods consumed, posing risks to child development and long-term consequences for pregnant/breastfeeding women and their babies. Moreover, more than a third of all children aged 6-23 months and 15.9 percent of all children aged 24-59 months have inadequate diet quality.⁹

These factors have led to poor feeding practices, limited access to nutrient-rich foods, and a lack of dietary diversity, potentially increasing malnutrition, particularly among children and pregnant/breastfeeding women, although precise assessments have been hindered by limited access.

The nutritional situation for children is becoming increasingly fragile, marked by severe acute malnutrition cases observed in small-scale assessments. These cases carry a ninefold higher risk of mortality if left untreated. Supply chain challenges, including the non-issuance of tax exemption certificates, threatened the availability of therapeutic foods crucial for treating acute malnutrition in children.

Internally displaced persons (IDPs), particularly those in hard-to-reach areas, communities most affected by conflicts or underserved host communities, faced service interruptions, exacerbating their vulnerability to preventable health issues including malnutrition and childhood illnesses.

The Myanmar National Social Protection Strategic Plan 2014¹⁰, endorsed by the President of Myanmar, includes eight flagship programs. One of the flagship programs is the provision of a cash allowance for pregnant women and children up to age two years (Maternal and Child Cash Transfer with SBC for Nutrition).

In conclusion, the ongoing conflict patterns, and trends in 2023 may further worsen nutrition needs and gaps, placing vulnerable groups, especially children and pregnant/breastfeeding women, at significant risk.

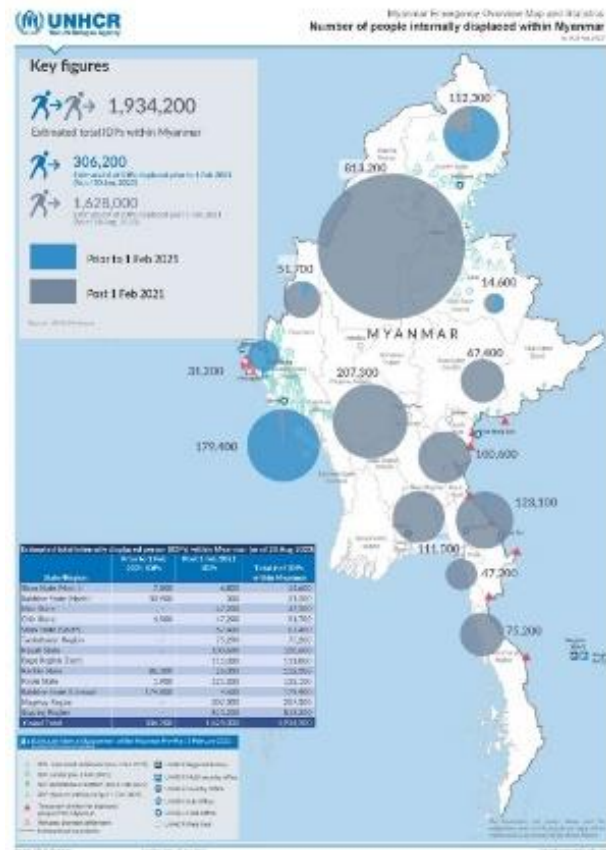


Figure 1. Number of people internally displaced within Myanmar.

⁸ Nationwide Food Security and Livelihoods Assessment. Myanmar: Humanitarian Needs Overview 2023

⁹ IFPRI April 2023, Strategy Support Program Research Note.

¹⁰ https://www.dsw.gov.mm/sites/default/files/ebooks-download/Myanmar_National_Social_Protection_Strategic_Plan%20English.pdf

1.2 Overview of Cash and Voucher Assistance (CVA) in Myanmar

The landscape of Cash and Voucher Assistance (CVA) has undergone a substantial evolution in Myanmar over the last half-decade. Initially centering on cash for food assistance, partners have increasingly recognized the broader possibilities to address multi-sectoral needs among program participants.

In recent years, CVA has seen a significant increase in use in Myanmar including the adoption of digital forms of delivery. After years of resistance, in 2020, the Myanmar Authorities became more accepting of the digital modality in part due to COVID-19. As a result of the current political crisis and subsequent conflict, across the country there are currently 17.6 million people in need of humanitarian assistance with over 1.5 million people displaced across Myanmar¹¹. CVA has become a crucial tool for delivering humanitarian assistance, particularly in hard-to-reach areas. In-kind assistance has faced many challenges including difficulties with procurement and imports, high fuel costs, and transport restrictions. The majority of the humanitarian CVA is being implemented via remote management and through local partners.

The total amount of CVA disbursed in Myanmar was \$36 million in 2020, \$39 million in 2021 and \$49 million in 2022. The total number of people reached via CVA was 400,000 in 2020, 1.1 million in 2021 and 1.5 million in 2022. In 2022, there were 42 organizations reporting CVA activities in Myanmar, of which 97 local implementing partners were utilized. Out of the total of \$49 million CVA disbursed in 2022, \$3.83 million was disbursed under nutrition activities reaching over 100,000 people.¹² Cash in envelope (physical cash) remains the primary delivery mechanism accounting for 84% of the assistance. From a market standpoint, CVA feasibility has largely remain unchanged.¹³

Currently, transferring cash into and around Myanmar has become a challenge for many organizations. Moreover, the use of formal forms of digital delivery raises concerns over data privacy and security for program participants. Coordination and information-sharing among different agencies is limited, hindering efforts to develop a coherent and coordinated response. Furthermore, physical access to the large markets can be difficult for the CVA beneficiaries due to active conflict and movement restrictions. Lack of transparency of physical cash distributions especially in conflict areas poses a challenge in monitoring activities on the ground. In addition, the movement of large amounts of cash for distributions raises security and fraud risks. Many local actors need additional capacity to implement quality CVA programming.

Despite these challenges, CVA is crucial for reaching those in need in Myanmar. In conflict-affected and access constrained regions, cash plays a pivotal role, particularly where delivering sector-specific in-kind support is difficult if not impossible. CVA is emerging as a strategic tool to address multi-sectoral and sectoral needs, acknowledging the diverse and intricate needs of individuals and households.

¹¹ Humanitarian Response Plan

¹² Cash Working Group Myanmar

¹³ CASH TRANSFER PROGRAMMES REVIEW IN KACHIN/ NORTHERN SHAN AND RAKHINE STATES, HARP-F, January 2022

2. Background & Justification

Myanmar exhibits one of the most elevated stunting prevalence rates within the Southeast Asia. Approximately 27% of children under the age of five in Myanmar suffer from stunting, a condition characterized by being too short for their age, primarily caused by chronic malnutrition. In certain areas of Myanmar, stunting rates soar as high as 40%¹⁴.

In Myanmar in 2022, the CVA for Nutrition interventions in Myanmar amounted to \$3.83 million reaching over 100,000 people.¹⁵ The activities include Cash transfers to support PBW/G and CU5 with Acute Malnutrition, Social Protection- Mother and Child Cash Transfer, cash Assistance for Prevention of Stunting for Children under 2 years and Pregnant and Breastfeeding mother, Cash Assistance for Nutrition Support to HIV and TB patients and Cash for AN Care Visits. During the same period, CVA for food assistance accounted for \$28.3M, mainly provided by WFP.

According to Myanmar Nutrition Cluster, there are 2.3 million people that require assistance to maintain a healthy nutrition status. Out of the 2.3M people in need, the nutrition cluster targets to support 590,000 individuals requiring a total of USD52M. However, as of July 2023, only USD8M representing 16.1% of the total required funding has been received.¹⁶

It is also important to note that CVA is in place as part of the State run MCCT program which is designed only for responding to stunting in development contexts, not humanitarian emergencies.

The State of Food Security and Nutrition report¹⁷ revealed that the state of food security and nutrition has deteriorated in Myanmar in 2022. Hence, the report recommended the following actions:

- Expanded implementation of nutrition-sensitive social protection programs, including maternal and child cash transfers, particularly to vulnerable groups is called for; and
- Given the importance of remittances as an effective coping mechanism, supporting migration and the flow of remittances would help to improve the welfare of the Myanmar population.

Cash and Voucher Assistance (CVA) to support maternal and child nutrition outcomes is an emerging area of practice globally, particularly in emergencies. Please see annex 2 for more details. Below are key reflections from the Technical Consultation on CVA for Nutrition Outcomes Workshop justifying the need for CVA interventions for Nutrition Outcomes in Myanmar.

CVA allows households or individuals to purchase goods and access services that can have a positive impact on maternal and child nutrition. These include purchase of nutritionally dense and diverse foods, items to prepare food, hygiene and sanitation items, safe water, health services and medication, transportation, and productive inputs.

CVA can promote participation in nutrition social and behavioral change (SBC) activities and attendance to priority health services. The temporary increase in household budget can have

¹⁴ Myanmar Micronutrient and Food Consumption Survey, MMFCS 2017-2018, Interim Report

¹⁵ Refer CWG Dashboard 2022 - SUMMARY OF CASH FOR NUTRITION

¹⁶ Nutrition Cluster Dashboard, July 2023.

¹⁷ The State of Food Security and Nutrition in Myanmar 2022, IFPRI Report, April 2023

additional positive or negative consequences which can impact child and maternal nutrition, including but not limited to reduced or increased household tensions, reduced economic pressure within households which can increase time available for caregiving, improved decision-making power of women, improved psychological well-being of caregivers, etc. Empowering women in their access and control over dietary decisions can facilitate better and informed decisions over what they want to eat without thinking of the economic pressures. However, this is dependent on the primary recipient of assistance and HH dynamics in terms of who spends the money.

For high-risk MAM and SAM specially, fortified foods are the gold-standard approach, but that for non-high-risk MAM local and family foods are a viable option to meet supplementation needs if appropriately calibrated. In the Myanmar context, CVA could be appropriate for individual nutrition top-up and to facilitate access to treatment services/ increase the attendance to priority health services.

3. Purpose of the Guideline

The UNOCHA retreat for clusters that was carried out in early 2023 in Bangkok recommended to expand the response modalities, that includes Cash Voucher Assistance (CVA) programs as the CVA will be important to reach out to persons inaccessible, in hard to reach and underserved areas and will also expand on available options to reach the vulnerable with humanitarian support. As an initial activity, a global webinar on “Introductory Concepts/ Orientation on Cash Voucher Assistance Programme in Nutrition in Emergencies and Explore opportunities for Adoption and Implementation in Myanmar” was held on 10 May 2023. In the global webinar, it was recommended that Myanmar Guidelines for the CVA in Nutrition in Emergencies be drafted. This recommendation was also endorsed by the SAG+ which invariably includes all cluster partners – UN agencies, INGOs, and NGOs.

This Operational guidance was developed collaboratively with Myanmar Nutrition cluster member agencies and the Cash Working Group (CWG), using lessons learnt across the sectors to contextualize, harmonize, and standardize commonly agreed approaches and methodologies. The gendered technical support of the Gender in Humanitarian Action and the Protection Cluster developed the section on Mainstreaming Gender and Protection on CVA for Nutrition. The AAP/CE Cluster developed the section on Accountability to Affected Population on CVA for Nutrition.

The purpose of this operational guideline is to ensure harmonization of the use of CVA to improve Maternal, Infant and Young Child Nutrition (MIYCN) outcomes in Emergency Contexts of Myanmar.

This Operational Guidance is not exhaustive and therefore may need to be adapted to each specific context and programming circumstances. The document is intended to be a living document and will be updated by CVA-Nutrition Task Force on yearly basis and/or whenever significant change of context occurs and/or refined over time to incorporate new evidence and successful best practices on using CVA to improve maternal and child nutrition outcomes.

It is recommended that the Guideline be further developed around linking to social protection systems like MCCT, for harmonizing transfer values and delivery mechanisms to ensure a more seamless transition between programmes. Moreover, it is recommended that other key stakeholders, such as the WASH cluster, FS cluster, Health cluster and possibly also donors be consulted or involved in the further development of the guideline.

3.1. Target Audience

The target audience of this Operational Guidance are primarily the members of Nutrition Cluster, members of the Cash Working Group and any other partners who would like to implement CVA for nutrition activities in Myanmar. This guidance provides the information and guidance needed to design and implement CVA for nutrition programmes both at the Country Office and at the field level and will serve as a basis to better define the use of CVA to promote nutrition outcomes by providing practical context specific recommendations and ensure alignment and complementarity with CWG CVA standards. This guidance also aims to support the work of other clusters such as Health, WaSH, CWG and FS, who's programming directly or indirectly contributes to nutritional outcomes. The implementing partners will use this Operational Guidance when making CVA programming decisions related to:

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

4. Global Overview on CVA to achieve Nutrition Outcomes

Evidence on the use of CVA on improving maternal and child nutrition has consistently increased in the past years. CVA can significantly impact dietary diversity, wasting, and even stunting^{18 19 20}, beyond development contexts.

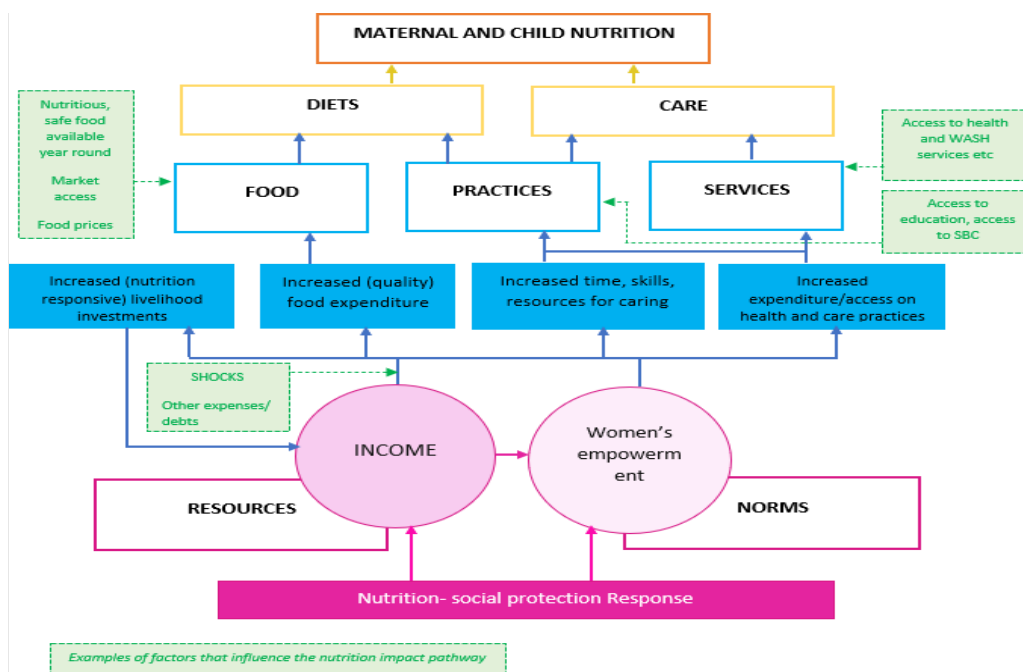


Figure 2 Modified UNICEF conceptual framework on the determinant of maternal and child malnutrition.

CVA can impact immediate and underlying determinants of malnutrition in multiple ways as illustrated in Figure 2. For instance, CVA can improve dietary diversity and/or food consumption of all household members; increase time for caring; foster positive health seeking and feeding practices of nutritionally vulnerable groups; improve access and utilization of health and nutrition services for nutritionally vulnerable groups; sustain and increase household food and incomes throughout the year and consequently minimized negative coping mechanisms and reduce household tensions and economic pressure while enhancing decision making power of women.

CVA for nutrition is best when provided alongside a greater set of complementary nutrition services such as screening (Family MUAC), referral, vitamin A supplementation, growth monitoring and promotion as well as treatment of acute malnutrition. Additionally, SBC should be an integral part of CVA to enhance its effectiveness²¹. Moreover, empowering women in their access and control over dietary decisions can facilitate better informed decisions over what they want to eat without thinking of the economic pressures. Specific attention should however be paid to prevent any negative effects on women if they are the primary recipients of assistance.

¹⁸ Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies | Global Nutrition Cluster

¹⁹ The evidence-base for the utilization of cash and voucher assistance to achieve nutrition outcomes is growing quickly and in the most recent (2022) and comprehensive systematic review of 129 studies, Manley et al found significant effects of CTs on nutritional outcomes, including impacts on HAZ, stunting, wasting and diet and a decline in incidence of diarrhoea

²⁰ Manley, et al, 2022. More evidence on cash transfers and child nutritional outcomes: a systematic review and meta-analysis.

²¹ Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies

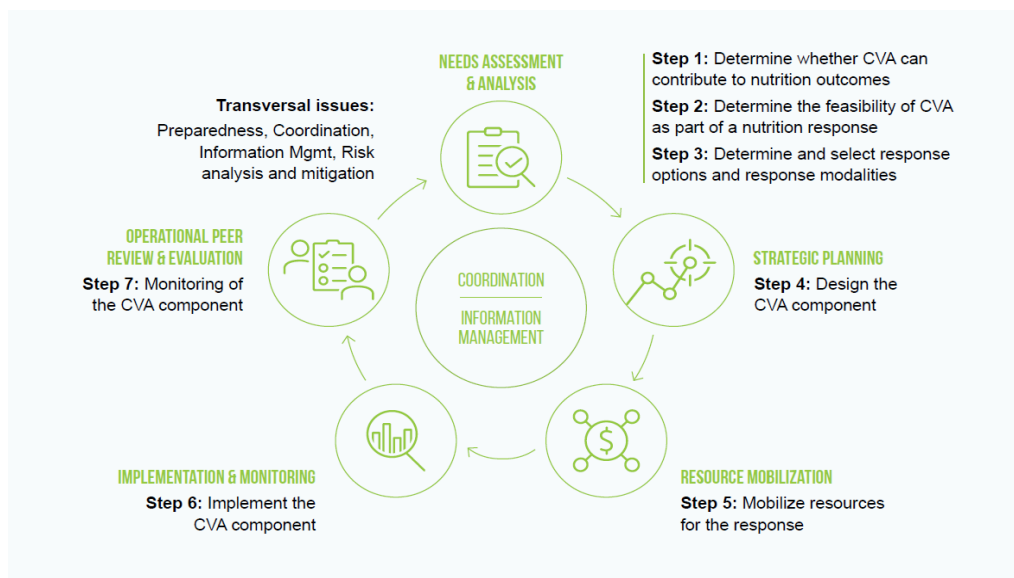
4.1. Steps to design and implement CVA for nutrition outcomes.

The following seven steps are recommended when considering using CVA as a modality to improve maternal and child nutrition outcomes:^{Error! Bookmark not defined.,22}

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

The above steps should be aligned with the elements of the humanitarian programme cycle and incorporate transversal issues throughout the response, such as preparedness, coordination, information management, and risk analysis and mitigation as illustrated in Figure 3.

Figure 3 Steps and transversal issues throughout the humanitarian program cycle



4.2. Key questions to determine feasibility and suitability of CVA for nutrition interventions.

Table 1 below presents the different steps and elements for consideration to inform the decision of using CVA for nutrition outcomes. The table is adopted from the USAID's Modality Decision Tool Nutrition Addendum²³ and further analysis should be conducted by actors in Myanmar to refine and contextualize the tool.

²² USAID. 2021. [Modality Decision Tool: Nutrition Addendum](#)

²³ https://www.advancingnutrition.org/sites/default/files/2021-04/usaidd_mdt_nutrition_addendum_tagged.pdf

Table 1 Key questions to ask when considering using CVA in the nutrition response Error! Bookmark not defined.,22

Step	Key questions
1) Determine whether CVA can contribute to nutrition outcomes	<ul style="list-style-type: none"> ● Economic barriers to adequate nutrition: To what extent is the lack of purchasing power impacting households' abilities to access and prepare nutritious foods, access health services, safe water, and improve hygiene conditions?
2) Determine the feasibility of CVA as part of a nutrition response	<ul style="list-style-type: none"> ● Market capacity and functionality: Can a nutritious diet be achieved using locally available foods? Is the local market physically accessible by the target group? Are the main food and hygiene items available in the local market? Are there any seasonal factors that influence market functionality and price volatility? ● Health and transportation services: Are relevant health and nutrition services for the prevention and treatment of malnutrition available and of acceptable quality? Are transportation services available to access health and nutrition services? ● Delivery mechanisms: Are there safe and reliable ways to deliver cash or vouchers to targeted recipients? What is their level of coverage? Is it scalable and accessible for the targeted population? ● Community considerations: How would the targeted households like to be assisted? What delivery mechanism is best suited for the targeted group? Are there protection and safety concerns in relation to providing cash or vouchers? Can they access nutrition-relevant goods and services with additional purchasing power? ● National and local authorities: Do authorities allow or support the delivery of CVA to affected populations? What is their preferred modality? Do local mechanisms provide social assistance or safety net programs to support vulnerable populations? To what extent do these programs apply a nutrition lens to targeting, complementary programming, program objectives? ● Additional considerations: Does the organization and its partners have sufficient capacity to plan and implement the CVA component? If not, what do they need to scale up? How long does it take to set up the CVA component? What is the estimated cost associated to the setup of CVA operations? What type of vendors will most effectively meet the needs of the CVA component proposed?

Step	Key questions
3) Determine and select response options and response modalities	<ul style="list-style-type: none"> ● Appropriateness: Which modality (cash, voucher, in-kind) is most appropriate to achieve nutrition outcomes proposed by the objectives? ● Beneficiary and Community preference: How would the targeted households/individuals and community representatives prefer to be assisted? ● Costs: Which of the response modalities is most cost-efficient and/or cost-effective? ● Markets: Which modality is more adapted to local market conditions? ● Risks: Which modality is likely to be riskier? How can the risks be mitigated? ● Timeliness: Which modality is faster to implement? ● Organizational capacity: Which modality/mechanism would the organization be more capable to implement and scale-up?
4) Design the CVA component	<ul style="list-style-type: none"> ● Targeting: Which household member(s) is the transfer intended to benefit? What is the justification of needs for the specified group? For household rations, how will benefits translate to nutritionally vulnerable groups, depending on the modality chosen? ● Conditionality: If you plan to impose conditions on participation, how will the program manage those considerations related to the modality of transfer and the impact on nutrition? Will the programme apply soft or strict conditionality? ● Transfer value: How does the transfer value align with a set of in-kind food baskets or minimum expenditure basket (MEB) for food that demonstrate gap-filling for the needs of vulnerable groups targeted? What factors are used to calculate the transfer value, e.g., for transportation/treatment access, and how are they justified? What costs and items need to be monitored regularly in the market to ensure beneficiaries are getting adequate costs and items coverage? What is the tipping point for re-justification of transfer value based on the type of transfer? ● Transfer frequency: How often will beneficiaries receive their transfers (weekly, biweekly, monthly, etc.)? ● Duration: How many months of coverage will the program provide? Is coverage for a specific time of year, or rolling? ● Gender: How will gender roles and implications affect the modality selection for the target population, such as time and labor burdens, decision-making at the household level, civil conflict, or gender-based violence and security risks? ● Supporting interventions: What accompanying package of interventions will you include with the selected modality to optimize

Step	Key questions
	nutrition/food security impact? How will community members support cash/voucher programs/food distributions? What is their role?
5) Mobilize resources for the response	<ul style="list-style-type: none"> ● Cost efficiency and cost effectiveness: Is CVA more cost efficient and/or cost effective relative to other modalities? What are the context specific advantages of CVA in comparison with other modalities? What are the potential positive secondary impacts of CVA on markets and the local economy?
6) Implement the CVA component	<ul style="list-style-type: none"> ● Roles and responsibilities: Has the organization defined the roles and responsibilities of the various units/departments (programme, procurement, logistics, finance, etc.) in alignment with existing Standard Operating Procedures? Are internal and external coordination mechanisms established? ● Beneficiary registration, communication, and accountability systems: Has the organization set up beneficiary registration, communication, and accountability systems? Where protocols followed in selection and contracting service providers/ vendors to disburse cash transfers and the redemption of vouchers?
7) Monitoring of the CVA component	<ul style="list-style-type: none"> ● Monitoring, evaluation, and quality assurance plan: What indicators will be used to monitor the process, outputs, and outcomes of CVA?

5. Operational Guideline Development Process

The guideline development process involved a review of published and gray literature, and consultations with various stakeholders both at global, national, and subnational levels in Myanmar. The Myanmar Nutrition Cluster in collaboration with the Myanmar Cash Working Group conducted a 3-day technical consultation on CVA for nutrition in August 2023. A total of 27 CVA and Nutrition Specialists from 16 Agencies (8 from UN and 8 from INGOs) participated in the hybrid workshop where 12 participants were physically present at the workshop venue while the other 15 participated virtually via Zoom.

The topics below were covered in the technical consultation:

- Myanmar Nutrition Situation Analysis with CVA Lens
- Lessons Learned on CVA Programme for Nutrition in Myanmar (Practitioners' Experiences)
- Evidence on CVA for Nutrition (Global overview on CVA to achieve nutrition outcomes)
- Setting CVA Transfer Values
- Guidelines for Nutrition in Emergencies CVA
- CVA Feasibility and Appropriateness
- Safety, Security, and Accountability to Affected Populations
- Protection & Gender Mainstreaming
- Task Force for Nutrition in Emergencies CVA

The following results were reached during the technical consultation (Please see Annex 2 for details):

1. Cash Feasibility & Risk Assessment
2. Formation of Task Force for Nutrition in Emergencies CVA
3. Defining of Myanmar CVA Use Cases
4. Recommended Action Points

Most notably, the following four main approaches described in table 2 were agreed during the technical consultation as the entry points for using CVA to improve maternal and child nutrition outcomes in Myanmar. These approaches, by means of providing in-kind assistance are already being used by partners in Myanmar, and these guidelines capture learnings and best practices from those existing experiences.

Table 2. Four main approaches for integrating CVA into the nutrition response in Myanmar

Use- case Title / Approach	Main objectives of the CVA component	Name of CVA Intervention
CVA for nutritional adequacy (Preventive)	To enhance growth and prevent deterioration of the nutritional status	Maternal and child cash transfer (MCCT) in Emergency
	To prevent deterioration in the nutritional status of at-risk groups	Individual feeding assistance CVA for PBWG
	To reduce the prevalence of moderate acute malnutrition (MAM) in children under two and to enhance growth	Individual feeding assistance CVA for Children aged 6-23 months
	Improve household food security and dietary diversity	CVA for household assistance combined with social and behavioral change (SBC) interventions
CVA to facilitate access to preventive health services (Preventive)	To improve attendance and use of essential health and nutrition services to improve maternal and child survival.	CVA to facilitate access to Antenatal Post Natal Care Services
		CVA for Pregnancy-related complications (EmOC)
		CVA for Emergency newborn care
		CVA for Newborn care Services
CVA to facilitate access to nutrition services for MAM children (Supplementation)	To improve treatment outcomes: reduce defaulting and non-response to supplementation	CVA to caregivers of children with MAM to facilitate access to TSFP
		CVA to malnourished PBW/G to facilitate access to TSFP
CVA to facilitate access to nutrition services for SAM children (Treatment)	To improve treatment outcomes: reduce defaulting, non-response to treatment and relapse	CVA to caregivers of children with SAM without medical complications to facilitate access to OTP
		CVA to caregivers of children with SAM with medical complications to facilitate access to SC/ ITP

These approaches are in alignment with the objectives of the Humanitarian Response Plan²⁴, most notably aligned with Strategic Objective SO2 of the 2023 Myanmar HRP - Suffering, morbidity, and mortality is prevented or reduced among 3.1 million displaced, returned, stateless and other crisis-affected people experiencing or at risk of food insecurity, malnutrition, and health threats. The approaches are also aligned with Myanmar Nutrition Cluster Specific Objectives²⁵.

²⁴ <https://myanmar.un.org/en/216732-myanmar-humanitarian-response-plan-2023-january-2023>

²⁵ <https://myanmar.un.org/en/216732-myanmar-humanitarian-response-plan-2023-january-2023>

6. Recommended CVA Design Consideration for Myanmar

This section covers the recommended CVA design considerations for the identified use -cases, in terms of Targeting Criteria, Transfer Modality, Restrictions, Conditionality, Transfer Value, Frequency, Duration and Delivery Mechanisms.

Transfer Modality: The choice of the transfer modality, whether it's cash, vouchers, or a hybrid approach, should be determined based on factors such as feasibility, appropriateness, the implementing organization's capacity, the preferences of beneficiaries, and the local market's capacity and functionality.

Delivery Mechanisms: Cash can be delivered either physically or electronically (mobile cash transfers) through financial service providers. Similarly, the vouchers can also be delivered physically or electronically through service providers. Financial Services (Providers) can be formal or informal. The implementing partners need to select the delivery option and the service provider depending on availability, sensitivity, safety and preference of the targeted population.

The availability of Cash agents or mobile money (MM) networks, which can facilitate financial transactions and payments related to the project is a critical factor. Ensuring the security and safety of the entire process is paramount, as it instills confidence among community members and project stakeholders.

Transfer Values: The transfer values, whether in the form of cash assistance or vouchers assistance, need to be harmonized among agencies implementing CVA for nutrition outcome interventions. It is recommended that Myanmar Nutrition Cluster and CWG lead this process. Please note that in humanitarian situations the stress and needs are above and beyond the steady state needs, thus, the transfer value should be calibrated to meet the needs of those target populations.

The implementing partners should derive the transfer values based on the local market value of the required commodities and services at the time of program design/implementation. Therefore, the implementing partners must perform a pre-programming cost survey of their local market to establish reasonable transfer values. The prices of the commodities covered by the voucher can be negotiated and fixed with participating vendors to ensure a stable value is provided throughout the implementation period.

Social and Behavior Change (SBC): The global evidence also indicates that SBC messaging alongside any transfer for a nutrition outcome is not optional from a programming perspective. SBC messaging should be available, but participation should not be required for program participants to receive their transfers. Therefore, it is utmost important that SBC services MUST be provided as an integral part of the program.

Complementary Interventions: The recommended complementary interventions are presented in the Table 3 below.

Table 3 Use case and recommended complementary intervention.

Use- case Title / Approach	Recommended Complementary Interventions
CVA for nutritional adequacy (Preventive)	
CVA to facilitate access to preventive health services (Preventive)	
CVA to facilitate access to nutrition services for MAM children (Supplementation)	
CVA to facilitate access to nutrition services for SAM children (Treatment)	

Note: Further exploration is needed to identify the plus component, i.e. the package of complementary intervention for beneficiaries. Eg. Cash for Training, Cooking Demonstrations, Kitchen/ Home Gardening, Conditional Cash Grants for Households Livelihoods, Food Fairs, WASH Facilities, Cash for Work.

Common Cash Transfer Components: The description of the common cash transfer activities across the use cases are presented in the Table 4 below.

Table 4 The common cash transfer activities across the use cases

Description	Transfer Value	Remarks
Transportation Cost	Actual cost	as per receipt to be reimbursed. Eligible for those who have to travel either more than 30 minutes or more than 5Km.
Medical charges/ Medicine Cost	Actual cost	as per receipt to be reimbursed. Prescription needs to be attached.
Investigation charges/ Hospitalization cost	Actual cost	as per receipt to be reimbursed. Admission notes to be attached.
Meal cost for mothers or caregivers	TBD	TBD according to location. For actual number of daily hospitalized. Maximum allowance of MMK5,000/day covering for 3 meals
Communication support	Actual cost	as per receipt or screen shot to be reimbursed. A maximum of 5,000 MMK per week during hospitalization.

The above information needs to be updated regularly by adding basic market monitoring questions to market monitoring surveys for other sectors like food assistance.

Use Case 1 - CVA for Nutritional Adequacy

The primary objective of this use case is to enhance growth and to improve household food security and dietary diversity by providing CVA to cover the needs of HH and individuals. The approach encompasses (i) enhancing growth and prevent deterioration of the nutritional status; (ii) preventing deterioration in the nutritional status of at-risk (iii) reducing the prevalence of moderate acute malnutrition (MAM) in children under five and to enhance growth; and (iv) improving household food security and dietary diversity through CVA for household assistance combined with social and behavioral change (SBC) interventions.

Myanmar exhibits one of the most elevated stunting prevalence rates within the Southeast Asia. Approximately 27% of children under the age of five in Myanmar suffer from stunting, a condition characterized by being too short for their age, primarily caused by chronic malnutrition. In certain areas of Myanmar, stunting rates soar as high as 40%²⁶. Evidence from both Myanmar MCCT Programme and other countries indicate that combining cash transfers with Social and Behavior Change (SBC) yields a more substantial impact on child growth compared to solely providing cash assistance or SBC in isolation.²⁷

Hence, this CVA approach along with SBC will increase access to a nutritious diet to enhance growth and prevent deterioration of the nutritional status. This approach should be guided by a situational analysis that identifies behavioral barriers and health service attendance as significant contributors to undernutrition within the specific context. Assurance or reinforcement activities would also be essentially needed, such as post-distribution monitoring, home visits during lunchtime, or counseling at critical times (before delivery or before starting complementary feeding)

The use cases are also in line with WFP recommended package for the prevention of acute malnutrition in highly food insecure areas²⁸:

1. Combine household food assistance with the provision of an individually targeted nutrition top-up using Cash based transfers to meet specific nutrient needs of most vulnerable target groups (i.e., children 6-23/6-59 months and/or pregnant and breastfeeding women and girls);
2. Include robust Social Behavior Change activities to guide the use of the top-up through promotion of optimal infant and young feeding practices and maternal nutrition; and
3. Support nutritional screening, early detection, and referral to health and nutrition services to achieve an early diagnostic of acute malnutrition.

²⁶ Myanmar Micronutrient and Food Consumption Survey, MMFCS 2017-2018, Interim Report

²⁷ LIFT, 2019, LEGACY Program Myanmar RCT. Ahmed A, Hoddinott J, Roy S and Sraboni E (2017). Linking Social Protection and Nutrition in Bangladesh: Results from the Transfer Modality Research Initiative (TMR), presentation given at Evidence for Action in South Asia event, 8 July 2017.

²⁸ WFP: Summary interim recommendations for the use of Cash Based Transfers (CBT) for the prevention of acute malnutrition in response to the Global Food Crisis

Table 5. Targeting criteria for use case 1

Name of CVA Intervention	Targeting Criteria
Maternal and child cash transfer (MCCT) in Emergency	PBWG and Children aged 0-23 months
Individual feeding assistance CVA for PBWG	PBWG
Individual feeding assistance CVA for Children	Children aged 6-23 months
CVA for household assistance combined with social and behavioral change (SBC) interventions	HH with children aged 0-59 months admitted in IMAM program.

Transfer Modality, Delivery Mechanism, Conditionality

Unconditional cash transfers either through providing physical cash or through e cash.

Transfer Value, Frequency & Duration

The initial MCCT transfer amount was established by the government at the launch of the national MCCT program, primarily based on the Cost of the Diet Assessment of Save the Children in Rakhine. However, due to significant inflation that has occurred since the onset of the COVID pandemic and political changes, it is evident that the original MCCT amount is no longer sufficient to meet the nutritional needs of mothers/PBWG and children. In general, the Transfer values for all the interventions under this use-case need to be determined in consultation with (i) the NC to list local available nutritious food based on CotD/FNG or market monitoring data; and (ii) the SP WG, FSC and CWG to harmonize the amount.

A monthly distribution is recommended, though a bimonthly option with an extended redemption period can also be considered depending on the situation. The duration of the assistance should be for a minimum of 6 months throughout the complementary feeding periods 6-23 months of child age.

Table 6. Summary of recommended CVA design considerations for use-case 1

Approach	Target Groups	CVA Intervention	Transfer Modality/ Conditionality	Transfer Value (MMK)	Frequency of Transfer	Duration	Delivery Mechanism	Remarks	
Preventive	CVA to increase access to a nutritious diet to enhance growth and prevent deterioration of the nutritional status.	PBWG and Children aged 0-23 months	Maternal and child cash transfer (MCCT) in Emergency	Cash Transfer/ Unconditional	TBD	Recommend monthly transfers	Minimum 6 month suggested ²⁹	Physical cash E- cash 24500 MMK/month ³⁰ To be based on SMEB/MEB	
		Children aged 6-23 months	Individual feeding assistance CVA for Children	Cash Transfer/ Unconditional	TBD	Recommend monthly transfers	Minimum 6 months suggested.	Physical cash E- cash	
		PBWG	Individual feeding assistance CVA for PBWG	Cash Transfer/ Unconditional	TBD	Recommend monthly transfers	Minimum 6 months suggested.	Physical cash E- cash	-
		HH with children aged 0-59 months admitted in IMAM program.	CVA for household assistance combined with social and behavioral change (SBC) interventions	Cash Transfer/ Unconditional	TBD	Recommend monthly transfers	Minimum 6 months suggested.	Physical cash E- cash	To be based on SMEB/MEB

²⁹ SCI RCT showed the longer the duration of the program the better nutrition impact for the children.

³⁰ Key partners adapted MCCT amount to 20000-24500 mmk/month after the COVID while the original National MCCT transfer amount was 15000mmk/month set by the Government in 2017 based on the lesson learned and Save the Children Cost of The Diet in Rakhine.

6.2 Use Case 2 - CVA to facilitate access to preventive health services

The primary objective of this use case is to increase attendance for quality maternal and newborn care services in Myanmar to improve maternal and child survival by providing cash transfer to ANC, PNC, EmoC, Emergency Newborn Care and Newborn Care services. The CVA for nutrition modality can be used to address the financial barriers to health seeking behavior and enable mothers to attend MNCH program sites for services. The purpose is to increase attendance for quality maternal and newborn care services in Myanmar to improve maternal and child survival.

For an effective cash transfer modality to realize benefits; strong SBC related to the importance of ANC and PNC services, early seeking behaviors, danger signs during pregnancy and the newborns, and family planning services, breastfeeding counselling need to be incorporated into the project design to increase knowledge and desire to utilize services by the target group.

There are several key considerations to be considered to ensure its success. First and foremost, the availability of both public and private clinics is essential, as these facilities play a crucial role in providing healthcare services and support. Additionally, having reliable transport options is vital to ensure that community members can access these clinics and other essential services easily. For the project's success, it's imperative to assess the functionality and range of services for Maternal and Child Health Nutrition (MCHN). It is recommended that implementing partners carry out an analysis of availability and quality of health services prior to design/decision to use this approach.

Targeting Criteria

Pregnant women or girls to attend antenatal care (ANC) and delivery care, children 0- 24 months for routine health visits, breastfeeding women with babies up to 2 months for Postnatal Care (PNC) and Immunization services. Criteria of targeting should be: 1) geographic locations where there is low access and utilization of services; 2) HH that have been targeted based on economic vulnerabilities where there is a pregnant and breastfeeding woman or girl (PBWG).

PBWG who deliver in facilities that are supported by implementing partners should receive sanitary supplies and delivery items provided by the implementing partners and thus will not receive CVA for this purpose. Other targeting criteria can be identified by implementers but should be accepted after review by the Nutrition Sector and/or the Cash Working Group.

Transfer Modality & Delivery Mechanism

- Cash transfers either through providing physical cash or through e cash.
- Provision of vouchers (restricted) for new borne care kit. This voucher should be a one-off transfer at the time of a newborn delivery and can be delivered physically or electronically through existing service providers. In case provision of commodity vouchers are not possible, implementing partners should opt for cash transfer.

Transfer Value, Frequency & Duration

It is recommended that cash is transferred electronically or in person to cover transport costs per visit for the mothers or caregivers to attend MNCH services (ANC, PNC, Immunization) for as many visits as required for the index PBW/G, based on the assessment and prescription of the health worker.

Table 7. Summary of recommended CVA design considerations for use-case 2

Approach	Target Groups	CVA Intervention	Transfer Modality	Transfer Value	Frequency of Transfer	Duration	Delivery Mechanism	Remark	
Preventive	Provide CVA To increase attendance for quality maternal and newborn care services in Myanmar to improve maternal and child survival.	Pregnant women from the first trimester, children 0-24 months, breastfeeding women with babies up to 2 months	CVA to facilitate access to Antenatal Care (ANC) & Post Natal Care Services (PNC Services)	Cash Transfer	Actual cost	Each visit	Until delivery	Physical cash/ E cash	Transportation Cost Laboratory Cost Medical related cost
			CVA for Pregnancy-related complications (EmOC)	Cash Transfer	Actual cost	Each visit	Until Delivery	Physical cash/ E cash	Transport/Medical/ Hospitalization Costs
			CVA for Emergency newborn care	Cash Transfer	Actual cost	Need Basis	0-24 months	Physical cash/ E cash	transport cost hospitalization cost meal costs
			CVA for Newborn care Services	Voucher/ Restricted	Actual cost	Every Visit	0-45 days	Physical/ E vouchers	New borne Kits

6.3 Use Case 3 - CVA to facilitate access to nutrition services for MAM children.

The primary objective of this use case is to improve treatment outcomes: reduce defaulting, non-response to treatment through adherence to treatment (outpatient) by providing CVA to caregivers of children with MAM to cover the transportation cost and providing hygiene kits.

According to Myanmar Nutrition Cluster, there are 240,000 MAM children that require assistance. Out of the 240,000 SAM children, the nutrition cluster targets to support 58,000 children. As of July 2023, only 10,000 has been reached representing 18% of the target.³¹ Moreover, in the current context, MAM prevalence cases are likely to rise.

It is important to note that MAM supplementary feeding interventions were/are not carried out under the Government MCCT programme. Moreover, for the treatment of MAM, the main supply of RUSF (Super Cereal, WSB, RSB) in Myanmar is through WFP. Furthermore, SNFs are not being produced locally. There are suppliers producing nutritious food, but they do not have the capacity to meet the SNF quality requirements.

One of the key reflections during the Technical Consultation workshop cautioned that targeting CVA based only on the nutritional status of children in a treatment response may tempt caregivers to slow down their children's recovery in order to prolong the treatment period, or in some cases there have been experiences of certain strategies to make children lose weight in order to meet the admission criteria. For this reason, CVA for treatment response should be accompanied by a risk analysis and strong monitoring and accountability system. HH with children aged 6-59 months admitted in IMAM program will receive CVA for household assistance, which is covered under use-case 1.

Targeting Criteria

Mothers or caregivers of children aged 6-59 months with MAM

Pregnant, Breastfeeding Women and Girls (PBW/G) who are identified as malnourished.

Transfer Modality & Delivery Mechanism

- Cash transfers either through providing physical cash or through e cash.
- Provision of vouchers (restricted) for hygiene kit. This voucher should be a one-off transfer at the time of admission and can be delivered physically or electronically through existing service providers in case provision of commodity vouchers are not possible, implementing partners should opt for cash transfer. To ensure nutrition adequacy, this intervention is covered under use case 1.

³¹ Nutrition Cluster Dashboard, July 2023.

Transfer Value, Frequency & Duration

Table 8. Summary of recommended CVA design considerations for use-case 3 - CVA to facilitate access to nutrition services for MAM children.

Approach	Target Groups	CVA Intervention	Transfer Modality	Transfer Value	Frequency of Transfer	Duration	Delivery Mechanism	Remarks
Supplementary	Caregivers of children with MAM (6-59 months)	CVA to facilitate access	Cash	Actual Cost	Each visit	Up to Discharge	Physical cash/ E cash	Transportation cost
		CVA for Hygiene Kit	Voucher (Restricted)	TBD	One off	At Admission	Commodity Voucher	
	Pregnant, Breastfeeding Women and Girls (PBW/G) who are identified as malnourished	CVA to facilitate access	Cash	Actual Cost	Each visit	Up to Discharge	Physical cash/ E cash	Transportation cost

Note: When GAM prevalence rate is high (over 15%) or medium (10-15%) In contexts with limited financial and/or logistical resources where needs prioritization is required, the target group may be restricted to children aged 6 to 23 months.

6.4 Use Case 4 - CVA to facilitate access to nutrition services for SAM children.

The primary objective of this use case is to improve treatment outcomes through reducing defaulting, non-response to treatment and relapse. The proposed key CVA interventions are (i) CVA to caregivers of children with SAM without medical complications to facilitate access to OTP and (ii) CVA to caregivers of children with SAM with medical complications to facilitate access to ITP.

According to Myanmar Nutrition Cluster, there are 52,000 SAM children that require assistance. Out of the 52,000 SAM children, the nutrition cluster targets to support 15,000 children. As of July 2023, only 3,000 has been reached representing 21% of the target.³² Moreover, in the current context, SAM prevalence cases are likely to rise. Children suffering from severe acute malnutrition are at a greater risk of morbidity and mortality and therefore integrated management of acute malnutrition (IMAM) is crucial.

One of the key components of the IMAM is In-patient Therapeutic Programme (ITP) also referred to as Stabilization Centre (SC) for children with severe acute malnutrition (SAM) with medical complications. Provision of in-patient care is cost-intensive and is more technically demanding than other malnutrition treatment programs, hence, ITP are not as widely distributed in communities as other treatment programs (OTP/TSFP).

Therefore, children requiring inpatient treatment and their caregivers are often required to move from their communities (including hard-to-reach communities) to ITPs situated at Township and state and regional hospitals. In addition, the caregiver will have to stay with the child in the ITP facility for a period ranging from 5 to 15 days, as long as required for completion of the treatment. While at the facility, the caregiver will need a supply of meals, personal hygiene items as well as other out of pocket expenditures like airtime for communication.

This CVA approach will enable the caregivers to access safe transportation from their communities to and from the stabilization center, meals, and personal hygiene items, as well as cover out-of-pocket expenditure during hospital stay which will be supportive for caregivers of most vulnerable children to seek for appropriate services. HH with children aged 0-59 months admitted in IMAM program will receive CVA for household assistance, which is covered under use-case 1.

Targeting Criteria

Mothers or caregivers of children aged 0-59 months with SAM

Transfer Modality & Delivery Mechanism

- Cash transfers either through providing physical cash or through e cash.
- Provision of vouchers (restricted) for hygiene kit. This voucher should be a one-off transfer at the time of admission and can be delivered physically or electronically through existing service providers in case provision of commodity vouchers are not possible, implementing partners should opt for cash transfer.

³² Nutrition Cluster Dashboard, July 2023.

Transfer Value, Frequency, Duration & Delivery Mechanism

Table 9. Summary of recommended CVA design considerations for use-case 4 - CVA to facilitate access to nutrition services for SAM children

Approach	Target Groups	CVA Intervention	Transfer Modality	Transfer Value (MMK)	Frequency of Transfer	Duration	Delivery Mechanism	Remarks	
Treatment	Provide CVA to caregivers of children with SAM without medical complications to facilitate access to OTP	Caretaker of non-complicated SAM 6-59 months	CVA to facilitate access	Cash	Actual Cost	Each visit	Up to Discharged	Physical cash/ E cash	Transportation cost
			CVA for Hygiene Kit	Voucher (Restricted)	TBD	One off	At Admission	Commodity Voucher	
			CVA Top up for SAM-cured follow up	Cash / Unconditional	TBD	monthly	4 months	Physical cash/ E cash	To prevent relapse.
Treatment	Provide CVA to caregivers of children with SAM with medical complications to facilitate access to SC/ ITP	Caretaker of complicated SAM 0-59 months	CVA to facilitate access	Cash	Actual Cost/ TBD	Each visit	Up to discharged from ITP/SC	Physical cash/ E cash	Transportation
			CVA for out-of-pocket expenditures	Cash	actual cost	Daily	Number of days that child is on admission at the ITP/SC	Physical cash/ E cash	Medicine cost Investigation cost Meals costs Communication costs

7. Monitoring and Evaluation

Proper monitoring and evaluation of planned CVA for nutrition use cases is essential to create evidence on impact, keep track of progress, identify challenges and document achievements. It is proposed that during implementation, partners monitor the various processes and expected outputs and periodically evaluate expected nutritional outcomes. The identification of appropriate indicators to include in the monitoring and evaluation of the CVA programme component is key for understanding the contribution of the programme to nutrition outcomes as well as to interpret any deviation from the expected outcome.

Evaluating Outcome:

- Select outcome indicators based on the main objectives and duration of the programme that the CVA is expected to change within the given time.
- Consider including indicators to track any unintended effects due to the provision of CVA
- Pick indicators that the programming team has the capacity to collect, analyze and utilize in a timely way
- Move beyond household level indicators as these do not capture the nuances of intra-household distribution of food and cannot be extrapolated to all individuals in the household. CVA for nutrition indicators should focus on the nutritionally vulnerable individuals that are the target of the intervention.

Please see Annex 5 for illustrative list of outcome indicators for different use- cases, following the UNICEF concept framework of undernutrition.

Monitoring processes and Outputs:

Monitor output and process indicators for both the CVA component and any relevant to the nutrition/ health/ WASH activities to identify bottlenecks arising from programme implementation and help interpret the outcomes These should include:

- Standard CVA output indicators: Total transfer value to individual, total number of individuals receiving transfers disaggregated by sex and age as relevant, and total number of transfers to individual.
- Standard CVA process indicators. Timely distribution of transfer, value of the transfer, adequate transfer accessibility/connectivity, full redemption of the transfer.
- Nutrition-related output and process indicators. These should be developed from the outcome level indicators chosen and reflect the change pathways the intervention expects to influence.
- Process indicators to check if the required goods/food/services are available, at reasonable prices and at minimum standards. Monitoring food prices, availability of nutritious food, challenges with markets, health service provision, etc.

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

Post distribution monitoring: To mainstream AAP, partners should conduct regular post-distribution monitoring (PDM) to better understand beneficiary preference and satisfaction and feedback. This will help to further inform and guide programming. Efforts should be made to address concerns, adjust projects/programs where necessary, and ensure that appropriate corrective action is taken. PDMs are to be carried out two weeks after each distribution.

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

8. Risks and Mitigation Measures

In line with the humanitarian imperative, humanitarian actors are compelled to provide assistance to the most vulnerable populations, while mitigating the risk as much as possible. Risks should be identified during the feasibility assessment, considered during response options analysis, and mitigated through programme design and other measures, and monitored during implementation.

In addition, the likelihood of risk should be assessed, and the impact on program, staff safety, organizational reputation and financial risk should regularly be monitored. Moreover, the implementing partners are encouraged to work closely with local civil society to understand how the risks differ for them, as well as come to an understanding of how they can work together to mitigate those risks.

The risks are different according to the geographic area and stakeholders involved – and therefore the aim should be to take a do no harm approach to risk analysis.³³ The implementing partners should have a comprehensive understanding of the risk to themselves, and to the beneficiaries and local partners they are engaging with as well as the mitigations measures appropriate in place.

For details, please see annex 6- Risk Matrix for Risks and Mitigation Measures.

³³ Aid Actor use of financial modalities in Myanmar, HARP-F, April 2022

9. Accountability to Affected Populations

All humanitarian responders are accountable to the people they serve. Implementing partners should promote Accountability to Affected Populations (AAP) in line with the [Inter-Agency Standing Committee \(IASC\) Commitments](#) and institutionalize the [Operational Framework](#) in all aspects of their work. Partners should integrate accountability into program design, implementation, monitoring and evaluation. This will help to ensure the meaningful participation and contribution of affected people to improved nutrition outcomes in their communities.

Partners should carry out community awareness sessions to introduce the program and explain key information such as: targeted beneficiaries, promoted nutrition outcomes, transfer values, distribution modalities, and program timeframes. Throughout the program, they should ensure a 'Do No Harm' strategy. The provision of nutrition services should not exacerbate community tensions, encourage behaviors that will lead to ill health or malnutrition, or pose significant risk to beneficiaries.

It is important to provide a range of safe, accessible, and appropriate channels of communication, and use them to inform communities about the activities, structures and processes that impact them. Affected people need to be able to access timely, accurate and relevant information so that they can make informed decisions and choices. They should also know about their rights and entitlements. Partners should clearly and consistently communicate key information about their own organizations to affected people.

Partner organizations should develop a tailored communication strategy that ensures beneficiaries are informed throughout the entire nutrition program. This includes selecting communication channels and crafting suitable materials that consider the needs and preferences of affected people. Implementing partners and local field staff should also proactively facilitate constructive feedback to improve the quality of CVA in nutrition and inform future planning.

Partners should set up safe and accessible Complaint and Feedback Mechanisms (CFMs) that allow them to record, monitor and respond to issues of concern. Feedback channels can be proactive (focus group discussions, individual interviews, community meetings) and/or reactive (suggestion boxes, hotlines, email, SMS). A functional and appropriate CFM is useful for recording and tracking the types of feedback, as well as actions taken to close the feedback loop.

Partners are responsible for ensuring that affected people are aware of the CFMs in place, know how to use them, and can easily access different channels to express their views. Barriers, diversities and capacities should be taken into account so that a wide range of people are included. In particular, the needs of vulnerable and marginalized groups should be considered e.g., children, elderly, women, people with disabilities, and people who speak different languages. Sensitive feedback relating to PSEA, child safeguarding, fraud, corruption, and security must be managed carefully. It is important that partner organizations have policies in place to address these issues.

10. Mainstreaming Gender and Protection in Cash and Voucher Assistance for Nutrition

Access to quality and safe food for good nutrition is a universal human right. Improving nutrition is critical to achieving gender equality. Nutrition programs should be informed by basic sex- and gender-based analysis that is based on the needs of greater affected population age groups and reduces inequalities of access. Basic nutrition analysis considering gender dimensions including understanding of the social norms can contribute to women's empowerment in Myanmar because health and nutrition role in the family is still viewed and performed widely as a woman or young girls' responsibility. In order that nutritional programs contribute to the empowerment of women and girls in crisis/conflict affected areas of Myanmar, the following key actions should be taken into consideration:

Overall Programme:

- Design to respond to the unique needs of all genders through the conduct of conflict-sensitive gender analysis, understanding how vulnerabilities, needs, risks, barriers, and access vary according to sex, age and other diversities.
- Avoid exposing recipients to harm and risk. Put safety and security issues related to provision of CVA at the primary focus.
- Build on social norms work to understand how gender dynamics around decision-making and cash handling might affect access to and effective usage of CVA.

Design Phase:

- Ensure participation of different gender groups in CVA design processes to address any gender-specific concerns and opportunities, including around the delivery mechanisms, access to and use of CVA.
- Consider child headed households and children whose primary caregiver has a disability and ensure that these people have equal access tailored to their needs.
- Ensure that personnel are informed of the gendered protection risks faced by women and girls and that conflict assessments have been conducted prior to the CVA activities implementation.
- Needs assessments need to include gender analysis and collect data disaggregated by gender, age, and disability.
- Ensure that personnel distributing CVA and CFM operators are trained on PSEA, GBV, Child Protection, and referral pathways that can be used for safe and confidential reporting of incidents.
- Liaise with specialized services (GBV or protection) to enhance GBV awareness in communities and link to GBV referral pathways.
- Together with a child protection officer, include children in the assessment to identify risks and benefits for children, particularly when the older child is responsible for collecting the CVA. Engage with child headed households and ensure there are no barriers for child headed households in collecting CVA.

Implementation and Monitoring Phase:

- The CVA teams are trained on GBV and CP referral pathways, ensuring that part of their kits are hotlines to report incidents. Ensure there is a code of conduct in place covering PSEA and Child Safeguarding.
- Ensure that the CVA team understand and can converse in the language that the community is using including having a good understanding of the community practiced social norms that impacts access to good nutrition.
- In communities with strong ethnic representations, ensure a balance of gender among personnel and community participation in consultation, FGD's.
- Consider safe spaces when conducting CVA activities like women center and women friendly spaces (liaise with Child Protection and GBV organizations)

- Adapt all tools and materials to the local language and that communities are informed of the CVA process, consulted, and can express their views and recommendations that help decision-making.
- Pay attention to potential differences in terms of preferred ways of communications and receiving/providing information by different gender groups.
- Targeting criteria needs to consider gender differences and should be set in a way not to expose any particular population groups (for example, GBV and CP survivors) at safety and security risks.
- Regular gender-responsive conflict analyses are conducted to ensure the programme is not exacerbating conflict drivers.
- Monitor access to CVA, safety in reception and use, ability to feedback, and participation in programme design/adjustments for different gender groups, through collection of disaggregated data by gender, age and disability.
- Develop mechanisms for feedback and complaint which are safely and easily accessible by different gender groups.