A Comparative Study of Cash for Work and Social Cash Transfer in Addressing Food and Nutrition Insecurity and WASH-Related Diarrhoeal Diseases in Urban areas, a Case of Harare. A Research Protocol

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ABSTRACT

Background: In Zimbabwe, the use of cash in humanitarian emergencies to address food and nutrition insecurity and WASH-related diseases has been adopted by both the government and humanitarian partners in urban areas. Mostly, two methods have so far been popularly used namely Social Cash transfers and Cash for Work. This raises questions on which one works best for urban areas. Government has remained undecided on which of the methods to adopt as the best method for urban areas. The authors therefore seek to conduct a comparative study of Cash for Work and Social Cash Transfer in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas of Zimbabwe.

Methods: This study will use a mixed method approach in its comparative analysis. Firstly, a quantitative survey will be conducted on randomly selected beneficiaries of the two forms of cash transfers. Concurrently, focus group discussions will be conducted with randomly selected participants from household beneficiaries, from each of the cash transfer methods. Key Informant Interviews (KIIs) with key stakeholders namely the City Health Department, Department of Social Development and The Office of the District Development Coordinator (DDC) will complement the data collected from the field. Qualitative findings will be recorded, transcribed, and analysed using MAXQDA Version 20 Pro per each thematic area. Simultaneously, quantitative data will be collected using Kobo Collect, exported into Microsoft Excel 2024, and analysed using Ms. Excel 2024 version. The strengths, weaknesses, opportunities, and threats (SWOT) framework would guide the triangulation of the findings to come up with a comparative advantage of each over another of the cash transfers. A writeup with recommendations will be produced.

Discussion: The outcome of the proposed study has the potential to influence humanitarian aid delivery method in urban areas of Zimbabwe in the area of cash transfers. Zimbabwe has started using cash transfers in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases but has not yet done a context specific study to analyse which of the cash transfers (between Social Cash Transfer and Cash for Work) works better in its urban communities. This research, therefore, provides a window of opportunity to explore these gaps and possibly come up with recommendations that, if adopted, could lead to improvements in the way aid and cash transfer interventions are delivered to the urban communities, as there has been increased need in recent years.

Keywords*:* Cash Transfer, Cash for Work, Social Cash Transfer, Nutrition, WASH-related diarrhoeal diseases, humanitarian aid**.**

BACKGROUND

The use of cash transfers in humanitarian response situations dates back to the 1870s when cash transfer was

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used in the Franco-Prussian war by the Red Cross Crescent to assist victims of war to afford basic needs including food, water supplies, sanitation and hygiene enabling materials(1). Since then, Cash transfers were used to respond to the Famine in India in the 19th century, and also in Botswana and Ethiopia in the 1980s to address different humanitarian emergencies(2). However, cash transfers recently got more prominent as a humanitarian aid of choice (in Zimbabwe and world over) and got preference over in-kind assistance (in form of food items and basic goods). The increasing use of cash transfers in the 2000s as part of humanitarian aid started to generate lots of interest in the humanitarian field(3). Most development partners have adopted cash programming due to its flexibility as an aid delivery modality and also the independency it gives the assisted people.

Cash transfers, however, can be split into two broad categories: conditional cash transfers (like cash for work) and unconditional (like social cash transfers). Most cash transfers which were done in the early 1990s and 2000s were unconditional social cash transfers and were given to women head in the household as there was overwhelming evidence that women heads within households were likely to use the extra income productively to assist families(3).

Social cash transfer programs have been used globally to alleviate poverty and to improve food and nutrition security. They provide direct financial support to vulnerable households, enabling better to needs such as access to food, healthcare, and clean water. Evidence suggests that cash transfers significantly reduce stunting and improve dietary diversity, particularly among children in low-income settings. Programs such as Brazil's Bolsa Família and Mexico's Prospera have demonstrated how linking cash transfers to health and nutrition services can enhance outcomes, especially in underprivileged communities(4). Thus, one can agree that if social cash transfers were effective in this case in Mexico and Brazil as they are mostly likely to be effective in Zimbabwe to address family food and basic amenities including hygiene enabling Non-Food Items like soap and buckets.

In Africa, social cash transfer programs have been integral to national and regional poverty alleviation strategies. They are linked to improved household food security, access to healthcare, and reductions in malnutrition-related diseases. UNICEF asserts that programs like Zambia's Child Grant Program and Kenya's Hunger Safety Net Program have successfully improved nutrition and reduced incidences of diarrheal diseases by empowering families to invest in better hygiene practices and food quality(5). This was because of the improved food consumption scores, dietary diversity and the improved buying power to purchase hygiene enabling items. These initiatives highlight the role of cash transfers in mitigating the impacts of poor WASH facilities and food and nutrition insecurity

In Zimbabwe, social cash transfers have been an essential social protection pillar, addressing extreme poverty and vulnerabilities caused by economic instability and recurrent climate shocks. The Harmonized Social Cash Transfer (HSCT) program run under the Department of Social Development (DSD), supported by international organizations such as UNICEF and WFP, has significantly impacted nutrition and WASH-related diarrhoeal diseases outcomes. For instance, households benefiting from SCT reported better food consumption scores and low case of child malnutrition(5). In Highfields, Harare, such programs have helped combat malnutrition by promoting nutrition related topics and information alongside cash disbursements(2). Since 2021, UNICEF partnered Government to improve SCT disbursements in the middle of COVID-19 in an attempt to improve nutrition situation in the high density. START Network also joined the SCT with cash allocation for hygiene enabling Non-Food Items (NFIs) like soap, handwashing-buckets, buckets for drinking water, water guard for point-of-use water treatment in an attempt to curb the outbreak of WASH-related diseases within Highfields and other disease prone locations. It was assumed that cash injection would help to reduce cases of WASH-related diseases like Typhoid fever and Cholera and protect the beneficiary community. These interventions were somewhat effective but with lots of lessons yet to be explored.

Cash for Work (CfW) programs have been utilized worldwide to provide temporary employment opportunities while addressing community development needs, including nutrition and water, sanitation, and hygiene (WASH) concerns and other environmental problems. These initiatives have been particularly impactful in disaster recovery and poverty alleviation as they are designed to provide short-term employment opportunities to vulnerable individuals or communities(6). Participants are typically paid cash in exchange for their labour in

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public works or community development projects such as infrastructure repair, water management, and environmental conservation within their communities. The approach serves a dual purpose: Firstly, it enables cash injection in disaster affected population by helping households meet immediate needs such as food, healthcare, and education. Secondly, it enhances community Development by building or improving local infrastructure and resources for long-term benefits.

Globally, CfW programs are instrumental in mitigating the effects of climate-induced disasters, reducing food insecurity, and improving public health outcomes through infrastructure projects like sanitation facilities and safe water systems (7,8). For instance, CfW programs have supported vulnerable communities during emergencies by combining cash payments with sustainable improvements in local environments, thereby enhancing community resilience. CfW was also used in areas like Haiti (post-earthquake in 2011) and also in Syria after the earthquake in 2023 to bring back the situation to normalcy by clearing rubbles, remains of animals and collapsed buildings(6,9). This was to retain environmental conditions as well as to make the environment safer for human habitation. After an assessment of the Haiti earthquake response through Cash for Work as a response mechanism, it was concluded that CfW programs should be rolled out to people who are most in need (i.e., poor and food insecure)" and also that the programs should be targeted at the most disadvantaged people on the job market or in areas where unemployment is high due to shocks (economic, natural or human induced disasters)(6).

In Africa, CfW initiatives are tailored to address the dual challenge of unemployment and public health crises. Programs often focus on building or rehabilitating WASH facilities. A significant example is CfW projects implemented in drought-affected regions, which have successfully reduced malnutrition by improving access to water and enabling households to afford nutritious food(8). In Niger, UN international Organization for Migration (IOM) implemented CFW to integrate returnees of forced migration into the society. Teams of around 100 people, composed of returnees and members of the local communities, are tasked with cleaning areas such as beaches and other public spaces. Beneficiaries work 5 days per week on the project and a sixth day is dedicated to awareness raising (on irregular migration, reintegration, civic responsibilities, etc.) and payments for the work undertaken over the 5 working days. One-third of their salary is paid in cash and two-thirds are transferred on a bank account opened for each beneficiary(10). The integration of WASH components into CfW programs has proven effective in reducing diarrheal diseases, particularly in children, by ensuring access to clean water and promoting hygienic practices(11).

In Zimbabwe, CfW has played a pivotal role in addressing urban poverty and public health challenges. In Mbare, a high-density suburb of Harare, since 2021, CfW programs supported by organizations like USAID have focused on improving food and nutrition security and reducing WASH-related diarrhoeal diseases. Participants have been engaged in activities such as constructing drainage systems, rehabilitating water points, and community clean-up campaigns, earning cash that helps them meet immediate food and health needs (12). Although no research has been done to date, these activities (like drain clearing, water points cleaning and rehabilitations) have the potential to contribute to a reduction WASH-related diarrhoeal diseases prevention (like a reduction in Cholera outbreaks) and improved household food security by linking cash earnings to nutrition education and access to essential commodities

The combined focus on cash assistance and community health improvements highlights the potential of CfW programs to address multifaceted urban challenges in Zimbabwe, providing a template for scalability and adoption in other high-density areas.

Problem Statement

Zimbabwe's urban poor face a complex humanitarian crisis characterised by chronic food and nutrition insecurity, high levels of unemployment, and frequent outbreak of WASH-related diarrhoeal diseases such as cholera and typhoid. These challenges have been worsened by climate change-induced phenomena, including the 2023-2024 El Niño-induced drought, severe water scarcity leading to council water rationing, and increased reliance on community boreholes. The contamination of water sources through human activities and illegal dumping of waste further exacerbates these issues. Frequent WASH-related diarrhoeal disease outbreaks in urban areas highlight the severity of this crisis. Notable examples include the 2018-2019 typhoid outbreak

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with 3378 cases in Harare alone(13), and the cholera outbreak from March 2023 to July 2024, which recorded 1 471 cases and 35 deaths in Harare(14). Such humanitarian situations demand ongoing and collaborative interventions from government and humanitarian agencies to safeguard vulnerable populations.

In response to the protracted droughts and diarrhoeal diseases outbreaks in Harare, various cash transfer programs have been implemented to support urban communities. Cash for Work programs was supported by USAID in Mbare and focussed on addressing food and nutrition insecurity and WASH-related diarrhoeal diseases by engaging communities in productive work around the thematic areas. Social Cash Transfers which were funded by UNICEF, on the other hand, were adopted in Highfields, providing direct financial support to address household food and nutrition insecurity and respond to WASH-related diarrhoeal diseases.

Cash transfer programs are pivotal in addressing poverty and vulnerability, especially in urban settings with food insecurity and high disease burdens. Cash for Work (CFW) and Social Cash Transfer (SCT) programs are two approaches recently adopted to improve food and nutrition security and respond to WASH-related diarrhoeal diseases. From early 2000, Zimbabwean government has been warming up to the use of cash transfer in urban humanitarian settings to address urban food and nutrition insecurity and respond to WASH-related disease outbreaks. This was achieved by providing cash to improve access to WASH-related Non-Food Items (NFIs) like soap, buckets with taps, aqua tabs and water guard for purifying drinking water, among others. Cash for Work has been used in Mbare by Government in partnership with USAID whilst Social Cash Transfers have been implemented in Highfields. While both CFW and SCT were implemented in Harare, their effectiveness in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases remains inadequately explored. This study aims to compare the two models' efficacy in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases.

Despite the concurrent implementation of these interventions, no comprehensive study has been conducted to compare Cash for Work and Social Cash Transfers in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas of Zimbabwe. This gap in evidence limits stakeholders' (including development partners) ability to design and implement the cash transfer interventions for vulnerable urban households, particularly in response to food and nutrition insecurity and WASH-related disease.

Objectives

- To determine the impact of Cash for Work programs in Mbare on household food and nutrition security and the prevention of WASH-related diarrhoeal diseases.
- To ascertain the impact of Social Cash Transfer programs in Highfields in addressing food and nutrition security and WASH-related diarrhoeal diseases.
- To assess community perceptions on the most favourable type of cash transfer between Social Cash Transfer and Cash for Work
- To determine the sustainability of both Cash for Work and Social Cash Transfer in solving food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas of Zimbabwe

Research Questions

1. What is the impact of Cash for Work programs in Mbare on household food and nutrition security and the prevention of WASH-related diarrhoeal diseases?
2. What is the impact of Social Cash Transfer programs in Highfields in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases?
3. What are the community perceptions on the most favourable type of cash transfer between Social Cash Transfer and Cash for Work in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas?
4. Is any of Cash for Work or Social Cash Transfer sustainable in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas of Zimbabwe?

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Significance of study

Cash Transfers are becoming popular as a way of addressing food and nutrition security problems and WASH-related diarrhoeal diseases in urban communities of Zimbabwe and other countries. Whilst there are 2 major forms of cash transfers namely CFW and SCT, the government is in dilemma over the right form of Cash transfer to use and therefore is implementing both in darkness. No study has been conducted to date to provide evidence over which cash transfer methodology can be cheap, effective and sustainable for urban areas. The findings will help government to decide from an informed position, not only in Harare but also other urban communities within Zimbabwe.

RESEARCH METHODOLOGY

Description of the study area

The study will compare cash transfer interventions in 2 districts of Harare High Density Suburbs, namely Mbare and Highfields. Mbare District is the oldest high-density residential area in Zimbabwe established around 1905 which has now grown to 50 000 in terms of population size(15). It is located about 5 kilometres due south of the City of Harare from the central business district (CBD). The area is predominantly characterised by very old Hostels/Flats and housing mainly built for working class in the CBD and surrounding industrial areas like Southerton, Workington and Graniteside. Due to high unemployment caused by economic instability, the local authority is struggling to supply portable water and to attend sewage and drainage systems in Mbare just like many other districts. Mbare is heavily affected due to its location as it houses the Mbare Musika (the biggest farm produce market in Zimbabwe). Levels of vulnerability and poverty are high, and this also includes able-bodied young people and those who lose their jobs as industries are closing due to inflation. Mbare has had most of its public facilities like community halls, health facilities and health facilities, water supply facilities and drainages for waste water in damaged or in derelict due to poor maintenance by the local authority and local community. The poor water supply systems and drainage systems posed a great risk of WASH-related diarrhoeal diseases and outbreaks of Typhoid and Cholera have been frequent in the past decade.

Highfields on the other hand is located 15km due west the City of Harare and has a total population of 14,439,018 (15). The area was established in 1930, as the second-oldest high-density suburb in Harare(16). Highfield was established as a place for black workers to settle, providing labour for the industrial areas of Southerton and Workington. Just like Mbare, the area has portable water challenges, and its drainage systems is frequently failing. Most of its public infrastructure like grounds, feeder roads, health facilities, water supply facilities, and drainage systems for waste water are poorly maintained due to understaffed local authority failing to manage the situation. Like in Mbare, in Highfields, the poor water supply systems and drainage systems posed a great risk of WASH-related diarrhoeal diseases and outbreaks of Typhoid and Cholera have been frequent in the past decade.

Study Design

The study will use a cross-sectional study design. Cross-sectional study designs as studies that provide a ‘snapshot’ of the outcome and the characteristics associated with it at a specific point in time(17). In a cross-sectional study, the investigator measures the outcome and the exposures in the study participants at the same time. Unlike in case–control studies (participants selected based on the outcome status) or cohort studies (participants selected based on the exposure status), the participants in a cross-sectional study are just selected based on the inclusion and exclusion criteria set for the study(18). Cross-sectional designs are used for population-based surveys and to assess the prevalence of diseases in clinic-based samples(17,19). The researcher will choose cross-sectional study design because survey technics that are used to gather data in this study design are relatively inexpensive (but robust) and take up little time to conduct. Cross sectional studies are also good in comparative analysis as they are also used in various researches to compare differences between communities, towns, cities and countries.

The research will also make use of mixed methods whereby both qualitative and quantitative methods will be

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used to ensure a thorough analysis of the study. Mixed methods permit a more complete and synergistic utilization of data than do separate quantitative and qualitative data collection and analysis(18).

Study Population and Sampling

Sampling is necessary to reduce the burden of visiting all the 2500 beneficiaries of SCT in Highfields and all the 1600 beneficiaries of CFW in Mbare District. This study will make use of stratified random sampling to select

all the areas with both Mbare and Highfields.

Sample Size

The researcher will use Rao soft sample size calculator with a confidence level of 95% and a margin of error of 5% for both High fields and Mbare districts. For Highfields, the sample size for the questionnaire will be 334 and for Mbare it will be 310. Table 1 shows the sample size for both data collection methods to be used.

Table 1: Sample size

District	Study Population	Questionnaires	Key Informants Interviews (KIIs)	Focus Group Discussions
Mbare	1600	310 (or more)	-Department of Social Development -Local Government -DDC -City Health-(EHO/EHT, Nutritionist, CHW)	3 Groups (10 people per group) (Women only, Mixed Adults, Youths and Children)
Highfields	2500	334 (or more)	-Department of Social Development -Local Government -DDC -City Health-(EHO/EHT, Nutritionist, CHW)	3 Groups (10 people per group) (Women only, Mixed Adults, Youths)

DATA COLLECTION METHODS AND TOOLS

The study will make use of questionnaires, focus group discussions, and, interviews for data collection. Qualitative findings will be recorded, transcribed, and analysed using MAXQDA Version 20 Pro per each thematic area. Quantitative data will be collected using Kobo Collect, exported into Microsoft Excel, and analysed using Microsoft Excel 2024 version.

Focus Group Discussion: Three focus group discussions will be done per each district namely: with women, mixed adults and youths. Each group discussion will have at least 10 people. Focus Group Discussions will stimulate participants to express their views openly on the issues raised and allow for a dialogue between them. Since questions are directed to the group as opposed to individuals, the dialogue has its own peculiar flow. Rather than a simple question and answer type, the discussion tends to grasp information regarding the ideas and opinion of the group towards an issue. The discussions will be moderated by the researcher and will last about forty minutes on average.

Questionnaires: These will be administered to beneficiaries of in the respective districts to ascertain their views on the impact of CFW and SCT. In Highfields, 334 questionnaires will be administered whilst in Mbare 310 questionnaires will be administered following the outcome of the Rao soft sample size calculator. The most important part of the research is in questionnaires, which is a formal and effective means of collecting

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opinionated data from respondents. The primary purpose of a questionnaire is to measure the effectiveness of CFW and SCT since the data collected will be presented in the form of words as well as figures or statistics. The questionnaires consist of a list of preset questions. All questionnaires will be electronic and will be uploaded on Kobo Collect and also deployed to mobile devices for the data collection. The researcher will reserve the first two (2) minutes explaining the purpose of the study and seeking consent. Clarifications will be made to the satisfaction of the respondents as well as when they are answering question by question.

Interviews: These will be administered to key informants (KIIs) like the District Social Development Officers,

Environmental Health Practitioners, Nutritionists and Community Health Workers. Structured interviews will be used for data gathering to get uniform data which is easy to analyse. KIIs will be interviewed in person or by telephone when physical interview is not possible. It is anticipated that key informants are more likely to present a less biased picture of the real situation on the ground since they are professionals.

Interview Design The researcher will make use of an interview guide which comprises a list of questions that are used to get answers from the respondents and to guide the researcher on questions to ask. In the guide, the researcher will deliberately use both structured and unstructured interview questions. The unstructured interview format is more useful because the researcher gets required in-depth knowledge about the situation and could ask follow up questions to probe further. The interview sessions will be made to last for about twenty minutes. During the interview the researcher makes no assumptions, a lot of follow-up questions and probes will be used to unearth and understand issues which will emerge during data collection.

Data Management, analysis and Presentation

Data from this research will be presented using tables, bar graphs and pie charts where necessary. Quantitative data collected will be analyzed using Microsoft Excel 2021 enabling the researcher to produce frequency tables, graphs, pie charts and statistics comparing different variables. The study will also use a Likert Scale to assess levels of food consumption score, dietary diversity and other variables, a sample of which is shown on Table 2 below. The Likert scale will have three (3) levels based on the number of meals eaten and correct responses. Mid-Upper Arm Circumference (MUAC) readings will be used to measure each of the cash transfers' impact on under two (2 years) children's nutrition. To measure the impact of SCT and CFW on WASH-related diseases, the study will make use of WASH indicators to track changes in access to safe improved water sources, improved sanitation facilities and hygiene practices such as washing hands with soap. Also, the study will assess if there are any changes in the incidence of diarrhoeal diseases before and after CFW or SCT programme. Qualitative data will be analyzed using the thematic approach and presented in a discussion manner and as per thematic area. Descriptive analysis and chi-square tests will be conducted to assess the association between each of the CFW and or SCT type of cash transfer and improved food and nutrition security and prevention of WASH-related diarrhoeal diseases.

Table 2: Likert Scale for measuring food consumption score

Scale	**Score**
Good	3+ meals per day
Fair	2 meals
Poor	1 meal per day

Strength and Limitations of the study

- The study will use a mixed method approach to collect and analyse data that would provide an in-depth understanding of the impacts of CFW and SCT on food and nutrition security and WASH-related diarrhoeal diseases in urban areas of Zimbabwe.

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- The study has high potential of being supported by the Ministry of Labour Social Welfare and the Ministry of Health and Child Care which are already battling food insecurity and WASH-related diarrhoeal diseases outbreaks respectively in urban areas and therefore findings of this study will also be shared by these relevant ministries.

- Literacy may be a challenge in most of the beneficiary households of CFW and SCT as they may struggle to answer technical questions and data provided could be prone to exaggeration. To address this, the researcher will use simplified questions. Mixed methods for both qualitative and quantitative data will be used and also triangulate data from questionnaires with interviews and focus group discussion to get the true picture of the impacts of both CFW and SCT.

- The study will also focus mainly on the benefits of CFW and SCT on improving food and nutrition insecurity and WASH-related diarrhoeal diseases prevention and ignore other benefits such as economic benefits and the ability to improve social cohesion.

- Broader economic challenges in Zimbabwe like inflation and increase in food prices may undermine the impact of both cash-based programmes which the study has no control over.

Ethical Considerations

Ethical issues will be important in this study because the study setting is a community environment with both adults and vulnerable children. Therefore, the researcher will apply the "do no harm" principle to ensure everyone is safe at all times and that their rights and freedoms are upheld. Other ethical considerations which will be considered include informed consent, confidentiality, and respect for intellectual property. This research will be conducted under the guidelines of the NUST Institutional Review Board (IRB) which will also give necessary ethical clearances.

Informed Consent: All participants will be engaged on voluntary basis and their consent will be sought first. Written informed consent will be sought for all the participants who will be interviewed physically and for those who will be virtually interviewed, a verbal consent will be sought. Participants will be informed at the beginning that their participation is voluntary and that they are free to withdraw during the assessment period. Participants will also be told beforehand of the assessment purpose and the benefits, or lack thereof, of participating.

Confidentiality: All responses which will be given during data collection will be kept secret. No names of participants will be made to appear in the write up. The collected datasets will be stored in a lockable machine or REDCAP which is a secure online data storage platform. A copy of this research protocol will also be submitted to NUST Research Review Board which are key stakeholders guiding this research. The research data will be kept safe for a maximum of five years; after which it will be destroyed per the protocols guiding this research process.

Respect for Intellectual property: All published work which have been used in this write up was cited as such. Credit was given where it was due. The researcher to ensured the originality of every piece of work in this research protocol.

List of Abbreviations

CFW	Cash for Work
CHW	Community Health Worker
COVID-19	Corona virus Diseases
DDC	District Development Coordinator / Government District Head

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DSD	Department of Social Development
EHT	Environmental Health Technician
EHO	Environmental Health Officer
FGD	Focus Group Discussion
IOM	International Organization for Migration
KIs	Key Informants
KII	Key Informants Interviews
MoHCC	Ministry of Health and Child Care
MUAC	Mid-Upper Arm Circumference
NUST	National University of Science and Technology
SCT	Social Cash Transfer
SDGs	Sustainable Development Goals
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

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APPENDIX 1: INFORMATION SHEET / CONSENT FORM

Title of the Research Study: " **A comparative study of Cash for Work and Social Cash Transfer in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas, a case of Harare**

Investigator: Sithole Polite Simon.

Greetings I am a MSc Environmental Health student in the department of Environmental Health at the National University of Science and Technology. As part of the partial fulfilment of my studies, I am required to conduct research and my topic is titled "**A comparative study of Cash for Work and Social Cash Transfer in addressing food and nutrition insecurity and WASH-related diarrhoeal diseases in urban areas, a case of Harare**. **A mixed-method research protocol"**. The aim of the research is to compare which type of cash transfer works better between social cash transfer and Cash for Work in addressing food and nutrition security and WASH-related diarrhoeal diseases in the Zimbabwean context.

Outline of the Procedures: You have been selected to participate in this study. You will be required to either respond to a structured questionnaire or be interviewed on issues pertinent to this study. This data collection process is estimated to take between 30 to 45 minutes of your time on average. This time could be shorter or longer depending on the issues raised.

Risks or Discomforts to the Participant: No foreseen risks would occur due to your participation in this study.

Benefits: There are no direct benefits that will be realised through participation in this study; however, your response would help in developing policy briefs that have recommendations that could be taken up by the relevant policymakers and lead to improved policies that are progressive and inclusive as far as one health approaches are concerned.

Reason/s why the Participant May Be Withdrawn from the Study: The participants are free to withdraw if they are not feeling well or are no longer comfortable with being part of the study. Participants will also be removed from the study if they do not comply with the stipulated rules or react in a way that could cause harm or discomfort to other participants and the research. It should be noted that if a participant chooses to withdraw or is withdrawn from the study, there will be no adverse consequences.

Remuneration: There will be no monetary benefits that will be realised through participation in the study. Participation will be voluntary.

Costs of the Study: Participants will not be expected to cover any costs towards the study.

Confidentiality: Participants will not be identified; they will be assigned participant numbers that are not traceable to the actual participants. The information will be confidential and only available to the researchers and the supervisors. The data collected would only be meant for academic purposes.

Research-related Injury: No injuries are expected to occur due to participating in this research as it is a survey. No experiments would be conducted on the participants.

Consent

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researchers about the nature, conduct, benefits and risks of this study.
- I have also received, read and understood the above-written information (Participant Letter of Information) regarding the study.

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- I know the study's results, including personal details regarding my sex, age, date of birth, initials and diagnosis, will be anonymously processed into a study report.
- In view of the research requirements, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- At any stage, without prejudice, I may withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during this research which may relate to my participation, will be made available to me.

Full Name of Participant

……. Date……/……/… Time …… Signature ……

(……) herewith confirm that the above participant has been fully informed about the study's nature, conduct and risks.

Full Name of Researcher

Sithole Polite Simon. Date……/……/……. Signature……

Full Name of Witness

……. Date ……/……/……. Signature……..

You Will Be Offered a Copy of This Consent Form to Keep.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher team, please feel free to contact:

Mr Taremba Chirigo

Project Supervisor

Appendix 2

QUESTIONNAIRE

Greetings! My name is Sithole Polite Simon. I am an MSc Environmental Health Student in the Department of Environmental Science at NUST. As part of my fulfillment of my studies, I am conducting a research study entitled **"A comparative study of Cash for Work and Social cash transfer in addressing food and nutrition security and WASH-related diseases in Harare high density suburbs."**

Your participation in this research study is voluntary and you are free to withdraw at any time. There are no monetary benefits attached to participating in this research. The data collected in this study will only be used for academic purposes only. Your name will not appear in the writeup or any publications that will emanate from this study. The data collection will take approximately 20 – 30 minutes.

Section A: Household Information

1. District: Mbare/Highfields

2. Type of Cash transfer you are participating you in

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a) Social Cash Transfer

b) Cash for Work

c) Other

d) Number of household members: _____

3. Do you currently receive any other government assistance programs?

a) Yes

b) No

4. How long have you been participating in the cash transfer program?

a) Less than 6 months,

b) longer than 6 months but less than 12 months

c) More than 12 months but less than 24 months

d) More than 24 months

Section B: Food and Nutrition Security

5. How many meals does your household typically eat per day?

a) Three times or more
b) Two times
c) Once

6. If food was inadequate, have you ever had to do any of the following in the past 12 months (Select all that apply):

a) Skip meals

b) Reduce pot size

c) Consistently eat less expensive foods

d) None of the above

7. Does this household have a Child under 2 years? Yes/No

(NB: If yes continue with the question, if no, skip to question 8)

a. Has this child ever been diagnosed with malnutrition? (Yes/No)

b. Child's age: ___

c. MUAC reading ___

8. Please indicate which food groups your household typically consumes in a week (tick all that apply):

- Grains
- Legumes

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- Vegetables
- Fruits
- Meat/Fish
- Dairy

Impact of Cash transfer on WASH-related diseases

9. What was your primary source of drinking water before the cash transfer?
   a) Piped water (council)
   b) Borehole (including upgraded to Piped Water Schemes)
   c) River/Stream
   d) Other (specify)
10. What was your primary source of drinking water after the cash transfer?
   e) Piped water (council)
   f) Borehole (including upgraded to Piped Water Schemes)
   g) River/Stream
   h) Other (specify)
11. Did your access to safe drinking water improved during the cash transfer period as a result of the program? Yes/No
12. How often did you use soap for handwashing before the cash transfer?
   a) Always
   b) Sometimes
   c) Rarely
   d) Never
13. How often do you use soap for handwashing now?
   a) Always
   b) Sometimes
   c) Rarely
   d) Never
14. Did you use any portion of the cash transfer for WASH-related improvements? (Yes/No)

(NB: Skip 13 and 14 if respondent answer is NO)

15. If yes, what did you invest in? (Select all that apply)

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a) Improved water access (e.g., buying storage tanks, pipes)

b) Sanitation facilities (e.g., constructing toilets)

c) Hygiene supplies (e.g., soap, detergent, water treatment tablets)

d) Other (specify)

16. What influenced your decision to invest in WASH-related improvements?

a) Health concerns

b) Community awareness campaigns

c) Guidance from cash transfer program

d) Other (specify)

17. Did any of the following happen in your area _____(tick all that apply)

a) Upgrading of Boreholes

b) Rehabilitation of boreholes

c) Storm drain clearing

d) Clearing of dump sites

e) Cleaning of water points

18. Have you or any household members experienced WASH-related illnesses (e.g., diarrhea, cholera, typhoid) in the last 12 months? Yes/No

19. What challenges did you face in using the cash transfer for WASH-related improvements?

a) Insufficient funds

b) Lack of awareness

c) Lack of supplies in the market

d) Other (specify)

20. What recommendations do you have to enhance the impact of cash transfers on WASH-related issues? _____

End Of Questionnaire

Appendix 3

FOCUS GROUP DISCUSSION (Community Members)

Greetings! My name is Sithole Polite Simon. I am an MSc Environmental Health Student in the Department of Environmental Science at NUST. As part of my fulfillment of my studies, I am conducting a research study entitled **"A comparative study of Cash for Work and Social cash transfer in addressing food and nutrition security and WASH-related diseases in Harare high density suburbs."**

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Your participation in this research study is voluntary and you are free to withdraw at any time. There are no monetary benefits attached to participating in this research. The data collected in this study will only be used for academic purposes only. Your name will not appear in the writeup or any publications that will emanate from this study. The data collection will take approximately 30 - 45 minutes.

1. Do you believe the cash transfer program has improved beneficiaries' household's food and nutrition security? (Yes/No) Why?
2. How has the cash transfer program impacted the ability to provide nutritious food for your children?
3. What improvements could be made to the cash transfer program to address food and nutrition security and WASH-related diseases?
4. What gaps/ missed opportunities did you observe in the cash transfer programmme?
5. What recommendations will you put forward for future consideration in the Cash transfer programme?

Appendix 4

Key Informant Interviews (City Health/DSD/Local Government)

Greetings! My name is Sithole Polite Simon. I am an MSc Environmental Health Student in the Department of Environmental Science at NUST. As part of my fulfillment of my studies, I am conducting a research study entitled **"A comparative study of Cash for Work and Social cash transfer in addressing food and nutrition security and WASH-related diseases in Harare high density suburbs."**

Your participation in this research study is voluntary and you are free to withdraw at any time. There are no monetary benefits attached to participating in this research. The data collected in this study will only be used for academic purposes only. Your name will not appear in the writeup or any publications that will emanate from this study. The data collection will take approximately 20 – 30 minutes.

1. Was there a reduction in the number of cases of nutrition related diseases/ conditions after the cash transfer program? Percentage of reduction____
2. Was there a reduction in the number of cases of WASH related diseases/ conditions after the cash transfer program? Percentage of reduction_____
3. Do you believe the cash transfer managed to resolve the food and nutrition related problems in the targeted area, and why?
4. Do you believe the cash transfer managed to resolve WASH-related problems in the targeted areas and why?
5. What recommendations do you have for the cash transfer programme in your area?