

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



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Special thanks for inputs and review to:

Alice Golay (CaLP)	Kathleen Myer (USAID/OFDA)
André Griekspoor (GHC)	Lauren Smith (WFP)
Andrew Beckingham (Save the Children)	Marie Sophie Whitney (ECHO)
Andrew Seal (University College London)	Marlene Hebie (GOAL)
Angeline Grant (GNC)	Masumi Yamashina (Child Protection AoR)
Anna Ziolkovska (GNC)	Mjabuli Jamela (WVI)
Belete Temesgen (WVI)	Nathalie Klein (CaLP)
Celine Sinitzky (Action Against Hunger)	Patricia Hoorelbeke (ECHO)
Ciara O'Malley (GOAL)	Rachel Lozano (ICRC)
Danka Pantchova (GNC)	Sajia Mehjabeen (Concern)
Dana Truhlarova Cristescu (UNICEF/CashCap)	Sona Sharma (Tech RRT)
Denise Costa Coitinho Delmue (UNSCN)	Stefano Fedele (GNC)
Gabriele Erba (UNICEF)	Stephane Meaux (WFP)
Jacqueline Fritz (CashCap)	Victoria Sauveplane Stirling (GNC)
Jihane Latrous (Child Protection AoR)	Yara Sfeir (GNC)
Kate McMahon (Mercy Corps)	

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Acronyms

AAH	Action Against Hunger
BMS	Breastmilk substitutes
CaLP	Cash Learning Partnership
CCT	Conditional cash transfer
CDDS	Child Dietary Diversity Score
CMAM	Community Management of Acute Malnutrition
CotD	Cost of the Diet
CVA	Cash and Voucher Assistance
DRC	Democratic Republic of the Congo
FAO	Food and Agriculture Organization
FCS	Food Consumption Score
FFV	Fresh food vouchers
FSL	Food Security and Livelihoods
GAM	Global Acute Malnutrition
GBV	Gender-based violence
GFD	General Food Distribution
GHC	Global Health Cluster
GNC	Global Nutrition Cluster
GTAM	Global Technical Assistance Mechanism
GWC	Global Wash Cluster
HAZ	Height-for-age score
HDDS	Household Dietary Diversity Score
ICRC	International Committee of the Red Cross
IYCF	Infant and Youth Child Feeding
KAP	Knowledge, Attitudes, Practices
LNS	Lipid-based Nutrient Supplement
MAM	Moderate acute malnutrition
MEB	Minimum Expenditure Basket
MFB	Minimum Food Basket
MPC	Multipurpose cash assistance
MUAC	Middle-Upper Arm Circumference
NCA	Nutrition Causal Analysis
NiE	Nutrition in Emergencies
OTP	Outpatient Therapeutic Program
PDM	Post Distribution Monitoring
PLW	Pregnant and Lactating Women
ROA	Response options analysis
SAM	Severe Acute Malnutrition
SBC	Social Behaviour Change
SC(+)	Supercereal (plus)
SNF	Specialized nutritious foods
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
UCT	Unconditional cash transfer
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WAZ	Weight-for-age score
WDDS	Women Dietary Diversity Score
WFP	World Food Programme
WHZ	Weight-for-height score
WVI	World Vision International

Terminology

The following terms are frequently used in this document and require clarification because they are new or lack common understanding among practitioners:

- *Household assistance* shall be defined as assistance that is provided at the household level in the form of in-kind, cash, or vouchers based on average household requirements for food/nutrition and sometimes (but not necessarily) other basic needs. Household in-kind assistance typically includes general food distributions (GFD) and non-food item distributions. Household Cash and Voucher Assistance (CVA) includes cash transfers or vouchers. Household cash transfers can be based on household food/nutrition requirements alone, or on needs across different sectors, i.e. multi-purpose cash (MPC).
- *Individual feeding assistance* shall be defined as assistance that is provided to meet the macro and micro-nutrient requirements of individuals (typically pregnant and lactating women (PLW) or children under 59 months) in the form of specialized nutritious food (SNF), cash or vouchers. It includes supplementary feeding, complementary feeding and micronutrient supplementation.
- *Nutrition outcomes* shall be 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. Also, 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.
- A *healthy or nutritious diet* describes a diet that is diversified and contains fruits and vegetables, whole grains, fibres, nuts and seeds, and during the complementary feeding phase, animal source foods (milk and dairy products, meat, fish, and eggs) (UNICEF, 2019). It should meet requirements for macro and micro-nutrients, including protein, vitamins and minerals, but does not exceed an individual's energy and fat requirement (WFP, 2019). *Healthy or nutritious foods* form the basis of a healthy diet.
- *Specialized nutritious foods* (SNF) are foods designed and produced for nutritional purposes as a form of dietary supplement. They range from fortified blended foods (FBF) and micronutrient powders to ready-to-use foods and high-energy biscuits. They are usually not commercially available in local markets in humanitarian settings.

For more information on key nutrition concepts and terms, please consult Action Against Hunger's [nutrition glossary](#).

All terminology related to CVA is based on the Cash Learning Partnership (CaLP) [glossary](#). Nonetheless, some of the CVA vocabulary warrants further exploration in the context of nutrition programming:

- CVA includes the provision of cash transfers and vouchers to targeted beneficiaries.
- *Cash transfers* include the provision of money (physical currency or electronic cash) to targeted recipients (individuals, households or communities). An example for cash transfers in the nutrition sector is the provision of money to PLW to access a nutritious diet or to pay the transportation fees to access health services. However, not all financial transactions in nutrition programmes constitute cash transfers. For example, the payment of incentives for volunteers or community health/nutrition workers, financial contributions to institutions such as schools, health centres, or government bodies are not considered cash transfers.
- *Vouchers* can be provided in paper or electronically and can be exchanged for a set quantity or value of goods or services, denominated either as value voucher (e.g. US\$ 15), commodity voucher (e.g. one cooking set, 5kg of rice) or service voucher (e.g. milling), or a combination thereof.
- *Conditionality* refers to prerequisite activities or obligations that a recipient must fulfil in order to receive assistance. The most common conditionalities in nutrition programming are related to participation in social and behavioural change (SBC) interventions or attendance to health services.

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Executive summary

Evidence Note

There is a growing recognition that Cash and Voucher Assistance (CVA) can contribute to improving maternal and child nutrition by impacting on the underlying determinants of adequate nutrition. This can occur in three main ways.

- i. CVA allows targeted households and individuals to purchase goods and access services that can have a positive impact on maternal and child nutrition. These include nutritious foods, items to prepare food, hygiene items, safe water, health services and medication, transportation, and productive inputs.
- ii. If provided conditionally, CVA can improve participation in nutrition Social Behaviour Change (SBC) activities and attendance to priority preventive health services.
- iii. Further, the increase in household income associated with CVA can reduce economic pressures and household tensions, in turn increasing the time available for caregiving, enhancing women's decision-making power, and improving psychological well-being of caregivers.

CVA can be effective in addressing economic barriers to adequate nutrition. These include financial barriers related to the lack of purchasing power at the household level to access goods and services, as well as opportunity costs of care giving behaviours. The potential of CVA to address economic barriers depends on a functioning supply side (e.g. the availability of nutritious foods in the market). The precise pathways of how CVA impacts nutrition are to a large extent determined by the spending decisions of households and individuals, which are again determined by social and cultural norms, programmatic decisions in relation to design and targeting and other contextual factors.

There is a sizable and growing body of evidence about CVA and nutrition outcomes, derived mainly from development settings but increasingly also from humanitarian settings. The evidence base for the impact of CVA on acute and chronic malnutrition is mixed. At the level of immediate determinants of nutrition, the evidence for the impact of CVA on the dietary diversity of children is mostly positive, while the evidence for impact on the health status of children is limited. At the level of underlying determinants, the evidence for the impact of CVA on household food security indicators and the uptake of preventative health services is relatively strong and mostly positive. There is no evidence for an impact of CVA on care behaviours.

Based on the existing evidence, there is a broad consensus within the nutrition sector that CVA alone is in most circumstances not sufficient to impact nutrition outcomes. CVA is most effective when complemented with other nutrition-specific and nutrition-sensitive interventions. Based on this consensus, many humanitarian organizations have developed cash plus or complementary programming approaches that call for household cash transfers to be complemented by additional measures to holistically address the most important demand and supply-side barriers.

Based on a review of peer-reviewed studies and operational examples, this Evidence Note identifies five main approaches to integrate CVA in nutrition response to prevent or treat malnutrition. These approaches can sometimes form the basis of a response on their own, can be combined with each other, or can be part of a wider integrated response. They include:

- 1) *Use CVA for household assistance and/or individual feeding assistance:* CVA modalities can be considered for both components with important limitations on individual feeding assistance. Combining household cash transfers with specialised nutritious foods is a promising approach to prevent malnutrition that warrants further exploration. Also, various humanitarian organizations have had positive operational experiences with the provision of fresh food vouchers to diversify diets.
- 2) *Combine household CVA with SBC interventions:* There is relatively strong evidence that combining household cash transfers with SBC can be an effective strategy to prevent child malnutrition. The two components seem to mutually reinforce each other in the sense that SBC activities seem to

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promote child/women-centred spending decisions, while the cash transfers allow caregivers to put some of their acquired knowledge and skills into practice. Therefore, CVA modalities that aim to contribute to nutrition outcomes need to be accompanied with context-specific SBC interventions.

- 3) *Provide conditional cash transfers as an incentive to attend to priority health services:* There is relatively strong evidence (mainly from development settings) that cash transfers conditional on the attendance of free priority preventative health services can improve the uptake of these services.
- 4) *Cash or vouchers to facilitate access to treatment of malnutrition:* CVA can be effective in addressing indirect costs to accessing treatment of malnutrition related to transportation as well as food and accommodation if the child requires in-patient care and the caregiver needs to stay at the treatment centre.
- 5) *Provide household cash or vouchers as part of treatment of severe acute malnutrition (SAM):* The provision of household CVA to caregivers who bring their child for the treatment of SAM has demonstrated potential to improve recovery and reducing defaulting and non-response to treatment. At the same time, there is anecdotal evidence that some caregivers may keep or make their child malnourished in order to access assistance.

Guidance Note

The Guidance Note identifies seven steps throughout the humanitarian programme cycle and four transversal issues that need to be considered when incorporating CVA in a nutrition response. All steps require close collaboration and coordination between the nutrition sector, the Cash Working Group (CWG), and other sectors notably food security, health, WASH and protection. The nutrition cluster/sector coordination team is responsible for the overall coordination of CVA components of a nutrition in emergency response.

In the *first step*, the sector needs to determine whether CVA can contribute to nutrition outcomes by analysing the role of economic barriers in maternal and child malnutrition. Nutrition assessment tools as well as tools from other sectors can help to gain a comprehensive overview of barriers to adequate nutrition, including economic barriers.

In the *second step*, the feasibility of using CVA as part of a nutrition response is determined. The feasibility assessment should be primarily based on already available information on the capacity of markets for the supply of food and non-food items, the availability of health and delivery services, the availability of transfer mechanisms and other feasibility considerations.

In the *third step*, feasible CVA approaches should be included in the response options analysis. While CVA does not change the way nutrition practitioners define objectives and select nutrition response options, there are additional modalities to be considered. In contexts where communities face economic barriers to the underlying determinants, feasible CVA modalities and approaches should be considered as part of response options analysis.

In the *fourth step*, the CVA component of the response is designed. The quality of design of the CVA component is a major contributor to its potential impact on maternal and child nutrition. Design decisions need to be taken regarding targeting, conditionality, transfer amount, frequency, timing and duration. Targeting criteria are largely determined by the programme objectives and type of response rather than the assistance modality. When considering conditionality to enhance participation in SBC activities and attendance to priority health services, the expected benefits of introducing the conditionality, i.e. improved participation or uptake, need to be weighed against estimated costs, resource requirements and other factors. A softer approach to conditionality can reduce costs and resource requirements and might be a more suitable approach in emergency settings. While transfer amount, duration and frequency of transfers depend on the objective of the CVA component, more generous transfers, a longer duration and more regular transfers are more likely to have a positive impact on nutrition.

Steps five, six and seven cover the mobilization of resources, and the implementation and monitoring of the CVA component. The implementation of the CVA component should follow existing organizational

guidelines and procedures and available best practice. The definition of indicators to monitor nutrition outcomes depends on the programme objective and is not tied to the assistance modality. When the CVA component aims to provide access to a nutritious diet, it is important to measure dietary diversity and food consumption at the level of children and women to be able to capture intra-household differences. Furthermore, the use of CVA needs to be monitored to understand whether the assistance was used to access nutrition relevant goods and services.

Transversal issues cut across the humanitarian programme cycle and include preparedness, coordination, information management and risk analysis and mitigation. Preparedness actions should be extended to CVA in contexts where cash and/or vouchers are likely to be feasible and adequate response options in nutrition in emergencies. All relevant risks of the CVA component need to be identified and measures to mitigate these need to be adopted. Most risks associated with CVA can be mitigated through project design and a strong accountability framework.

With the rapidly increasing use of household cash transfers (including multi-purpose cash (MPC)) in humanitarian response, there is an opportunity to better incorporate nutrition considerations in cash-based responses. Household cash transfers alone, including MPC, should not be expected to contribute to nutrition outcomes of individual household members. However, different measures can be taken to increase the likelihood that they do. These measures include the integration of context-specific SBC with household cash transfers; appropriately reflecting nutrition in the minimum expenditure basket and transfer amount calculation; choosing nutrition sensitive targeting criteria; and including nutrition objectives and indicators in the project design.

Introduction

Background and justification

Malnutrition¹ continues to pose a major challenge to human well-being around the world. In 2020, an estimated 144 million children under five suffer from stunting (i.e. chronic malnutrition)², 47 million children under five were wasted (i.e. acute malnutrition)³, of which 14.3 million were severely wasted, and an additional 340 million suffered from micronutrient deficiencies (UNICEF/WHO/WB group, 2020). Poor diets drive malnutrition in early childhood: 44 per cent of children aged 6 to 23 months are not fed fruits or vegetables and 59 per cent are not fed eggs, dairy, fish or meat (UNICEF, 2019). The ongoing COVID-19 pandemic is further exacerbating these deficiencies and as undernourished people have weaker immune systems, they may be at greater risk of severe illness due to the virus.

The problem of malnutrition is particularly pronounced in humanitarian crises. These are characterized by limited access to adequate safe food and water, disruptions in health and nutrition services, disruptions of livelihoods, food production and income generation opportunities, and constraints to protecting, promoting and supporting optimal infant and young child feeding.

The use of Cash and Voucher Assistance (CVA) as a modality of humanitarian assistance has been increasing rapidly in the past years. The amount of CVA programmed increased from US\$ 2.8 billion in 2016 to US\$ 5.6 billion in 2019, constituting 17.9 per cent of total international humanitarian assistance in 2019 (CaLP, 2020). The use of cash and voucher modalities has been increasing within all humanitarian sectors and to address needs across sectors.

There is a growing recognition that CVA modalities can contribute to nutrition outcomes, however, the use of CVA for nutrition outcomes in emergencies has been limited. There are several likely reasons for this, e.g. a rather limited yet growing evidence base, and limited familiarity of nutrition practitioners with CVA modalities and approaches. Further, there has been no guidance on why, when, and how to integrate cash and voucher modalities in nutrition interventions, what information and analysis is required to make these decisions and on how the CVA component should be designed to maximize effectiveness and to minimize risks. This document attempts to address this gap.

Purpose, objectives and structure

The main purpose of this document is to provide the nutrition sector with evidence and guidance to more routinely consider and, if appropriate, use cash and voucher modalities in nutrition in emergencies response in order to better address the nutritional needs of vulnerable populations. It consists of the following parts:

[Part 1](#) – Evidence Note: Provides an overview on the evidence base on the use of CVA for nutrition outcomes in emergencies⁴ and identifies the most common approaches and best practice to integrate CVA in nutrition response.

[Part 2](#) – Guidance Note: Provides operational guidance on considering and using cash and voucher modalities in nutrition in emergencies response. It further provides entry points on how to improve the potential of household cash transfers, including multi-purpose cash to contribute to nutrition outcomes.

¹ The term malnutrition describes both undernutrition (including stunting, wasting and micronutrient deficiencies) and overnutrition (including overweight and obesity). This document will focus entirely on undernutrition. As such, the terms malnutrition and undernutrition are used interchangeably.

² Stunting refers to a child who is too short for his or her age. These children can suffer severe irreversible physical and cognitive damage that accompanies stunted growth.

³ Wasting refers to a child who is too thin for his or her height. Wasting is the result of recent rapid weight loss or the failure to gain weight. A child who is moderately or severely wasted has an increased risk of death, but treatment is possible.

⁴ The term 'emergency' shall be used interchangeably with the term 'humanitarian settings'. Emergency/humanitarian settings shall include the acute emergency phase, recovery and protracted situation with humanitarian needs.

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It concludes with [recommendations](#) to the nutrition sector and other humanitarian actors on key actions that are required to more routinely consider and, if appropriate, use cash and voucher modalities in nutrition in emergencies. The Guidance Note draws on key findings in the Evidence Note and includes cross-referenced relevant sections. It can however be read as a stand-alone document.

Target audience

The primary audience of this document are nutrition practitioners, be they nutrition cluster/sector coordination teams or nutrition programme staff. The secondary audience are CVA practitioners aiming to use CVA to contribute to nutrition outcomes.

Methodology

The methodology used in the development of this document relied on:

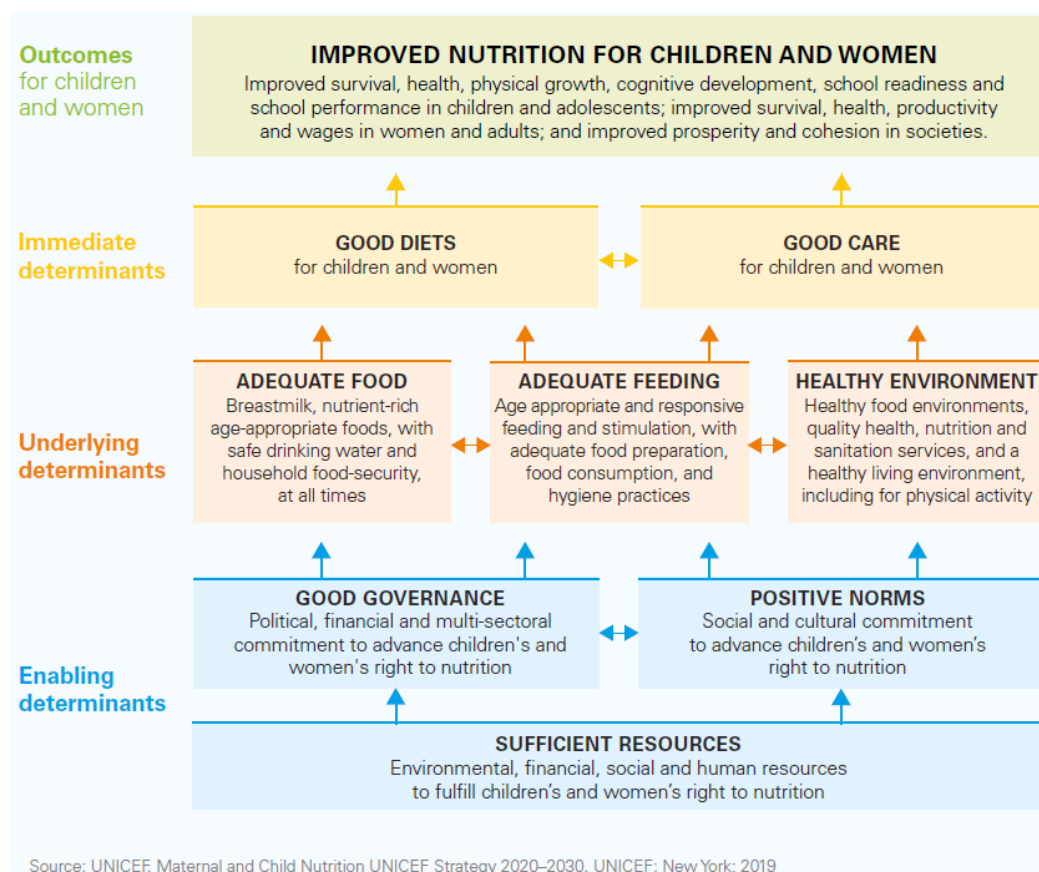
- A desk-based review of peer-reviewed studies on CVA and nutrition: priority was given to studies in humanitarian settings, but findings from development settings have been included as well, especially in areas where the evidence base from humanitarian settings is weak. An overview and summary of reviewed studies can be found in [Annex 2](#).
- A desk-based review of nutrition programmes with a CVA component: Programme documentation was collected from various contexts and separate case studies were conducted for Nigeria and Somalia to better document ongoing practices. An overview and summary of reviewed programmes and documents can be found in [Annex 2](#).
- Over 50 key informant interviews with humanitarian practitioners and researchers with experience in CVA and/or nutrition.
- Support provided by a reference group: A reference group representing more than 15 humanitarian organizations under the umbrella of the Global Technical Assistance Mechanism (GTAM) was set up to guide the development of this note and to validate its content.

Part 1: Evidence Note on the use of Cash and Voucher Assistance for nutrition outcomes

This Evidence Note starts by linking CVA with the conceptual framework for adequate maternal and child nutrition. It further introduces demand and supply side barriers to achieving adequate nutrition and how cash and voucher modalities can address some of these barriers. It continues with providing an overview on the impact of cash and vouchers on the nutrition status of children and determinants of adequate nutrition, concluding that CVA alone is mostly not enough to achieve nutrition outcomes. Lastly, based on reviewed studies and programme documents, the note identifies and assesses the main approaches to integrate CVA in a nutrition response.

1.1 Cash and Voucher Assistance and the conceptual framework on maternal and child nutrition

Figure 1. UNICEF’s updated conceptual framework of the determinants of maternal and child nutrition



In its 2019 *State of the World’s Children* report, UNICEF (2019) updated its conceptual framework on the causes of malnutrition (see Figure 1), acknowledging the evolving and multiple nature of maternal and child malnutrition and incorporating new knowledge on the drivers of malnutrition.

The framework lists different resources that contribute to achieving the underlying determinants. CVA can contribute to the enabling determinants, as it can be considered a financial resource of a crisis-affected household. Other financial resources include savings, income, remittances, credit, selling of assets, etc. For the most vulnerable households in a humanitarian crisis, CVA is often an important if not the only financial resource they can access.

In principle, CVA can impact the underlying determinants of maternal and child nutrition in three main ways:

- a. It allows households to purchase goods and access services that can have a positive impact on maternal and child nutrition. These include foods as part of a healthy diet, items to prepare food, hygiene items, safe water, health services and medication, transportation, and productive inputs.
- b. If provided conditionally, CVA can be an incentive to participate in nutrition Social Behaviour Change (SBC) activities and attend priority preventive health services.
- c. It can positively impact child and maternal nutrition through increased household income that can reduce household tensions and economic pressures, in turn increasing time available for caregiving, enhancing women's decision-making power, improving psychological well-being of caregivers, etc.

CVA cannot address all barriers to adequate nutrition and relies on functioning and accessible systems on the supply side (e.g. food markets or health services) to be effective. Also, it rarely directly acts upon the immediate determinants of adequate nutrition, i.e. good diets and good care, but can complement and reinforce other nutrition-specific measures that do.

It is important to note that cash transfers are in principle unrestricted and individuals or households will take their own decisions on how best to spend the money. These decisions might or might not be nutrition sensitive and/or child centred. The precise pathways of CVA for adequate nutrition are to a large extent determined by the spending decisions of households and individuals, which are again determined by social and cultural norms, programmatic decisions in relation to design and targeting and other contextual factors. Vouchers are by nature restricted and usually earmarked towards specific sectoral purchases (e.g. vouchers to access fresh and fortified foods or transport vouchers). Despite these restrictions, vouchers or the items obtained with them can be monetized, as it is the case for in-kind aid, if households consider other needs as more pressing. Based on their research and analysis, Seal et al. (2017) developed a theory of change ([see Annex 1](#)) which visualizes the flow of money, the role of household decision making, and the multiple pathways through which CVA can improve the underlying determinants of adequate nutrition and contribute to nutrition outcomes.

1.2 Demand and supply side barriers to adequate nutrition

The conceptual framework for adequate nutrition presented above helps understanding the potential pathways for CVA to improve nutrition outcomes. It does not, however, help understanding the different barriers to the underlying determinants and the role of CVA in addressing these. *Table 1* highlights common barriers⁵ to adequate nutrition on the demand and supply side⁶ for each of the underlying determinants. The barriers highlighted in yellow are considered 'economic barriers' and can be addressed by enhancing additional purchasing power, e.g. CVA. Economic barriers are all on the demand side. They include both financial barriers related to the lack of financial resources at the household level to access goods and services as well as opportunity costs. The term opportunity costs is used to describe the decision made by caregiver to devote limited time to care giving or not to attend health and nutrition services because the direct/indirect costs and implications of doing so (e.g. loss of income, agricultural yield, etc.) are perceived as too high (Puett et al., 2012). Most additional barriers on the demand side are of behavioural nature, which are typically addressed through SBC activities.

⁵ While the table lists the most common barriers, it cannot list all possible barriers to the underlying determinants, many of which are context-specific barriers. Some of these barriers might only apply to certain vulnerable groups. For example, social norms and cultural factors might inhibit access to markets or health services for women or minority groups.

⁶ Demand side barriers shall be understood as factors that negatively influence the ability of individuals, households and communities to access nutrition-relevant goods and services or to provide care. Supply side barriers shall be understood as factors that negatively impact the ability of support structures and systems to supply nutrition-relevant goods and services.

Table 1. Potential demand and supply side barriers to adequate nutrition

Demand-side barriers	Supply-side barriers
Underlying determinant: adequate food	
<ul style="list-style-type: none"> - Inadequate production of nutritious foods for household consumption - Insufficient knowledge and skills on nutritious diet preparation - Nutritious diet not affordable - Transportation to markets not affordable - Markets not accessible due to distance, safety concerns, social and cultural factors, etc. - Cooking utensils and cooking fuel not affordable - Inadequate storage and preparation of food at the household level - Household income not used to purchase nutritious foods - Inadequate sharing of food within households (not child or women centred) 	<ul style="list-style-type: none"> - Insufficient availability and/or quality of productive inputs - Insufficient food production and/or importation - Insufficient availability and/or quality of nutritious food in local markets - Inadequate handling and storage of foods (especially fresh foods) along the supply chain - Insufficient availability of cooking utensils and fuel in local markets
Underlying determinant: adequate feeding and care⁷	
<ul style="list-style-type: none"> - Preparation of adequate complementary food for children 6-24 months not affordable - Inadequate knowledge and skills on how to prepare nutritious complementary food - Lack of caregivers' time for optimal feeding and care due to economic pressure (e.g. work) - inadequate caring practice due to lack of knowledge and skills - Traditional beliefs, practices and perceptions that negatively impact adequate feeding and care of infants, young children and women - Lack of caregivers' control over resources contributing to spending decisions that are not child or women centred - Inadequate physical and mental well-being of caregivers 	<ul style="list-style-type: none"> - Infant and young child feeding (IYCF) policies at central and local level not adequate - IYCF services and support for adequate care (e.g. health services, IYCF counselling services, women support groups) are not available or not functional - Insufficient availability of nutrition dense complementary foods - Inadequate social protection policies (e.g. paid parental leave; support of breast-feeding in the workplace or in society)
Underlying determinants: healthy environment	
<ul style="list-style-type: none"> - Accessing and using health services is not affordable due to direct costs (e.g. consultation fees, diagnostic tests and/or medicines) and indirect costs (e.g. transport or accommodation costs) - Health services not accessible due to distance, safety concerns, acceptability by community, social and cultural factors, etc. - Opportunity costs of seeking health and nutrition services are considered too high - Lack of knowledge on existing (preventive) health services - Inadequate health seeking behaviour due to lack of knowledge of malnutrition and other disease, traditional beliefs, etc. - Hygiene items for general and specific needs (e.g. new-born hygiene, menstrual hygiene) not affordable - Lack of knowledge and skills on hygiene and sanitation practices - Safe water and water treatment not affordable 	<ul style="list-style-type: none"> - Health services not sufficiently available - Health service of insufficient quality - Adequate drugs, supplies (e.g. therapeutic foods) and equipment for maternal and child health services are not available - Hygiene and sanitation items for general and specific needs not available in the local market - Inadequate availability and quality of water at household, community and health facilities level - Inadequate water and sanitation infrastructure - Inadequate and insufficient water storage at household and health facility level - Lack of hygiene items in the market

Note: **Economic barriers** are highlighted in yellow

CVA is mainly effective on the demand side by providing households or individuals with the financial means to address economic barriers to compensate for a loss or lack of income. However, the ability of CVA to address demand side barriers depends on other barriers and a functioning supply side. For example, if nutritious food is not or insufficiently available in local markets, CVA will not be effective in improving access to a nutritious diet. If access to preventive health services is mainly inhibited by a lack of acceptability, safety concerns or a lack of acceptability within the community, CVA alone will not improve access. Therefore, a comprehensive understanding of causes and barriers and a holistic

⁷ Optimal infant and young child feeding and care includes adequate protection, promotion and support of breastfeeding, adequate complementary feeding and adequate care practices.

approach to address both the demand and supply side is paramount to achieve programme objective in a sustainable manner.

CVA is less effective in addressing supply side barriers, although some programmatic approaches exist to increase food availability: Cash grants or vouchers to obtain productive inputs (seeds, fertilizer, etc.) can be provided to local farmers to boost food production. Cash-for-work⁸ can support local food production by rehabilitating productive infrastructure (e.g. irrigation). Food traders can be encouraged to increase the supply of nutritious foods as part of a voucher response, where contracted vendors can anticipate an additional demand.

Additional market support interventions (MSI) can address supply side barriers to adequate nutrition. MSI aim to improve the situation of crisis affected populations by providing support to critical market systems on which the target population relies for goods, services, labour or income (CaLP, 2018). In the context of addressing supply side barriers to adequate nutrition, critical market systems concern mainly the markets for food items, non-food items and health services. Possible MSI to strengthen the supply side include the provision of SNF and nutrition supplements; increasing nutrient content of foods (food fortification); support to traders, producers and other actors within relevant supply chains to improve the availability of nutritious foods, water and hygiene items in local markets. Also, linking local smallholder farmers with school feeding programmes (*home grown school feeding*); reducing post-harvest losses; grants to schools to support school feeding programmes; water and health infrastructure support to improve the quality and availability of services⁹.

1.3 The impact of cash and vouchers on the nutrition status of children and the determinants of adequate nutrition

The previous chapter looked at how CVA can potentially impact nutrition through different pathways and by addressing economic barriers to adequate nutrition. This chapter summarizes the overall evidence base for these pathways and for achieving nutrition outcomes at different levels, with a focus on humanitarian settings. It further looks at evidence of the impact of design on nutrition outcomes. The summary builds on comprehensive evidence reviews which have been conducted by [Fenn \(2015\)](#), [Fenn \(2017\)](#), [Bastagli et al. \(2016\)](#), [De Groot et al. \(2015\)](#), and [Bailey et al. \(2012\)](#).

There is a sizable and growing body of evidence on the impact of CVA on nutrition outcomes. The bulk of evidence is in development settings, but an increasing number of studies are looking at humanitarian settings as well. The evidence is a mixture of the positive impacts, where cash transfers contributes to nutrition outcomes, and the non-significant, where no clear contribution is identifiable (Harvey et al., 2018). *Table 2* provides a summary of impacts on determinants of adequate nutrition and nutrition status.

Table 2. Summary of Impacts of CVA on Nutrition¹⁰

Level of impact	Mostly positive	Mixed	None	Comment
Impact on nutrition status of children				

⁸ Cash for Work is probably the most common conditional approach in humanitarian situations. In a Cash for Work programme, participants provide their work to build or repair a community asset in exchange for a financial incentive. The work usually requires participants to be able to partake in physical labour which is often not appropriate for PLW or children. As such, Cash for Work is not a recommended CVA modality to increase household income as part of nutrition programming and will not be covered in this document.

⁹ For more generic information on MSI, please consult the [market support interventions tip sheet](#). For additional examples and guidance on addressing supply side barriers related to adequate nutrition, please consult FAO's [key recommendations for improving nutrition through agriculture and food systems](#), the [UNICEF Health Systems Strengthening Approach](#), and GWC's [Guidance on Market Based Programming for Humanitarian WASH Practitioners](#).

¹⁰ This table is adopted from De Groot et al., 2015, and Fenn, 2017, and updated based on new evidence.

Child nutrition status		**		Mostly positive evidence on stunting, mixed evidence on wasting, limited and inconsistent evidence on micronutrient status
Impact on immediate determinants				
Dietary diversity of children	**			Growing positive evidence for children, limited evidence for women
Health status of children	*			Positive impact on improving treatment results in one study
Impact on underlying determinants				
Household food expenditure	***			
Household food consumption and dietary diversity	***			Consistent positive impact of CVA
Uptake in preventive health services	**			Evidence mostly from development settings
Water, sanitation and hygiene	*			Limited positive evidence on access to water, sanitation and hygiene items
Feeding behaviours and practices			*	No evidence mainly due to the heterogeneity of indicators used
Psychosocial care for children			*	No evidence mainly due to the heterogeneity of indicators used
Intra-household decision making	**			
Intimate partner violence	**			Positive results are mainly due to a reduction in income-related tension, frustration, and fighting
Caregivers' mental health			*	Psychosocial well-being as positive spill-over from receiving CVA

Strength of evidence: * none or limited, ** growing, *** moderate, **** strong

Nutrition status of children and women

Bastagli et al. (2016) found statistically significant positive changes in anthropometric outcomes for *wasting* in one out of five studies. More recent studies in humanitarian settings also documented statistically significant impacts of CVA on wasting (Kurdi et al., 2019a; Bliss et al., 2018; Fenn et al., 2017). Other studies (e.g. Grijalva-Eternod et al., 2018; Sibson et al., Hougbe et al. (2017) did however not find any impact of CVA on children's risk of being wasted, even though the interventions consistently contributed to improved household food security and dietary diversity¹¹. Despite the lack of documented impact in some studies, Fenn (2017) concludes that there is a limited but growing number of studies with statistically significant results showing positive impacts of CVA on the risk of wasting among children between 6 and 59 months in both emergency and development programmes.

As compared to wasting, the evidence base for the impact of CVA on *stunting* is stronger, particularly in development settings. Bastagli et al. (2016) found statistically significant positive changes in anthropometric outcomes for stunting in 5 out of 13 studies. More recent studies also documented

¹¹ Grijalva-Eternod et al. (2018) acknowledge that they cannot satisfactorily explain the lack of impact of the intervention on the risk of malnutrition in children and raise the question whether modifications to these interventions such as adding SNF or SBC activities could make a difference. Sibson et al. (2018) suggest that the surge in malaria limited the effectiveness of the intervention. Hougbe et al. (2017) suggest that the transfer amount might have been too low to address the needs of the household and the children's specific needs.

statistically significant impacts of CVA on stunting in both development (Ahmed et al. in Bangladesh) and humanitarian settings. Fenn et al. (2017) in Pakistan looked at the effectiveness of different CVA modalities (single cash, double cash¹², fresh food vouchers) on nutrition outcomes. They found that all three modalities reduced stunting (increased mean height-for-age score (HAZ)) at both six 6 months and 12 months of follow up, but only double cash had an impact on wasting and only at six months of follow up. Fenn (2017) concludes that there is a growing number of studies with statistically significant results showing positive impacts on the HAZ score.

The evidence of statistically significant improvements in underweight children is more limited than measures for wasting and stunting and evidence in improving micronutrient status is inconsistent (Fenn, 2017).

Immediate determinants of maternal and child nutrition

As remarked previously, CVA usually indirectly act upon the immediate determinants through the underlying determinants. The evidence base for the impact of CVA on the dietary intake of children and women is less robust compared to the evidence at the household level. Nevertheless, there is growing evidence that CVA often leads to an increase in *expenditure on food for children*¹³ and to improvements in the *dietary diversity of children (and women)* in both development and humanitarian settings (see for example Fenn et al., 2014, 2017; Grijalva-Eternod et al., 2018; Kurdi et al., 2019a; OPM, 2019).

There is very limited evidence on the impact of CVA on the treatment of child illness (Fenn, 2017). CVA can increase the uptake of health services, which is likely to improve the health of children thus resulting in reduced perceived need for treatment. A number of organizations have begun to use service vouchers to enable access to reproductive, maternal and new-born care services as well as treatment of child illness in humanitarian settings. Grellety et al. (2017) studied the impact of cash transfers provided alongside the treatment of children with severe acute malnutrition (SAM) in the Democratic Republic of the Congo (DRC). They found that children in households that received cash transfers gained weight faster, were more likely to recover from SAM and less likely to default or fail to respond to treatment compared with children in the control group.

Underlying determinants of maternal and child nutrition

There is strong evidence from both development and humanitarian settings suggesting that CVA consistently increases *household food expenditure* and improves *household food consumption* and *household dietary diversity* (Fenn, 2017, 2015; Bastagli et al., 2016; de Groot et al., 2015; Manley et al., 2013; Bailey et al., 2012;). There is an ongoing debate on whether cash transfers or vouchers are better suited to improve household food security and how this compares with in-kind food assistance. In general, CVA may be more effective than in-kind food transfers for improving dietary diversity, while in-kind food transfers may more effective than CVA at increasing caloric intake (Fenn, 2017; Bailey, 2013). However, as Gentilini (2016) points out, the relative effectiveness of different transfer modalities cannot be generalized and although some differences emerge in terms of food consumption and dietary diversity, average impacts tend to depend on context, programme objectives and design.

Evidence from development settings seems to suggest that cash transfers, both conditional and unconditional, can improve *uptake in preventive health services*. Bastagli et al. (2016) reviewed 15 studies reporting overall effects on the use of health facilities and services, of which nine report

¹² Double cash was twice the amount of single cash.

¹³ Increased expenditure on food for children does not automatically translate into improved nutrition status. Bliss et al. (2016) researched the factors associated with the risk of acute malnutrition among children aged 6 to 36 months in households targeted by emergency cash transfers in Niger. They found that food expenditures for children and other diet-related factors were not associated with the risk of acute malnutrition. Rather, low baseline weight-for-height Z-score (WHZ), baseline household poverty status, and the occurrence of child illness were significantly associated with high risk.

statistically significant increases. Furthermore, three studies tested the effect of conditionalities, two finding that conditions on attending health services led to a higher number of visits compared to transfers with no conditions. The evidence from humanitarian settings is much more limited. A study in Somalia (UCL and Concern, 2020) found that conditional cash transfers were associated with a strong and significant increase in the likelihood of children being vaccinated, thus supporting the findings from other studies that conditional cash transfers may be better suited to promote health seeking behaviour than unconditional transfers. On the other hand, a study in Mali (Le Pont et al., 2019) did not find any evidence on the incentive value of conditional cash transfers.

There is limited evidence on the impact of CVA on Water, Sanitation and Hygiene (WASH). However, there is emerging evidence that CVA modalities have a positive effect on access to water, sanitation items and hygiene items (GWC, 2020).

There is no evidence for the impact of CVA on aspects of care behaviours, such as feeding behaviours and psychosocial care for child. Nonetheless, there is growing evidence that CVA can contribute to positive outcomes on gender-based violence (GBV), which might have a positive impact on care behaviours. Cross et al. (2018) reviewed 28 studies related to CVA and GBV and found that the clear majority of CVA interventions (71 per cent) had a positive impact on GBV indicators, while only 4 per cent had a negative impact. The positive impact was concentrated in intra-household decision-making and most interventions with positive impact on decision-making targeted women as beneficiaries. Beneficiaries felt improved joint decision-making and/ or increased bargaining power in their households following CVA. Also, they noted that the most common positive spill-over effect from CVA cited across the literature was psychosocial well-being of women receiving CVA. Little to no evidence was found on the impact of CVA on other indicators of GBV, such as early or forced marriage, asset ownership, or exposure to sexual harassment, exploitation or abuse.

As for intimate partner violence, Cross et al. (2018) found that 80 per cent of the evidence indicates that the impact of CVA on intimate partner violence is positive. Positive results are mainly due to a reduction in income-related tension, frustration, and fighting. Intimate partner violence tended to increase when there were not enough resources to meet basic needs; when there was unemployment; and when heads of households felt powerless to provide for their families.

Some programmes reviewed by Bailey et al. (2012) have shown that cash transfers reduced the time spent away from home and increased time for domestic activities, including caring for children.

The impact of programme design on nutrition outcomes

Studies from development contexts suggest that higher transfer amounts showed positive effects on HAZ and weight-for-height score (WHZ) and access to preventive health care. There is a consensus that the transfer amounts need to represent a significant contribution to the household economy, e.g. transfers of between 15 and 30 per cent of the overall household expenditure, if it is to have an impact on nutritional status (Fenn, 2017). Only one study is looking at the impact of different transfer amounts on nutrition outcomes in humanitarian settings. Fenn et al. (2017) looked at the impact of four different interventions in Pakistan (two different-sized unconditional grants, a fresh food voucher, and a control group). They found that the amount of cash given was important and only in the group that received the higher amount were the odds of a child being wasted significantly lower compared to the control group.

In a study in Niger, Aker et al. (2014) compared the effect of delivery mechanisms (the effect of mobile payment mechanisms compared to manual cash delivery) on household dietary diversity. The results suggest that mobile payments in Niger led to a statistically significant improvement in dietary diversity of around 16 percentage points. Also, households receiving mobile transfers consumed more meals per day. The authors attribute the results to two factors: time saving (i.e. recipients spent less time traveling to and waiting for their transfer) and increased intra-household bargaining power of women who received the mobile payments. Apart from the Niger study, there is no evidence to suggest that some delivery mechanisms are better suited to achieve nutrition outcomes than others.

The determinants of malnutrition are often seasonal and are likely to change in response to shocks and disasters. Consequently, the timeliness of initiation and duration of CVA are likely to be important factors affecting its ability to prevent undernutrition (Fenn, 2015). Bastagli et al. (2016) identified seven studies that looked at the effect of the duration of receipt in development settings, five of which found a significant improvement in child anthropometric measures and increasing use of health care due to a longer duration of a programme. As for timing, Bailey (2008) in a qualitative study in Niger observed that cash given before or during the hungry season would most likely be spent on food, whereas cash given at the end or after the hungry season would more likely be used for productive assets and paying off debts. Sibson et al. (2018) in Niger compared the impact of two unconditional cash transfers (UCT) where one group received four transfers during the 'lean season' between June and September and the other group six transfers, initiated prior to the lean season (April to September). The cumulative amount of cash received by the groups was equal, i.e. FCFA 130,000 (approximately US\$ 220). They found no difference in the prevalence of GAM between the two interventions and no evidence that early initiation of assistance prior to the lean season would have a positive impact on children's nutritional status.

As for the frequency of transfers, some evidence from development settings suggests that regular payments (e.g. monthly) have a greater short-term impact on nutrition outcomes and the underlying causes of undernutrition, such as food expenditure, while less frequent and lump sum transfers are more likely to be invested in productive activities such as agricultural production (Fenn, 2015). Ecker et al. (2019) assess the mitigation effect of the national cash transfer programme of the Social Welfare Fund on child malnutrition in Yemen. They found that the mitigation effect tends to be larger the more regular payments are received, as regular assistance allows beneficiary households to regulate their food consumption and other demands influencing child nutrition outcomes.

1.4 Cash and Voucher Assistance alone is not enough

As outlined in the previous chapter, CVA can lead and contribute to nutrition outcomes, but its success largely depends on contextual factors, intervention design and implementation features. Based on the expanding evidence base, there is today a broad consensus within the sector that:

- CVA alone is in most circumstances not sufficient to impact nutrition outcomes
- CVA is most effective when complemented with other nutrition-specific and nutrition-sensitive interventions

For a nutrition response to succeed, the different demand and supply side barriers to adequate nutrition including behavioural barriers and access to and quality of services need to be addressed. The exact mix of interventions will depend on the nature of the emergency, the resources and infrastructures available to the affected population and the availability of goods and services in local markets (Seal et al., 2017).

This broad consensus led to the development and adaptation of the 'cash plus'¹⁴ approach by different humanitarian and development organizations. The cash plus approach calls for household cash transfers to be supplemented by additional measures to address the most important demand and supply side barriers more holistically and thereby better achieve anticipated outcomes and impacts.

Box 1. Examples of organizational approaches to 'cash plus'

Save the Children's cash plus for nutrition approach combines the household cash transfer with complementary nutrition-specific interventions. Complementary interventions are informed by an understanding of the context-specific drivers of malnutrition in a given area. They should always include SBC activities and referrals and linkages to health and nutrition services as core components. In

¹⁴ Some organizations prefer to use the term complementary or integrated programming, as cash plus might give the impression that the cash component is at the centre of the intervention.

addition, if required, they can also include micronutrient supplementation, provision of SNF, and investments in nutrition, health and sanitation services. (Save the Children, 2019a)

UNICEF in collaboration with Roelen et al. (2017) analysed different ‘cash plus’ programmes in development contexts to identify key factors for successful implementation. They find that complementary components addressed some of the non-financial and structural barriers that poor people face and have reinforced the positive effects of cash transfers and thereby contributed to greater impacts of the respective programmes. In a recent publication, Trenouth (2020) analysed the cost of UNICEF’s ‘cash plus’ interventions in Lebanon and the DRC.

FAO’s ‘cash plus’ approach is more geared towards livelihoods and resilience. It defines ‘cash plus’ as an intervention that combines cash transfers with productive assets, inputs, and/or technical training and activities to enhance the livelihoods and productive capacities of poor and vulnerable households (FAO, 2018). Nutrition-sensitive approaches are promoted through the selection of nutrient-rich and diverse inputs and assets and through nutrition education and nutrition sensitive agricultural practices as part of the technical training.

1.5 Main approaches for integrating cash and vouchers in nutrition response

Based on the review of peer-reviewed studies and operational examples, five main approaches to integrate CVA in nutrition response were identified (see Table 3). These approaches can form the basis of a response, can be combined with each other, or can be part of a wider integrated response.

Table 3. Five main approaches for integrating CVA in a nutrition response

Approach		Main objectives of the CVA component
Prevention	Combine household assistance with individual feeding assistance	Household CVA: <ul style="list-style-type: none"> • Improve household food security and dietary diversity • Protect nutritional status Individual feeding CVA:
	Cash or vouchers can be considered for both components	<ul style="list-style-type: none"> • To prevent deterioration in the nutritional status of at-risk groups • To reduce the prevalence of MAM in children under five • Support dietary diversification
	Combine household cash or vouchers with SBC interventions	<ul style="list-style-type: none"> • Improve household food security and dietary diversity • Protect nutritional status • To prevent deterioration in the nutritional status of at-risk groups
	Provide conditional cash transfers to incentivise attendance to priority preventative health services	<ul style="list-style-type: none"> • Improve attendance to priority health services • Cover indirect costs and reduce opportunity costs of seeking health services • Improve household food security and dietary diversity • Protect nutritional status
Treatment	Provide cash or vouchers to facilitate access to treatment of malnutrition	<ul style="list-style-type: none"> • Facilitate access to treatment services by covering indirect costs
	Provide household cash or vouchers assistance to caregivers of children with SAM	<ul style="list-style-type: none"> • Improve treatment outcomes: reduce defaulting, non-response to treatment and relapse • Improve household food security and dietary diversity • Protect nutritional status

In the following chapters, each approach is explored in more detail using evidence from peer-reviewed studies and examples from operation responses in mainly humanitarian settings. The detailed results and learning from peer-reviewed studies and operational examples can be found in [Annex 2](#).

1.5.1 Combine household assistance and individual feeding assistance

A common preventive strategy utilized in various contexts is to combine household assistance (in-kind food, cash or voucher) with individual feeding assistance (usually provided through SNF) targeting at-risk groups within households.

In many humanitarian contexts, cash transfers or vouchers have fully or partially replaced the in-kind household assistance (GFD and non-food items) over the last decade. As for individual feeding assistance, there is a growing recognition that cash or vouchers have a role to play. Sphere (2018) for example recognizes cash and vouchers as possible response options in complementary feeding and the prevention of micronutrient deficiencies to access nutritious foods on local markets.

Nonetheless, there has been a lack of agreement on whether and when CVA in the form of cash top-ups and vouchers to access fresh and fortified foods can be considered as an alternative to the in-kind provision of Specialized Nutritious Foods (SNF)¹⁵. Similarly, there has not been a strong consensus on whether and how cash or voucher modalities can be considered as an alternative to the in-kind provision of breastmilk substitutes (BMS) as part of artificial feeding management. This document proposes the following guidelines:

Box 2. Guidelines for when (not) to consider CVA as an alternative to the in-kind distribution of SNF and BMS

- CVA modalities can be considered as an alternative to the in-kind provision of lipid nutrient spread (LNS) and fortified blended foods (FBFs) for the prevention of malnutrition if nutritious and fortified foods with the required micro and macronutrients are locally available, accessible and can be prepared with sufficient nutrient density¹⁶. The transfer amount of CVA for individual feeding assistance should be based on the nutrient requirements of at-risk groups and should at minimum be sufficient for recipients to access the nutrient content equivalent to the SNF that is being replaced in the local market.
- Cash transfers and value vouchers to access locally available nutritious foods should not be considered as an alternative to the in-kind distribution of micro-nutrient powders (MNPs). In the rare circumstances where MNPs are available in local pharmacies and the quality can be assured, commodity vouchers can be considered for targeted individuals to access such products.
- CVA to access locally available nutritious foods should not be considered an alternative to the distribution of in-kind SNF for the treatment of MAM and SAM where a specific lack in nutrients needs to be addressed. CVA to facilitate access to treatment or as household assistance can however complement treatment strategies to enhance treatment outcomes.
- As part of artificial feeding management¹⁷, cash transfers or value vouchers should not be considered as an alternative to the in-kind provision of BMS. In contexts where code-compliant products are available in the local market, e.g. in local pharmacies, the IFE core group (2017) suggests that commodity vouchers can be considered an alternative to the procurement and direct distribution of in-kind BMS. If commodity vouchers are used to access code compliant BMS, vendors should be supported as required to address labelling shortfalls and Code violations should

¹⁵ For an overview on SNF for the prevention and treatment of malnutrition, please consult [MAM decision tool for emergencies](#), Appendix C (GNC, 2017) or WFP's [Specialized Nutritious Foods Sheet](#).

¹⁶ Infants and young children have comparatively high energy requirements per kilogram of body weight (FAO, 2001) and have limited capacities to consume food. They need complementary foods with a high nutrient density (particularly for iron and zinc), with a texture and a density that is palatable and likeable by children, taking into account their capacity to chew, the small size of their stomach, and safety considerations (ECHO, 2014).

¹⁷ Artificial feeding management irrespective of the assistance modality requires needs and risk assessment and critical situational analysis, informed by technical guidance. Analysis should include whether a demand for BMS constitutes an actual need and/or whether other interventions, including improved support for breastfeeding, are indicated to ensure infant nutrition and health (IFE core group, 2017). All programming to support artificial feeding, including use of vouchers for BMS, requires close consultation with the IFE coordination authority.

be reported. Furthermore, caregivers should be advised on appropriate and inappropriate BMS for different age groups (IFE Core Group, 2017).

- Where household cash transfers are implemented and there is a risk that caregivers purchase locally available BMS, the cash transfer should be accompanied with strong messaging on the value of breastfeeding, on recommended IYCF practices, and provide information on where all infants can access IYCF support (IFE Core Group, 2017).

Peer-reviewed evidence

Langendorf et al. (2014) compared seven strategies to prevent acute malnutrition in 6 to 23-month old children in Niger, all providing household assistance in the form of cash or in-kind food and/or LNS/Supercereal plus (SC+). They observed the lowest MAM and SAM incidences in the 'cash plus' SC+ group. Distributions combining household assistance (cash or in-kind food) and supplementary food had a better preventive effect on MAM and SAM than strategies relying on cash or supplementary food alone. It is worth noting that the cash plus SC+ strategy was more effective for the prevention of SAM than the in-kind food plus SC+ strategy. Also, the incidence of MAM in groups receiving both nutritious supplementary food (SC+, LNS- medium quantity, LNS- high quantity) and cash was half of that seen in the group that received cash only, although the latter received a top-up to cover the additional cost of buying locally available nutritious foods for the targeted child. This finding indicates that direct provision of nutritious supplementary food has greater benefit than a comparable cash top-up amount in terms of nutrition outcomes for young children.

The benefits of complementing household cash transfers with SNF is also documented in two studies from Mexico. Ramírez-Silva et al. (2013) found evidence that the effect of the cash-based social protection programme on improved dietary intake of iron, zinc and vitamin A was the result of the in-kind food supplement rather than improvements in the household diet, which largely resulted from the cash transfer. Behrman and Hodinott (2005) show that the actual intake of nutritional supplements as part of the cash-based social protection programme led to a significant increase of about a sixth in mean growth per year for children aged from 12 to 36 months.

Operational examples

Operational experience of using CVA in either household or individual feeding assistance is more diverse than in peer-reviewed settings. Various organizations have used fresh food vouchers or cash top-ups in combination with household assistance to prevent malnutrition.

Fresh food vouchers (FFV) are usually provided on top of household assistance (often GFD) targeted towards PLW or children below two years of age, with the objective to diversify diets and enhance access to fresh foods and animal source products, thereby preventing malnutrition among children and PLW. FFV have consistently proven to increase dietary diversity at household level and to a lesser extent at individual level (*see examples in Annex 2*). A meta evaluation of FFV in several countries found that: FFV correlated with lower rates of anaemia (Bolivia); increased nutritional programme attendance (Dadaab); declines in acute malnutrition (Dadaab and Haiti); and income replacement and therefore reallocation of income to other livelihoods needs and protection of assets (occupied Palestinian Territories and Pakistan) (AAH, 2012a).

When providing FFV as a top-up, it is essential to guarantee a staple food supply through household assistance (CVA or in-kind food). They should be accompanied with sensitization and support on how to use fresh foods to prepare nutritious meals. Their design can be adjusted based on programme requirements and the needs of at-risk groups in terms of choice (value or commodity vouchers) and items to include. Commodity vouchers that do not allow for any choice can direct recipients towards fresh foods that are rich in specific micronutrients. In a pilot in Bolivia, AAH provided commodity vouchers to PLW with the objective of increasing the consumption of micronutrient-rich fresh food and

to reduce anaemia (AAH, 2012a). Value vouchers on the other hand allow for more choice, taking into consideration beneficiary preferences, seasonality of fresh food supplies and other food available to the household (AAH, 2012b).

Despite encouraging examples from peer-reviewed studies of pairing household cash transfers with SNF, there are almost no operational examples for this approach. To prevent further deterioration in the nutrition situation and reduce malnutrition prevalence, the ICRC in Somalia from 2017 to 2018 designed a two-phase intervention using UCT, food vouchers and SNF. Eligible households received UCT plus high energy biscuits (BP5) in a first round and commodity food vouchers and SC in a second and third round. Monitoring results showed an important improvement of the GAM and particularly SAM rate among assisted households. The approach of combining commodity food vouchers with SC was later replicated in other regions, with similar positive results.

The provision of a cash top-up to diversify diets in combination with GFD is even less common in practice, probably because if a cash transfer can be provided as a top-up, it is tempting and probably more efficient to provide the household component in cash as well. UNHCR and WFP provided cash top-ups for dietary diversification in addition to an in-kind food assistance to refugees in Kakuma Camp, Kenya. Despite the assistance, a scurvy outbreak was observed in the camp in 2017. A subsequent study (Ververs et al., 2019) found that the cash transfer intended for dietary diversification was not used to purchase fresh foods but rather to complement the insufficient food rations with more calorically dense and cheaper staple foods to secure the missing calories, leading to vitamin C deficiency in adolescent and young adult male refugees who have comparatively high energy requirements. This example illustrates that more attention needs to be paid to household composition and size when determining food rations and transfer amounts.

A cash transfer amount that is based on the macro- and micro-nutrient requirements of an individual or a household would not require an additional top-up. In reality, transfer amounts are usually calculated on an average household size and average macro- and (rarely) micro-nutrient requirement per person. Therefore, an individualized cash top-up in addition to household cash assistance can be justified to account for the detailed household composition and the additional nutrient needs of at-risk groups to prevent malnutrition. No operational experience for such cash top-ups was found. Langendorf et al. (2014) looked at the provision of household cash transfers plus a cash top-up to buy locally available nutritious foods as one of seven preventive strategies. They found that household cash transfers plus the top-up was significantly less effective in preventing malnutrition than providing household cash transfers plus supplementary nutritious foods for the children.

Conclusion

There are multiple possibilities to include CVA in a preventive food security-based strategy. From the limited existing evidence, it is not possible to identify a combination with a track record of working well in various contexts¹⁸. While CVA can be considered for both components with important limitations on individual feeding assistance, cash transfers might be more suitable to household assistance, while vouchers to access fresh and fortified foods might work better for individual feeding assistance. Langendorf et al. (2014) found positive results for combining household cash transfers and SNF to prevent acute malnutrition, which should encourage further exploration and documentation of this approach. Also, various organizations have had positive experiences and were able to encourage diversity in diets using fresh food vouchers complemented with household assistance. More research is required on the best combinations of modalities for the household and individual feeding component to achieve nutrition outcomes.

¹⁸ Similar to the debate on the best assistance modality for food security outcomes, the effectiveness of different modalities and their combinations might depend to a large extent on context, specific objectives, target group and programme design.

1.5.2 Combine household cash transfers or vouchers with social and behavioural change interventions

Spending decisions at the household level are a critical factor when it comes to CVA having a direct impact on the nutritional status of women and/or children. These spending decisions can, to some extent, be influenced by SBC interventions, which often accompany in-kind interventions but are of particular importance in CVA interventions as cash transfers are unrestricted and allow recipients to spend the assistance according to their preferences and needs.

SBC¹⁹ aims to improve behaviours and the social conditions to create an enabling environment to support positive maternal, infant and young child feeding, health and WASH practices (Save the Children, 2019a). SBC and CVA can make a mutually reinforcing contribution to adequate nutrition. SBC can equip households with the required knowledge, skills and motivation to make nutritious food purchases in the marketplace, also to use healthier food preparation methods at home, and to ensure equitable intra-household food allocation (WFP, 2019). CVA allows them to put this knowledge and skills into practice.

The specific behaviours to be targeted through SBC vary according to the context and should be informed by adequate research and assessments. They can include, but are not limited to, the following (Save the Children, 2019):

- pregnancy nutrition and care;
- optimal breastfeeding;
- appropriate complementary feeding²⁰ (including frequency, consistency, quantity, diversity);
- composition of healthy diets;
- hygiene and sanitation (e.g. personal and household hygiene, food hygiene, use of latrines, handwashing, safe drinking water).

In addition, and particularly relevant when transferring cash, SBC may also tackle household decision making (such as control over resources, resource allocation, purchase of nutritious foods), household dynamics (such as food sharing and prioritizing nutritional needs) and financial management. Some organizations (AAH, WFP) have started to reflect how these new topics could be integrated into SBC when pairing it with cash transfers.

Gender inequality commonly creates barriers to nutrition and health, e.g. via limited decision-making power, mobility, literacy. Save the Children (2019a) highlights the importance of integrating gender equality across all areas to ensure that SBC addresses discriminatory social and gender norms that prevent women and children from claiming their full and equal rights. Nutrition practitioners can work with GBV actors to achieve this. In addition to reaching pregnant women and mothers of young children, SBC activities must engage fathers and other family influencers. They must also create conditions for a supportive care environment that encourages a child-centred use of household resources.

A variety of approaches and channels can be used to conduct SBC, including interpersonal communication²¹, mass communication²² or community mobilization²³. In general, using multiple SBC approaches and channels to change behaviours is more effective than using only one approach,

¹⁹ SBC draws from the understanding that knowledge is necessary, but not sufficient for nutrition-related behaviour change. Thus, SBC is an extension of previous approaches, including behavioural change communication (BCC), as SBC acknowledges the underlying multi-level social and contextual dimensions of behaviour (WFP, 2019).

²⁰ SBC materials for community based infant and young child feeding can be found [here](#).

²¹ Interpersonal communication with mothers, fathers and family members, delivered by frontline workers or volunteers. For example, one-to-one counselling, interactive nutrition and hygiene promotion sessions, mother-to-mother support groups, father's/men's groups, and food or cooking demonstrations, voice and text messaging.

²² Mass communication can come in the form of radio, television, and video programming, print and social media and community theatre.

²³ Community mobilization, such as action-oriented groups, to build capacity of existing community structures and key stakeholders to identify, prioritise, plan, implement, monitor and evaluate solutions to address issues around nutrition.

targeting multiple contacts has a greater effect than targeting women alone, and more visits or contacts result in greater change (Lamstein et al., 2014). SBC interventions can also be integrated into CVA implementation. For example, nudging, choice architecture, and promotion of locally available nutritious foods can be used to influence consumer choices at contracted vendors.

In programmes where CVA and SBC are combined, CVA can be provided in a number of ways:

- conditionally, i.e. the assistance is tied to the participation in interpersonal SBC activities,
- unconditionally, i.e. the assistance is not tied to the participation in interpersonal SBC activities, or with
- a soft conditionality, i.e. participants are still required or at least expected to fulfil a certain condition, but in case of non-compliance, there is a follow up and encouragement to fulfil the conditionality in the next round.

Soft conditionality has emerged as an alternative, particularly in humanitarian settings where enforcing conditionality can be challenging (see Kurdi et al., 2019a, and Ahmed et al., 2019, for examples).

Peer-reviewed evidence

Several peer-reviewed studies in the past years have documented positive impacts of combining cash transfers with SBC on child nutrition. Fenn et al. (2017) in Pakistan conclude that larger amounts of cash combined with SBC can benefit child growth. They also suspect that the larger financial amount may have led to a better uptake of SBC messages. Bliss et al. (2018) in Niger suspect that the conditional SBC activities and the sizable transfer amount were key features in achieving the positive results on child nutrition. They speculate whether the high attendance to effective SBC activities in combination with household cash transfers can fulfil a similar role as supplementary food in the prevention of malnutrition. Kurdi et al. (2019a) in Yemen conclude that cash transfers combined with SBC in a conflict setting can have significant positive impacts on indicators of maternal and child nutrition. They highlight the benefits of soft conditionality, which can be an effective alternative to unconditional or strictly conditional cash transfers in conflict settings, because it encourages high attendance at SBC sessions without excluding non-attendees.

Ahmed et al. (2019) conducted two randomized control trials in Bangladesh to compare different combinations of assistance modalities and SBC. The treatment arms include cash transfers, a food ration, or a mixed food and cash transfer, as well as treatments where cash and nutrition SBC (only in the North) or where food and nutrition SBC (only in the South) were provided. The study found that 'cash plus' nutrition SBC performed significantly better than cash alone or other assistance responses (food ration, mixed food and cash transfer, food ration plus SBC). Only the 'cash plus' SBC approach had a significant impact on the nutritional status of children. Improved diets in the cash and SBC arm, including increased intake of animal source foods, seem to be a key factor for these results.

In IDP camps around Mogadishu, UCL and Concern (2020) compared the impact of cash transfers (conditional upon attending child health visits) on reducing the risk of acute malnutrition among children 6-59 months with and without SBC. The SBC component was delivered through weekly voice message directly to caregivers' cell phones (mHealth). The study found that mHealth led to an increase in household expenditure on food and an improvement in the child dietary diversity score, as well as to a significant reduction of the risk of mortality in children younger than five years.

Operational examples

More and more organizations are recognizing the potential of pairing cash transfers and SBC as a preventive strategy. Save the Children (2019a) identifies SBC as a central component of their 'cash plus' for nutrition approach. World Vision International (2019) sees SBC as a key component of cash transfers aimed at improving nutrition outcomes and argues that continuous sensitization and

counselling for beneficiaries on how to spend their money can encourage spending patterns that are in line with improving nutrition outcomes. Furthermore, they see SBC as a means to promote the sustainability of health and nutrition outcomes, since there is a risk that quantity and quality of beneficiary diets may decrease once the cash assistance stops.

The operational experience of pairing cash transfers and SBC in development and humanitarian contexts is expanding rapidly. Save the Children in Myanmar implemented the Maternal and Child Cash Transfer (MCCT) programme, which provided monthly cash transfers to mothers in their last two trimesters of pregnancy until the child turned two years old ('first 1,000 days'). The SBC activity complementing the cash transfers covered a range of topics related to nutrition and child health. The end-line report (Maffioli et al., 2019) reviewed nutrition results in three groups: one group of mothers that received cash and SBC, one group that received only cash and one group that did not receive any intervention. The end-line study found that cash paired with SBC led to more expenditure on food and better results in terms of stunting and wasting as compared to the other groups. The cash plus SBC interventions had a positive impact on both mothers' and children's dietary diversity. Meanwhile, mothers in the 'cash plus' SBC group had a higher knowledge of breastfeeding practices, which led to a higher proportion of children (0-5 months old) receiving exclusive breastfeeding compared to the other groups.

The Child Development Grant Programme (CDGP) in Nigeria implemented by Save the Children and Action Against Hunger in Zamfara and Jigawa states also targeted the 'first 1,000 days' and provided targeted households with monthly cash transfers and SBC. The programme successfully led to a reduction in the prevalence of stunting among children. It had a strikingly positive impact on women's and men's knowledge and beliefs about healthy IYCF practices, as well as the reported adoption of such practices, including exclusive breastfeeding rates, the uptake of vaccines and antenatal care visits, and increased dietary diversity of infants over six months. For several of the indicators measured, the positive impacts of the CDGP were found to have continued even after households had stopped receiving transfers (OPM, 2019).

In Nigeria, Action Against Hunger (AAH) implemented three subsequent projects aiming to improve food and nutrition security of crisis-affected populations in Borno and Yobe States since 2016. These projects combined general household assistance (i.e. the provision of food, cash and/or vouchers) to increase immediate food consumption for food-insecure households and nutrition SBC targeting PLW, with a focus on adopting optimal IYCF practices. The implementation of the nutrition SBC approach varied between projects and states. In Yobe State, SBC was implemented through care groups. In Borno State, SBC was implemented through the 'porridge mum' approach. In the 'porridge mum' approach, each group (approximately 15 PLW), received a cooking utensils set including a locally made fuel efficient stove, monthly food vouchers to purchase ingredients for the daily cooking demonstration and a cash transfer to cover additional costs related to transportation and cooking. The food vouchers and cash transfer were administered by each group's treasurer. Also, each group was trained on preparation and cooking of nutritious foods.

Overall, the projects on Borno and Yobe led to improved dietary diversity and knowledge and uptake of IYCF practices, such as exclusive breastfeeding and adequate complementary feeding. However, the Borno evaluation also found that kitchen-based activities (i.e. the daily preparation of nutritious meals) stopped when AAH assistance stopped at the end of March 2019. In response, AAH changed its 'porridge mum' approach for the follow-up project and reduced the number of cooking demonstrations and feeding sessions to twice weekly. Instead of providing food vouchers and cash transfers to the 'porridge mum' group, the food vouchers were given directly to PLW.

Conclusion

There is relatively strong peer-reviewed and operational evidence that pairing household cash transfers with SBC can be an effective strategy to prevent child malnutrition. The two components seem to

mutually reinforce each other. The SBC component can promote nutrition-sensitive and child/women-centred spending decisions, while the cash transfer allows caregivers to put some of the acquired knowledge and skills into practice. Therefore, cash transfers that aim to contribute to nutrition outcomes need to be accompanied with context-specific SBC activities. Value vouchers aiming to contribute to nutrition outcomes should be accompanied with context-specific SBC activities.

1.5.3 Provide conditional cash transfers to incentivize attendance to priority health services

Disease and malnutrition are closely linked and mutually influence each other. There are a number of priority preventive health services that can significantly improve a population's nutritional status. These services can include (ENN, 2011):

- vitamin A supplementation for children between 6 and 60 months,
- six weeks postpartum for women;
- deworming treatment of all children;
- measles vaccination for all children between nine months and 15 years of age;
- supplementation of iron and folic acid for PLW;
- ante and postnatal care visits; and,
- growth monitoring

The package of priority preventive health services is context specific and needs to be defined at local level.

There are various barriers to seeking and accessing health services both on the demand and supply sides. If economic barriers are an important factor inhibiting health seeking, cash transfers conditional on attending priority preventive health services can be considered if these services are of sufficient quality and provided for free²⁴. Conditional cash transfers (CCTs) can serve multiple objectives: to cover indirect costs and reduce opportunity costs associated with the visits, to provide an incentive to attend priority preventive health services ('incentive value') and to provide household income to contribute to nutrition outcomes. They are often complemented by SBC intervention, which, among other things, cover the importance and value of these priority health visits for maternal and child health and nutrition and other non-economic barriers.

Peer-reviewed evidence

Two studies look at improving nutrition outcomes in humanitarian settings²⁵ using cash transfers that were conditional on recipients visiting priority health services.

In Mali, Le Port et al. (2019) assessed the incentive value of cash transfers conditional on health visits (antenatal care, delivery, vaccination, and growth monitoring). The size of the cash incentive ranged from US\$ 3 -12 depending on the type of visit and programme implementers' estimation of the costs for transportation and consultation fees, or the cost for delivery at the community health centre. They found limited incentive value of conditional cash for antenatal care, delivery, vaccination, and growth

²⁴ In most contexts, and even more so in humanitarian settings, preventive health services are provided for free. In situations where priority preventive health services are not provided for free, provider payment mechanisms should be prioritized. They include health insurance coverage for the most vulnerable and purchasing or reimbursing priority health services based on contracts with selected providers that meet minimum quality standards. If provider payment mechanisms cannot be implemented, service vouchers for specific priority health services can be considered. For more details, please consult the Global Health Cluster [working paper](#) on CVA for health in humanitarian settings (GHC, 2018).

²⁵ For the purpose of this document, only interventions aiming to achieve nutrition outcomes were considered. There is however an increasing number of examples for conditional cash transfers for health outcomes in humanitarian settings.

monitoring. Even so, they note that the incentive value might have been undermined by different factors, including implementation constraints, remoteness and inaccessibility of health centres and the low cash transfer amount.

Meanwhile, in IDP camps around Mogadishu, Somalia, UCL and Concern (2020) compared the impact of conditional and unconditional cash transfers on health service utilization and vaccine coverage in IDP camps. Both study arms received monthly cash transfers of US\$ 70 in the first three months and US\$ 35 for another six months. In the conditional arm, the caregiver was required to take any children under five years of age to a local health clinic for health screening, where they were issued with a health record card. The conditionality was associated with a strong and significant increase in vaccination coverage and a reduction in measles infection.

Operational examples

Meanwhile, the operational experience in humanitarian settings of providing cash transfers that are conditional on recipients visiting priority health services to achieve nutrition outcomes is limited²⁶.

In Northeast Nigeria, a consortium consisting of AAH, UNICEF and WFP implemented the Integrated Nutrition Programme plus (INP+) from 2017 to 2019. This programme involved a range of nutrition sensitive and specific interventions. The cash component consisted of a conditional cash transfer of 5,000 Naira or approximately US\$14 per month to cover the additional nutritional requirements of PLW and children during pregnancy and until the child turns two ('first 1,000 days' window of opportunity). The assistance was conditional on the initial enrolment at the local health centre. Once enrolled, PLW were actively encouraged to access preventive health services, such as antenatal care or vaccinations, and their attendance was monitored ('soft conditionality'). PLW were also referred to mother-to-mother support groups and actively encouraged to participate in SBC sessions ('soft conditionality'). The programme led to increased uptake and utilization of basic health services. Enrolment at the health centres seemed to positively impact on PLW's health seeking behaviour. Also, the cash transfer contributed to improved dietary diversity at household level and of children.

From 2015 to 2016 in Bangladesh, World Vision International (2019) provided monthly conditional cash transfers of 2,200 taka (or approximately US\$ 27.50) to pregnant and lactating women who lived below the lower poverty line for 15 months during their pregnancy and after the birth of their child. The assistance was conditional on three antenatal care check-ups during pregnancy, one postnatal check-up, monthly growth promotion and monitoring sessions and attendance at SBC sessions after birth. Women reported that they found it not difficult to meet the conditions for receiving cash assistance. Furthermore, the project applied a certain flexibility when it came to the conditionality: if a mother missed sessions for a non-emergency reason, they would not be paid that month, but they were still eligible to receive the full 15 payments if they attended future sessions. The programme led to an increase in women's attendance at health centres; it also improved health outcomes for children and mothers, and increased dietary diversity, quality and quantity of diets.

Conclusion

When it comes to achieving nutrition outcomes in humanitarian settings using cash transfers that are conditional on recipients visiting priority preventive health services, limited peer-reviewed evidence and operational experience exists. Nevertheless, the limited humanitarian experience alongside the larger evidence base from development settings suggest that CCTs tied to priority preventive health services

²⁶ For the purpose of this guidance, only programmes aiming to achieve nutrition outcomes were considered. There is, however, an increasing number of examples related to conditional cash transfers for health outcomes in humanitarian settings.

can increase service utilization by addressing economic barriers to health seeking, which in turn have a proven impact on maternal and child nutrition.

The examples above demonstrate the different ways in which conditionality and the transfer amount can be designed. In some interventions, the condition was the initial enrolment or screening at a health facility and attendance to follow-up health interventions was encouraged but not required to receive the assistance. In other interventions, the condition was to attend specific health interventions and the visits would trigger the assistance. The transfer amount can be based on indirect costs to access these services or basic needs at the household level. The larger the transfer amount, the larger the incentive value to comply with the condition.

1.5.4 Provide cash or vouchers to facilitate access to treatment for malnutrition²⁷

In humanitarian settings, the treatment of moderate and severe acute malnutrition should be provided for free within the primary and secondary or health care service provision. Facilities' coverage often limits people's uptake of these services as there are costs to the caregiver (e.g. transportation, food, and accommodation) if the child requires in-patient care and the caregiver needs to stay at the treatment centre for some time. Cash transfers or vouchers can be provided to cover these indirect costs if treatment services exist and are of sufficient quality. If services are non-existent or of poor quality, complementary supply side interventions need to be considered to improve the quality of the treatment according to protocols and ensure that enough nutrition and medical supplies are in stock.

A reportedly common, but poorly documented practice, is the provision of CVA for transportation. Cash transfers for transportation can either be advanced at the time of the referral or reimbursed at the stabilization centre. Vouchers for transportation are usually provided at the referral stage and provide access to contracted transportation services.

Several organizations have used cash transfers or vouchers to compensate caregivers for transportation costs to stabilization centres for the treatment of severe acute malnutrition. UNICEF in Pakistan, for example, provided PKR 2,000 or approximately US\$ 19 to caregivers of SAM children with complications to cover the cost of transportation to the stabilization centre. The project evaluation (UNICEF, 2016b) found that the amount was not sufficient for families living in remote areas and recommended to adjust the amount based on travel distances. AAH in DRC used transportation vouchers to refer patients from outpatient nutrition units to therapeutic feeding centres (TFC). At the same time, food expenses of caregivers at the TFC was covered by AAH. The voucher support led to a significant increase in successful referrals towards the TFCs.

No practical examples were found for the provision of CVA to cover food and accommodation related costs as part of CMAM.

Conclusion

CVA can be effective in addressing indirect costs related to accessing malnutrition treatment. The practice is however poorly documented and there is limited learning on how to do this in different operational contexts where distance, gender dynamics and the outreach capacity of health facilities are key influencing factors for timely detection and treatment of acute malnutrition. For example, is it better to advance the money at the point of referral or should the cash be provided at the health centre? How should the amount for transportation be calculated? What is the preferred modality (cash or voucher) to cover indirect costs to access treatment? There is a need to better document this approach and corresponding learning.

²⁷ Providing CVA to facilitate access to preventive health services is much more common for the treatment of MAM/SAM. The approach could however also be used to facilitate access to priority preventive health services.

1.5.5 Provide household cash and voucher assistance to caregivers of children with severe acute malnutrition

Peer-reviewed evidence

Grellety et al. (2017) tested whether household cash transfers improve the outcome of children treated for SAM in the Democratic Republic of Congo. All participating caregivers from the intervention group with one or more children with SAM received an UCT valued at US\$ 40 each month during treatment and follow-up for a total of six months (US\$ 240 in total). Caregivers in the control group did not receive cash transfers. The study results are encouraging: children in households that received cash transfers gained weight faster, were more likely to recover from SAM and less likely to default²⁸ or fail to respond to treatment²⁹ compared with children in the control group. All nutritional outcomes in the intervention group were significantly better than those in the control group. After six months from the beginning of the treatment (three to four months after the end of treatment), 80 per cent of children who benefitted from cash transfers had regained their MUAC measurements and WHZ and showed evidence of catch-up. Less than 40 per cent of the control group had a fully successful outcome, with many deteriorating after discharge.

Based on these results, the authors concluded that cash transfers can increase recovery from SAM and decrease default, non-response and relapse rates during and after treatment. They further suggest that, in the context of DRC, household cash transfers are a viable and more easily implemented alternative to a supplementary feeding programme following discharge.

The study did not find that parents purposefully made or kept their children malnourished to access the assistance. In fact, the study design itself might have eliminated this incentive: There was no continuous enrolment of children with SAM into the programme, reducing the incentive for families to present a child with SAM. Furthermore, the intervention arm would receive the cash transfer monthly for six months, independently of the recovery rate of the child if they did not default from the programme, thereby eliminating the incentive to keep a child malnourished during the follow up period. Thus, cash is likely to have deterred defaulting, but there was no incentive to keep the child malnourished to continue to benefit from the programme (Grellety et al., 2017).

Operational examples

The experience of humanitarian actors of combining household cash assistance with SAM treatment is relatively limited. UNICEF, AAH and ICRC used this approach in Nigeria, DRC and Somalia and programmes provided cash transfers to improve the food security situation of targeted households and reduce the risk of relapse. Unfortunately, the results of these programmes are not well documented. In terms of unintended consequences, the programme implemented by a consortium formed of AAH, UNICEF and WFP in Nigeria seemed to have led to a large increase in SAM admissions and there was anecdotal evidence that some caregivers would make or keep their child malnourished to be eligible for the assistance. As compared to the DRC example, the programme in Nigeria continuously enrolled SAM children. Further, both health workers and programme staff reportedly accepted bribes to enrol children who did not meet the criteria (AAH, 2017b). Other programmes were not able to verify unintended consequences. In fact, the ICRC in 2018 planned a study to look at the question of perverse incentive among other things, but the study had to be cancelled for security reasons.

Conclusion

²⁸ 'Default' was defined as failing to appear for two consecutive follow-up visits confirmed by a home visit.
²⁹ 'Non-response' was defined as not meeting the criteria for nutritional recovery by 12 weeks.

The DRC study (Grellety et al., 2017) provides very positive evidence that should encourage further exploration and documentation of this approach. At the same time, anecdotal evidence on the perverse incentive needs to be taken seriously and requires further investigation.

Programme design can potentially mitigate some of the risks around perverse incentives. Grellety et al. (2017) showed that the potential incentive can be reduced by not continuously enrolling caregivers and by providing cash transfers following discharge irrespective whether the child recovers or not. Not to use continuous enrolment is however hard to implement in practice as SAM children are usually treated on a rolling basis. The transfer amount is very likely to influence the incentive value of keeping children malnourished. An amount based on the indirect costs for accessing treatment would be significantly lower compared to an amount based on a minimum food or expenditure basket and could thus reduce the incentive value of the transfer. On the other hand, a lower amount would not have the same potential impact on reducing defaulting, improving household food security following discharge and reducing relapse. Lastly, the introduction of vulnerability criteria in addition to nutrition status might reduce the risk.

Organizations that are exploring this approach need to assess the risk of perverse incentive and possible mitigation measures during community consultations and monitor the risk during implementation through robust community feedback/monitoring mechanisms based on existing structures (e.g. mother-to-mother support groups). If the risk is considered significant and cannot be sufficiently mitigated, or if the risk is observed as part of monitoring, the CVA component needs to be reconsidered.

1.6 Research and evidence gaps

Despite the increasing evidence base on the contribution of CVA to better nutrition outcomes, many questions remain. The Research for Action (R4ACT) initiative recommends research focusing on the pathways of impact between CVA and nutrition, including inquiry around design and implementation features (Fenn, 2017). The REFANI project calls for more research on a range of topics. These include enhancing the effectiveness of CVA for nutrition and health outcomes, response analysis and decision support, optimising cost-effectiveness / cost-benefit analysis for CVA, use of fresh food vouchers, and post-intervention impact on stunting (Seal et al., 2017). Woodward et al. (2018) collected 189 research questions on CVA for health and nutrition in humanitarian settings and categorized these into nine overarching research areas: modalities, outcomes and impact, intermediate outcomes, initial considerations, effectiveness, pathways, methodologies and indicators, types of diseases or health issues, and context.

In addition to the research areas and questions already identified, this note suggests some specific questions to be explored through research and learning:

Observation	Questions to be explored
There has been no evidence on the impact of household CVA on some aspects of childcare practices, particularly on feeding practices and psychosocial care for children.	What is the impact of household cash transfers with or without SBC activities on maternal and childcare practices, particularly on feeding practices and psychosocial care for children?
Research by Langendorf et al. (2014) in Niger suggests that cash transfers might be better suited for household assistance while SNF might be better suited for an individual feeding component. More evidence from other contexts is required to validate this finding and to test other possible combinations.	What are the most promising combinations of cash, voucher and in-kind assistance when it comes to pairing household and individual feeding assistance to prevent acute malnutrition? What modalities are more adequate for the individual feeding component?

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<p>Some studies suggest that a soft approach to conditionality is better suited to humanitarian settings. However, no research on the effectiveness of different approaches to conditionality has been conducted.</p>	<p>What is the impact of soft conditionality vs hard conditionality vs no conditionality on participation in SBC activities or attendance to priority health services in humanitarian settings?</p>
<p>The potential risk of providing an incentive to caregivers to keep or make their children malnourished when providing cash transfers to caregivers of SAM children as part of CMAM is not well understood.</p>	<p>In programmes that use this approach, is there evidence for this perverse incentive when providing household cash transfers to the caregivers of SAM children? To what extent might this risk be context specific, for example based on social and cultural factors? To what extent can the risk be reduced through modality and design decisions, for example adjusting transfer amount or providing vouchers instead of cash? Is this risk any different to providing in-kind nutrition support as part of CMAM?</p>
<p>The practice of providing cash or vouchers to address indirect costs related to accessing treatment for malnutrition is poorly documented and there is limited learning on how to do this in practice.</p>	<p>is it better to advance the money at the point of referral or should the cash be provided at the health centre? How should the amount for transportation be calculated? What is the preferred modality (cash or voucher) to cover indirect costs to access treatment?</p>
<p>Even though some good practice on the design of CVA for nutrition outcomes is emerging, more research and learning is required to strengthen our understanding about how best to design CVA for nutrition outcomes.</p>	<p>How does timing, frequency, duration, transfer amount, and choice of recipient of CVA impact on nutrition outcomes? What duration of CVA is required to have a measurable impact on nutrition outcomes at individual level?</p>
<p>While cost effectiveness analysis is fairly common for household assistance modalities, it is rarely conducted for individual feeding assistance modalities. Langendorf et al. (2014) in Niger observed that the direct provision of nutritious supplementary food for a young child was more cost-effective than a comparable cash top-up amount in terms of nutrition outcomes.</p>	<p>What is the comparative cost effectiveness of the different assistance modalities for individual feeding assistance to prevent malnutrition?</p>

Part 2: Guidance Note on the use of cash and voucher assistance for nutrition outcomes

Part 2 contains three main chapters. Chapter 2.1 provides step-by-step generic guidance throughout the humanitarian programme cycle on how to incorporate CVA into a nutrition response. It provides references to additional resources and guidance on how to operationalize the guidance in practice. It focuses on CVA-specific considerations in nutrition response. Chapter 2.2 identifies measures that help to apply a nutrition lens to household cash transfer, including multi-purpose cash. Chapter 2.3 addresses recommendations to the nutrition sector and other humanitarian actors on key actions that are required to more routinely consider and, if appropriate, use cash and voucher modalities in nutrition in emergencies.

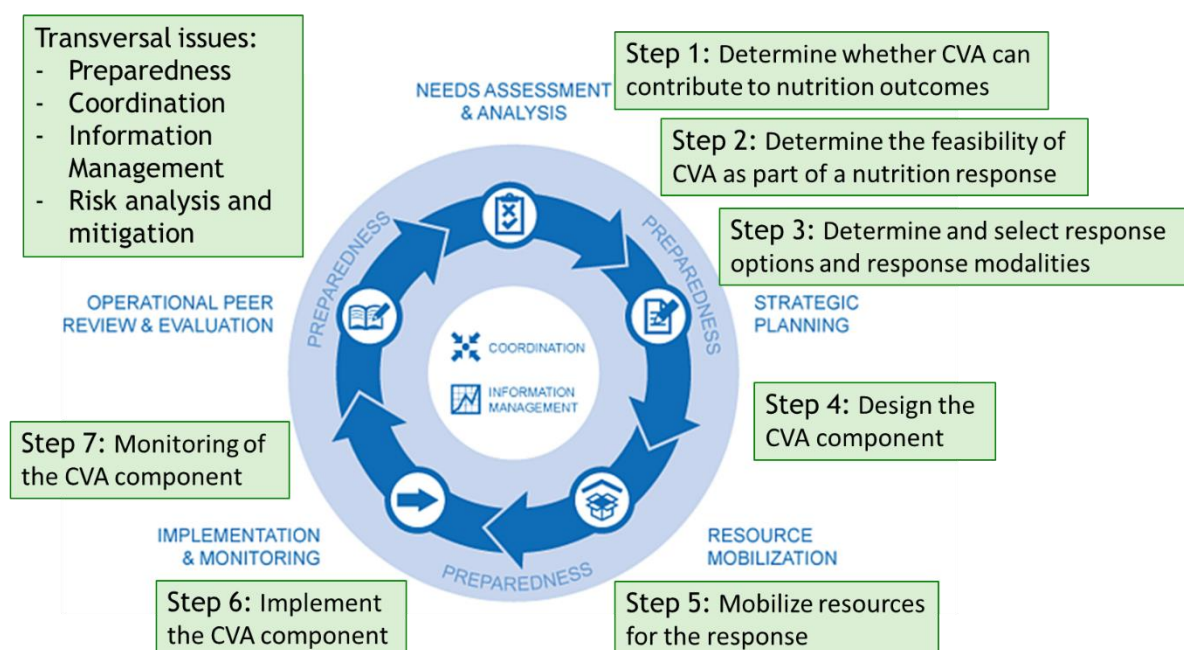
Due to the general lack of experience within the nutrition sector to systematically consider and use CVA modalities, this Guidance Note is based on expert opinion and extensive consultation with nutrition practitioners. As such, it should be regularly updated to reflect emerging learning and experiences in considering and using CVA modalities for nutrition outcomes.

Save the Children, CaLP and the French Red Cross jointly developed a short [decision-making tool on incorporating CVA in nutrition response](#). The tool can be considered complementary to this Guidance Note and intends to help nutrition practitioners to understand entry points for CVA in nutrition programming and encourages integrated approaches.

2.1 How to incorporate cash and voucher assistance into nutrition response

Figure 2 provides an overview on the main elements of the humanitarian programme cycle. It incorporates the seven steps that are required to consider and use CVA in nutrition response as well as transversal issues to consider throughout the response, such as preparedness, coordination, information management and risks,

Figure 2. Steps and transversal issues throughout the humanitarian programme cycle



Step 1: Determine whether CVA can contribute to nutrition outcomes

Nutrition assessments involve collecting and analysing representative data to establish prevalence of acute malnutrition, infant and young child feeding, and other care practices³⁰. This data, combined with analysis of the other underlying causes of malnutrition, and assessments of health and food security, presents a nutrition causal analysis (Sphere, 2018).

The main way for CVA to contribute to nutrition outcomes is by addressing the economic demand side barriers to adequate nutrition. Therefore, the most straightforward way to assess the potential for CVA in contributing to nutrition outcomes is to understand economic barriers and their significance to achieve adequate nutrition (i.e. to what extent is the lack of purchasing power impacting households' abilities to access and prepare nutritious foods, access health services, safe water, improve hygiene conditions). However, in order to effectively respond to malnutrition, it is important to have a comprehensive understanding of the different demand and supply barriers to adequate nutrition.

While commonly used nutrition assessment tools are not necessarily geared towards an understanding of economic barriers, some of them offer relevant insights for assessing the potential role of CVA in nutrition responses. Nutrition assessments are typically complemented with indicators and/or assessments on food security, livelihood, health, WASH and protection. *Table 4* provides an overview on commonly used sectoral and multi-sectoral assessment tools and how they can help to determine the potential contribution of CVA to nutrition outcomes. Nutrition practitioners need to closely collaborate with other sectors in order to obtain a comprehensive understanding regarding the economic barriers to adequate nutrition across the underlying determinants.

Table 4. Assessment tools to determine the potential contribution of CVA to nutrition outcomes

Assessment tool	Main purpose of the tool	Relevance for CVA
Multi-sectoral assessment tools		
Knowledge, Attitudes and Perceptions (KAP) survey	The tool is used to evaluate current knowledge, attitudes and practices of a community in order to measure the impact of interventions (pre and post survey).	KAP surveys and the Barrier Analysis tool can help to identify economic barriers to desirable WASH (e.g. water treatment), health and care practices.
Barrier Analysis tool	The tool helps to identify barriers to behaviour change that, if adopted, can have a significant positive impact on the health, nutrition, or well-being of targeted groups.	They are further used to design SBC interventions.
Basic Needs Assessment (BNA)	The tool produces a ranking of priorities for assistance as perceived by the population. It provides information on the access, availability, and quality constraints people face in securing what they need from local service providers and markets, and the perceived severity of related humanitarian consequences.	It can help to identify and prioritize demand and supply side barriers to adequate nutrition and how local communities think they should be met.
Nutrition assessment tools		
Standardized Monitoring and Assessment of Relief and Transitions (SMART)	The tool is used to assess the prevalence of nutrition outcomes and mortality, while other relevant indicators like infant and young child feeding practices are often included.	It can help to assess relevant indicators focusing on economic barriers commonly faced at household-level.

³⁰ For more information on nutrition in emergency assessments, please consult [Nutrition Humanitarian Needs Analysis Guidance](#)

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Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)	The tool is used to evaluate the coverage of existing nutrition treatment services in order to improve nutrition service delivery.	It can help to identify economic barriers to accessing health and nutrition services.
YCF assessment	The tool is designed to assist in gathering and presenting relevant information; in determining the strengths and weaknesses of national policies and programmes to protect, promote and support appropriate feeding practices.	It can help to identify economic barriers to adequate feeding and care, e.g. affordability of nutritious complementary foods.
Link Nutrition Causal Analysis (NCA)	A method for analysing the multi-causality of under-nutrition, as a starting point for improving the relevance and effectiveness of multi-sectoral nutrition security programming in a given context.	The NCA can provide insight into how economic vulnerabilities and economic barriers impact malnutrition.
Food security and livelihoods assessment tools		
Household Economy Analysis (HEA)	The HEA is a livelihoods-based framework for analysing the way households obtain access to the things they need to survive and prosper. It further helps determine people's food and non-food needs and identifies appropriate means of assistance.	The HEA establishes the patterns of food production, income and expenditure, thereby helping to identify vulnerabilities in relation to accessing a nutritious diet through own production or labour income.
Cost of the Diet (CotD) ³¹	CotD largely builds on market and price data for local foods to estimate the amount, combination and cost of local foods needed to provide a typical family with a diet that meets their averaged needs for energy and recommended intakes of protein, fat, and micronutrients. It helps to answer the following questions: 1. What is the minimum cost of foods that meet the nutrient needs of a typical household? 2. Can a nutritious diet be achieved using locally available foods? 3. Is this diet affordable? 4. If not, what could be done?	The CotD analysis determines how much a nutritious diet costs and whether people affected by a crisis can afford it. It can help to determine the gap of vulnerable groups in covering their basic needs and nutritional requirements.
Health assessment tools		
Health seeking behaviour survey Health expenditure surveys	Health seeking behaviour and health expenditure surveys help understand barriers to access priority health services.	To identify remaining direct or indirect costs for priority health services and consider different supply and demand side options to address these. To understand when CCT may be effective to incentivise the use of free preventive services.
Availability, Accessibility, Acceptability, Quality (AAAQ) framework	The framework helps to identify barriers women and girls may face in accessing humanitarian aid and services, including health and nutrition services.	The framework can assess the economic barriers (<i>financial accessibility</i>) to health and nutrition services.

³¹ The CotD tool is the main analytical tool for WFP's [Fill the Nutrient Gap](#) initiative. It has been mainly used in development settings but is increasingly applied in humanitarian contexts (e.g. Somalia, Niger) as well.

Step 2: Determine the feasibility of using cash or vouchers as part of a nutrition response

Feasibility needs to be verified before considering CVA modalities as part of a nutrition response. Feasibility is considered the ability of an organization to deliver CVA safely and for recipients to use CVA to access intended goods and services.

A key component of CVA feasibility is to understand the capacity and functioning of relevant markets for goods and services on the supply side that are relevant for adequate nutrition. These include the markets for nutritious foods, commercially available fortified foods and nutrition supplements, water, hygiene items, cooking items, health and nutrition services, and transportation services³². The selection of goods and services to be included in market assessment and analysis depends on the economic barriers identified and the objective of the CVA component. In addition to markets for goods and services, delivery mechanisms, the buy-in from communities and authorities, organizational capacity to use CVA, timeliness, risks and costs need to be assessed and verified. *Box 3* provides an overview on key questions of a feasibility assessment, each of which are explore in more detail below.

Box 3. Key questions to consider when assessing the feasibility of the CVA component

- *Market capacity and functionality*: can a nutritious diet be achieved using locally available foods? Are goods required for adequate WASH available?
- *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*: is there a safe and reliable way to deliver cash or vouchers to targeted recipients?
- *Community considerations*: how would the targeted group like to be assisted? What delivery mechanism is best suited for the targeted group? Are there protection and safety concerns in relation to providing cash or vouchers? Can they access nutrition-relevant goods and services with additional purchasing power?
- *Local authorities*: do local authorities allow or support the delivery of CVA to affected populations? Do local mechanisms provide social assistance or safety net programmes to support vulnerable populations? To what extent do these programmes apply a nutrition lens to targeting, complementary programming, programme objectives?
- *Additional considerations*: Does the organisation and its partners have sufficient capacity to plan and implement the CVA component? How long does it take to set up the CVA component? What is the estimated cost of the CVA component?

A good starting point to assess the feasibility of the CVA component is to consult with the Cash Working Group (CWG) and organizations that are already implementing CVA³³ and to review relevant secondary information. If the available information is insufficient, additional assessment and analysis needs to be conducted.

Market capacity and functionality³⁴

³² SNF are generally not commercially available, meaning that they cannot be purchased in local markets and there is no market system to study. Nonetheless, understanding their supply chains which are managed by humanitarian organizations can help to anticipate shortages.

³³ It is very likely that humanitarian actors are already using CVA modalities for purposes other than nutrition. They can provide invaluable insights into the feasibility considerations of CVA in different geographic areas.

³⁴ Sphere (2018) calls for all nutrition and food security assessments to include an analysis of markets that meets the Minimum Standard for Market Analysis (MISMA) and/or the Minimum Economic Recovery Standard (MERS) standards.

Key questions: can a nutritious diet be achieved using locally available foods? Are goods required for adequate WASH available?

To answer the key questions, market assessments and analysis should look at the availability and quality of locally available nutritious and fortified foods to determine whether a nutritious diet can be achieved using locally available foods. It should cover all food groups (including vegetables, fruits, and animal source products) and include a broad selection of locally consumed nutrient dense food items. It should further include goods that can positively impact nutrition such as water, hygiene items, and cooking items. If a minimum food or expenditure basket already exists, and if the basket represents a nutritious diet, the assessment and analysis should focus at a minimum on these items.

Humanitarian market assessment and analysis tools such as the Emergency Market Mapping and Analysis Toolkit (EMMA), Rapid Assessment of Markets (RAM), Market Analysis Guidance (MAG) and others³⁵ are all suited to analyse food and non-food market systems. Furthermore, the Cost of the Diet tool can provide information on the availability of nutritious foods as well as their ability to meet the macro and micro-nutrient requirements of different groups.

Health and transportation services

Key questions: 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?

CVA can cover expenditures related to accessing priority health services but should only be considered complementary to supply side financing mechanisms, and treatment of malnutrition. In contexts where the targeted population relies on transportation to access health services, the availability and cost of transportation services need to be verified either with the affected population or relevant service providers. Monitoring the availability and quality of health services during an emergency can be challenging. Uncertainties around access, security and time limitations often prevent systematic information gathering. Nonetheless, the availability and quality of services related to the prevention and treatment of malnutrition need to be verified.

Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) can be used evaluate the coverage of existing nutrition treatment services and to provide information on barriers to accessing health and nutrition services. The Health Resources and Services Availability Monitoring ([HeRAMS](#)) tool can be used to monitor the availability and quality health facilities, services and resources availability in emergencies. Distinctions need to be made between private and public providers. Health seeking surveys can be used to understand where people go when they need a service, and what barriers they may have to meet this need. Furthermore, health financing needs to be mapped to understand what the other household expenditures are for both direct and indirect costs related to accessing health services.

Delivery mechanisms

Key question: is there a safe and reliable way to deliver cash or vouchers to targeted recipients?

There are multiple ways to provide affected populations with cash or vouchers. Cash can be delivered in hand (e.g. directly in envelopes or 'over-the-counter' in branches of service providers) or electronically (e.g. mobile money, cards, accounts). Most of these delivery mechanisms require a financial service provider to deliver the cash transfers. Vouchers can be provided as paper vouchers or electronic

³⁵ For an overview on the most important market assessment tools, please consult this [comparative table](#).

vouchers (usually through smart cards). A voucher response further requires a network of contracted traders / vendors to provide goods and/or services in exchange for the vouchers.

It is important to keep in mind that some population groups might face difficulties in using electronic transfers. These can be related to financial literacy or the requirements of service providers³⁶. These obstacles should be identified during the feasibility assessment and inform the selection of delivery mechanisms during response analysis.

At the feasibility assessment stage, organizations that are considering CVA need to determine whether there is a safe and reliable way to deliver cash or vouchers to targeted recipients. A good starting point is to consult with the CWG to understand what mapping and analysis of delivery mechanisms has already taken place. If existing analysis is not sufficient to assess the adequacy of delivery mechanisms, UNHCR's [Cash Delivery Assessment Tool](#) can help to review and compare delivery mechanisms for cash transfers. The RC/RC [voucher checklist](#) helps to assess traders capacity and willingness to participate in a voucher response.

Community considerations

Key questions: How would the targeted group like to be assisted? What delivery mechanism is best suited for the targeted group? Are there protection and safety concerns in relation to providing cash or vouchers? Can they access nutrition-relevant goods and services with additional purchasing power?

A whole range of questions need to be explored with affected households and communities when considering the provision of cash or vouchers. These areas include data protection, preference on ways to be assisted, protection and safety considerations, access to money, access to markets, household decision making, possible tensions within households or communities. Community consultations should look within and beyond the household unit and consider different age, gender and diversity groups. They are essential for ensuring accountability to affected populations, minimizing harm and maximizing impact. Furthermore, community consultations can be used to assess the potential for SBC activities, e.g. the interest and availability of households to attend such sessions.

For possible questions to consider, please consult the [IRC Safer Cash Toolkit](#) (Tools 1.1 and 1.2) or the RC/RC [community](#) and [household](#) questionnaires.

Considerations vis-à-vis local authorities

Key question: do local authorities allow or support the delivery of CVA to affected populations? Do local mechanisms provide social assistance or safety nets to support vulnerable populations? To what extent do these programmes apply a nutrition lens to targeting, complementary programming, programme objectives?

Any type of humanitarian CVA needs to be closely coordinated with local authorities. In some contexts, the delivery of cash and/or vouchers is not permitted by the authorities, in which case CVA is not a programmatic response option and more advocacy for CVA might be required. In many contexts, authorities have their own cash-based social assistance programmes to support vulnerable communities in which case linkages between humanitarian CVA and government provided social assistance should be explored³⁷.

³⁶ Know your customer (KYC) refers to a mandatory process for financial service providers of identifying and verifying the identity of the customers. Such requirements might prevent some population groups from using some transfer mechanisms.

³⁷ For more information on the linkages between nutrition and social protection/assistance, please consult [FAO \(2015\)](#)

Step 3: Determine and select response options and response modalities

Response options analysis (ROA) refers to the analytical process by which the objectives and modalities (and associated delivery mechanisms) of programme response options in an emergency are determined, and potentially harmful impacts are minimised (Maxwell et al., 2013). ROA should ensure that operational, programmatic and contextual risks and opportunities are systematically considered when determining how assistance will be provided (Sphere, 2018). It should lead to the selection of the most appropriate response option and response modalities.

CVA does not change the way nutrition practitioners define objectives and select nutrition response options (e.g. treatment through CMAM, IYCF-E, supplementary feeding, micronutrient supplementation, etc.) in order to address identified nutritional needs³⁸. ROA can help to identify the timing of potential response and the choices available in terms of responding to a number of concurrent nutritional needs in a given context. CVA does add additional modalities for the implementation of these response options. **In contexts where communities face economic barriers to the underlying determinants, feasible CVA modalities and approaches should be considered as part of response options analysis.** The five main approaches for using CVA in nutrition response are:

Prevention	1)	Using cash or vouchers for household assistance and/or individual feeding assistance
	2)	Combine household cash transfer or vouchers with SBC interventions
	3)	Provide conditional cash transfers to incentivize attendance to priority preventative health services
Treatment	4)	Provide cash or vouchers to facilitate access to treatment of malnutrition
	5)	Providing household CVA to caregivers of children with SAM

In situations where CVA modalities are considered as an *alternative* to in-kind food assistance at household or individual level for the prevention of malnutrition, feasible response options (cash, vouchers, in-kind and their respective delivery mechanisms) can be compared. Criteria commonly used to compare different response options include:

- effectiveness (i.e. which modality is likely to achieve better nutrition outcomes),
- beneficiary preference (i.e. how would the targeted households/individuals prefer to be assisted),
- costs (i.e. which of the response modalities is most cost-efficient and/or cost-effective),
- markets (i.e. which modality is more adapted to local market conditions),
- risks (i.e. which modality is likely to be riskier),
- timeliness (i.e. which modality is faster to implement), and
- organizational capacity (which modality/mechanism would the organisation be more capable to implement).

Please consult the full list of possible [criteria for comparison](#) for additional information.

In situations where CVA can potentially *complement* a treatment response, the anticipated positive outcomes and added value of a CVA component needs to be weighed against the additional costs. For example, when considering whether to complement SAM treatment with household cash transfers provided to caregivers, the anticipated benefits in terms of nutrition outcomes, such as faster recovery and reduced relapse, need to be weighed against the estimated cost of adding the cash component³⁹.

³⁸ For example, the [MAM decision tool for emergencies](#) provides guidance on response options for the prevention and treatment of MAM (GNC, 2017).

³⁹ As an example, Trenouth (2020) found that adding a household cash transfer component to CMAM in the context of the DRC cost approximately US\$ 420 per child. The cash transfers had the effect of improving recovery rates,

Step 4: Design the cash and voucher assistance component

The quality of design of the CVA component is a major contributor to its potential impact on maternal and child nutrition. There are a range of design decisions that need to be taken for the CVA component. These decisions include targeting, conditionality, transfer amount, frequency, timing and duration, and sustainability.

Targeting

Considerations in targeting CVA components involve the definition of the eligibility criteria for CVA, finding people that fulfil these criteria and the decision on who should physically or electronically receive CVA. The targeting criteria are largely determined by the programme objectives and type of response rather than the assistance modality. Interventions aimed to prevent malnutrition usually target households and individuals that are most at-risk to malnutrition. Interventions aimed at treating malnutrition target based on nutrition status, i.e. malnourished children 6 to 59 months of age, malnourished PLW and malnourished people living with chronic illness such as HIV or tuberculosis (GNC, 2017). The [MAM decision tool for emergencies](#) (GNC, 2017) provides more details and additional considerations on targeting for nutrition prevention interventions.

Evidence from the development literature indicates that targeting interventions to PLW and younger children during the first 1,000 days has greater impact on child nutritional outcome (Fenn, 2015). Most development organizations have since revised their strategies to address malnutrition focused on the 1,000 days during pregnancy and the first two years of life (The Lancet, 2013). The timeframe of humanitarian nutrition programmes is usually shorter and its remains children between 6 and 59 months of age (Fenn, 2015). As we have seen previously, there are examples for programmes in humanitarian settings that use the first 1,000 days to define targeting and duration of the assistance.

Targeting based on the nutrition status of children should only be used if the CVA component is integrated with the treatment of malnutrition as part of CMAM. Nutritional status should not be used as a vulnerability criterion for the provision of household CVA.

As to the question who should physically or electronically receive CVA, it is important to keep in mind that assistance for nutrition outcomes is often targeted towards the individual (mainly children) but the assistance is provided to an adult household member. Individual CVA should, in principle, be given to the targeted individual or, in the case of children, to the child's caregiver. As for household CVA, the evidence generally suggests that giving cash to women, rather than men, will often lead to a greater improvement in children's well-being by increasing women's control of household resources and subsequently increasing spending that will benefit children's health, nutrition and education (Fenn, 2015). The decision on who within the household receives CVA should be informed by gender analysis⁴⁰ and requires buy-in from the affected community. Household CVA that does not consider household dynamics and ignores community acceptance risks unintended consequences and doing harm.

Conditionality

Project examples provided in [Part 1](#) illustrate the different ways conditionality can be designed and enforced (hard vs soft). For example, the conditionality on accessing preventive health services can be in relation to the initial registration at a health clinic or to each anticipated visit.

Conditionality can be considered when it is expected to improve participation in SBC interventions and the uptake of priority preventive health service that are of sufficient quality and provided for free. The

lowering treatment default rates, lowering relapse rates, and improving the proportion of households with an "acceptable" food consumption score. Each of these results cost US\$ 1,400 to US\$ 9,060 per case.

⁴⁰ For more information on how to conduct gender analysis, please consult the [Gender Analysis Tool](#)

expected benefits of introducing the conditionality (i.e. improved participation or uptake) need to be weighed against estimated costs, resource requirements and other factors, e.g. risks related to implementing the conditionality and technical feasibility of conditionality.

The monitoring of conditionality can be a complex and costly⁴¹ task that requires substantial data, administrative and human capacity, and coordination within and external to the programme (UNICEF, 2016b). Therefore, introducing conditionality may be more suitable in protracted situation and less suitable in sudden onset emergencies. Also, a ‘hard’ conditionality can exclude beneficiaries that are unable to fulfil the required activity. ‘Soft’ conditionality has proved a viable alternative to ‘hard’ conditionality in some humanitarian contexts (see [Kurdi et al., 2019a](#), and [Ahmed et al., 2019](#)). The main advantage being that the administrative and monitoring costs can be reduced, and beneficiaries are not excluded from the assistance if they fail to comply.

Expenditure basket and transfer amount

In principle, the transfer amount for cash transfers and value vouchers should reflect what recipients are expected to be able to purchase and access in local markets. The tool used to quantify what recipients are expected to be able to purchase is the **expenditure basket**. The content of the expenditure basket thus depends on the objective of the CVA component. *Table 5* provides an overview of different expenditure baskets based on the objective of the CVA component, the type of CVA, and different tools available to build these baskets.

Table 5. Objective of CVA component and corresponding content of different expenditure baskets

Immediate objective of CVA	Type of CVA	Content of expenditure basket	Available tools
Access nutritious diet	Household CVA or individual feeding CVA	<ul style="list-style-type: none"> Minimum food basket meeting the nutritional requirements/gap of households or individuals 	NutVal Cost of the diet
Access basic needs goods and services, including a nutritious diet	Household CVA	<ul style="list-style-type: none"> Minimum food basket meeting the nutritional requirements of a household Non-food expenditure, including housing, health, water, hygiene, sanitation, communication, transportation, etc. 	MEB decision making tool (CaLP) MEB Interim Guidance (WFP)
Access free preventive health services and treatment of malnutrition	CVA to access health services or treatment of malnutrition	<ul style="list-style-type: none"> Indirect cost to access free preventive health services and treatment of malnutrition 	

The most commonly used expenditure basket in humanitarian responses is the MEB, a tool that helps to identify and quantify basic needs items and services at the household level that are accessible through local markets and services (CaLP, 2019). MEBs have been established in most humanitarian contexts and their development and revision is usually coordinated by the Cash Working Group. They are calculated based on average household composition and usually do not factor in the specific needs of household members in relation to age or sex or health status. Items and services included in an MEB are those that households in a given context are likely to prioritize on a regular or seasonal basis. An

⁴¹ A study reviewing CCTs in Latin America estimated the administration of the conditionality at around 20 per cent of administrative costs (UNICEF, 2016b)

MEB is inherently multisectoral and based on the average cost of the items composing the basket. Food items often the most important component of an MEB. It should further contain expenditures related to goods and services that can contribute to nutrition outcomes, such as health, hygiene, sanitation, water and transportation.

The minimum food basket (MFB) can be a standalone expenditure basket or considered as the food component of an MEB. Both MEB and MFB should be designed to meet the macro and micronutrient needs of households or individuals⁴². In addition to staple foods, the MFB should also contain locally appropriate fruits, vegetables and animal source products. The CotD and NutVal tools can inform the composition of a nutritious MFB. It can further consider the household composition and specific nutritional needs of vulnerable household members such as PLW, children or adolescent girls. In reality, the MFB is often based on the caloric requirements of average households and falls short of providing access to a nutritious diet⁴³. An analysis of the MEBs for Somalia and Nigeria that was conducted as part of the case studies revealed that the proposed food components fall short of covering the majority of micro-nutrients based on average population requirements.

If a CVA component aims to promote access⁴⁴ to free preventive health services or the treatment of malnutrition, the basket should contain estimated expenditures in relation to transportation, accommodation and food of caregiver (for in-patient care).

The cost of the expenditure basket and the transfer amount are closely related but not necessarily the same. The transfer amount should only address the gap in relation to basic needs or nutritional requirements. For example, in the calculation of the transfer amount for MPC, the estimated average households' contribution to the MEB (income, remittances, savings, other humanitarian assistance, etc.) is subtracted from the cost of the MEB. The same logic can be applied to the transfer amount calculation based on a minimum food basket⁴⁴. Thus, the cost of the expenditure basket and the transfer amount are only equal if the households' or individuals' contribution to the expenditure basket is estimated to be zero. In reality, the household's contribution is difficult to determine, and the transfer amount is often influenced by available funding, donor requirements, and government policies, e.g. how much the authorities are providing as part of their own social safety net interventions.

Harmonized MEBs, MFBs and transfer amounts for household cash transfers exist in most humanitarian settings. Nutrition practitioners should work with existing contextualized MEB/MFB and transfer amounts, adjust these as required in accordance with programme objectives, and if necessary, advocate for adjustments to reflect a stronger nutrition lens. If there is an ongoing process to develop or revise an MEB/MFB, the nutrition sector should participate to make sure that nutrition considerations are adequately reflected. The Nutrition Cluster in Somalia for example set up a working group to review the food component of the MEB to ensure that it better reflects micronutrient requirements.

Timing, duration and frequency

Despite relatively weak evidence on the impact of programme duration on nutrition outcomes, there is strong logic that a longer duration of assistance and especially if it is tied to higher cumulative transfer amounts could be associated with improved nutrition outcomes (Fenn, 2017). Furthermore, since the 2008 Lancet series, there is a broad consensus within the nutrition community that good nutrition within the first 1,000 days (i.e. the time period from child's conception through to her second birthday) has lasting benefits on the cognitive and physical development of children.

⁴² Sphere food assistance standard 6.1.: Design food and cash-based assistance to meet the standard initial planning requirements for energy, protein, fat and micronutrients.

⁴³ Based on past experiences of using the Cost of the Diet tool, we can say that the cost of a nutritious diet is typically 2-4 times higher compared to the cost of a calorie-oriented diet.

⁴⁴ Sphere food assistance standard 6.1.: Plan rations to make up the difference between the nutritional requirements and what people can provide for themselves.

Duration and timing of assistance to prevent acute malnutrition irrespective of the modality should be based on the scale and severity of the emergency, the GAM prevalence and other factors such as food security, seasonality of food security and/or epidemic patterns of infectious diseases (GNC, 2017). Household or individual CVA for nutrition outcomes that aim to provide a safety net during the first 1,000 days can be provided throughout that period. Irrespective of the specific objective, household or individual CVA should not be provided for less than three months. Timeframes that are too short are unlikely to have any impact on nutrition outcomes. As for the frequency of transfers, regular (e.g. monthly) transfers are recommended if CVA aims to provide access to a diverse and nutritious diet.

Sustainability

Programmes with CVA components for the prevention and treatment of malnutrition are usually not sustainable if they fail to properly address the underlying causes of malnutrition related to the lack of income or other factors. As observed in Part 1, the positive impact of CVA on the nutrition and health of households often does not extend beyond the duration of assistance. Longer timeframes and a strong SBC component might be contributing factors for more sustainable maternal and child nutrition outcomes. For example, the [Child Development Grant programme in Nigeria](#) demonstrated that the programme's positive impacts on IYCF practices and food security continued even after households stopped receiving transfers (OPM, 2019).

Another approach to strengthen the sustainability of nutrition outcomes is to promote more sustainable livelihoods for at-risk households. [FAO's cash plus approach](#) (FAO, 2018) applied for example in their [project in Somalia](#) combines household cash transfers with productive inputs, asset transfers and technical training. Productive assets and inputs can include crop seeds, tools, fertilizers, livestock, fishing kits, home grown gardens, and are typically provided in-kind or through vouchers. Technical trainings are adapted to the needs of beneficiaries and can include training on sustainable farming and pastoral practices, business and other 'soft' skills, nutrition education, agricultural value chain development, access to markets, finance, information. Other organizations (e.g. WVI, Concern, Save the Children) utilize a graduation approach which contains a similar package and can be geared towards nutrition outcomes⁴⁵.

Lastly, more sustainable nutrition outcomes of nutrition interventions with a CVA component can also be achieved by strengthening linkages between humanitarian CVA and existing government social safety nets where such programmes exist⁴⁶ or advocating for nutrition-sensitive social protection interventions in their absence⁴⁷.

Step 5: Mobilise resources for the response

The mobilization of resources for a CVA component is in principle no different to resource mobilization for traditional nutrition response. CVA in 2019 constituted almost 18 per cent of globally programmed humanitarian assistance and all traditional donors have embraced its role in delivering humanitarian outcomes. When mobilizing resources for a response with a CVA component, it is important to stress context specific advantages in comparison with other modalities and to highlight the potential positive secondary impacts of CVA on markets and the local economy. Joint resource mobilization activities should be considered with other clusters/sectors as a coordinated approach can increase fundraising success. The nutrition cluster should highlight the potential impacts of CVA on nutrition (as per evidence presented in [Part 1](#)) as these may not be well known to other humanitarian practitioners and donors.

⁴⁵ For more information on maximizing nutrition outcomes of graduation approaches, please consult [Raza \(2017\)](#) and [Save the Children \(2019b\)](#).

⁴⁶ For more information on how to strengthen linkages between humanitarian CVA and social protection and social safety nets, please consult [UNHCR \(2018\)](#) and [Gentilini et al. \(2018\)](#).

⁴⁷ For more information on how to promote the nutrition sensitivity of social protection, please consult [FAO \(2015\)](#).

When preparing the budgets for a CVA component, partners need to pay attention to the CVA specific budget lines including the total amount to be transferred to beneficiaries and service provider costs and fees. Furthermore, sufficient funds for strong beneficiary communication, accountability and monitoring systems need to be included. Activity-based costing for household cash transfers, e.g. cash transfers provided for food or MPC, should be based on the MEB/MFB which can be calculated using [various approaches](#). The packages and amount should be discussed with the Cash Working Group, the food security cluster and other relevant actors and then clearly communicated to donors.

Step 6: Implementation of a cash and voucher assistance component

The implementation of CVA for nutrition outcomes is no different than the implementation of CVA for other objectives and should follow existing organizational guidelines and procedures. Successful implementation requires a close collaboration between programme, procurement, logistics, finance and other units/departments within an organization.

Essential components of the implementation stage include:

- defining roles and responsibilities in alignment with existing Standard Operating Procedures;
- putting in place internal and external coordination mechanisms;
- setting up beneficiary communication and accountability systems; selecting and contracting service providers/vendors to disburse cash transfers and the redemption of vouchers;
- identifying and registering beneficiaries; and
- carrying out and accompanying the distribution of cash or vouchers.

For more information, guidance and tools on implementation, please consult Mercy Corps [Cash Transfer Implementation Guide](#), WFP's [Cash and Voucher Manual](#) or CaLP's [Programme Quality Toolbox](#). For more information on how to adapt CVA programming and how to CVA safely and effectively in COVID-19 contexts, please consult CaLP's [guidance](#) on this topic.

Step 7: Monitoring of a cash and voucher assistance component

Proper monitoring of the CVA component and its contribution to nutrition outcomes is essential if the evidence base for using this approach in addressing nutrition issues is to be expanded.

The definition of indicators to *monitor outcomes* largely depends on the programme objective and is as such not tied to the assistance modality. Nutrition outcomes are usually assessed by looking at the prevalence of acute or chronic malnutrition within communities, the nutrition status of targeted individuals (typically measured through WHZ, HAZ, MUAC, WAZ and micronutrient status), indicators related to food consumption and dietary diversity at the population level or targeted individuals and access to health services.

To understand the impact of household CVA on maternal and child nutrition, it is important to move beyond the household level indicators such as the Household Dietary Diversity Score (HDDS) or the Food Consumption Score (FCS). These do not capture the nuances of intra-household distribution of food and cannot be extrapolated to the individual level. Indicators such as [Minimum Dietary Diversity for Women](#) (MDD-W), [Minimum Acceptable Diet](#) (MAD), [Minimum Dietary Diversity](#) (MDD) for children 6-23 months and [Minimum Meal Frequency](#) for children 6-23 months can help to capture intra-household differences in food consumption habits and to highlight consumption patterns that are deficient in micronutrient-rich foods (AAH, 2017).

Another interesting indicator that is particularly relevant for interventions including a household cash transfer component is the [coping strategy index](#) (CSI). The CSI was originally developed as a food security indicator and measures the extent to which households use harmful coping strategies when

they do not have enough food or enough money to buy food. Variations of the CSI exist, and it can be expanded to identify harmful coping strategies in relation to health and WASH⁴⁸ practices.

How households and individuals use CVA can be considered as an intermediate outcome and should be closely monitored when using CVA as part of a nutrition response. Specifically, expenditure on food, the composition of purchased food, expenditure on accessing health services and expenditure related to water and sanitation should be collected at sub-category level (i.e. what kind of food was purchased, what kind of expenditure to access health services occurred, and what water and hygiene goods and services were obtained). From expenditure data, vulnerability indicators such as the [household food expenditure share](#) or the [percentage of household expenditure on health](#) can be extrapolated.

The definition of indicators to *monitor process and outputs* is very much linked to the assistance modality. Typical indicators for CVA include:

- the number of households or individuals (disaggregated by gender) that have received CVA per distribution,
- the number of vouchers redeemed per distribution,
- the total amount transferred per distribution,
- the percentage of payments made according to schedule,
- the percentage of beneficiaries who report satisfaction with process and methods of implementation, etc.

Market monitoring is required to have up-to-date information on the value of the transfer in terms of what it can buy. In volatile contexts, the transfer amount may need to be adjusted in line with market prices or there is a risk of compromising the intended nutrition outcome. In many humanitarian contexts, systems to assess and monitor markets for food and non-food items are already in place. As such, the nutrition sector can benefit from secondary data on relevant market systems and does not necessarily have to collect additional market information. For food markets, it is important to keep in mind that the food items included in market analysis and monitoring for a food security or basic needs might not be diverse enough to constitute a nutritious diet. In such circumstances, the nutrition sector could advocate for additional nutritious food items such as fresh foods and animal source products to be included into market monitoring.

Lastly, positive and negative unintended consequences of CVA should be proactively captured through monitoring systems.

Transversal Issues

Preparedness

Preparedness is continuous processes to create and maintain an environment conducive to quick, appropriate and effective nutrition in emergency response. Preparedness is particularly relevant in contexts with relatively predictable slow or rapid onset shocks (e.g. related to seasonality). Preparedness actions should be extended to CVA in contexts where cash and/or vouchers are likely to be feasible and adequate response options in nutrition in emergencies.

Preparedness actions for CVA based on identified crisis scenarios are identical to the seven key steps covered in this guidance note. NiE assessment tools need to collect information that allows conclusions on the suitability of a CVA component to be drawn. CVA feasibility, including the market capacity, can be assessed pre-crisis and rapidly verified post-crisis. Organizational and partner capacities should be verified and strengthened as required in order to use cash or voucher modalities. Frame agreements with service providers to deliver cash or vouchers (such as vendors, financial service providers or e-voucher providers) need to be in place pre-crisis.

⁴⁸ An example for a multi-sectoral CSI developed in Afghanistan can be found [here](#).

For more information on preparedness for CVA, please consult the CaLP' [Programme Quality Toolbox](#). For more information on preparedness for NiE coordination, please consult the [Preparedness Guidelines for NiE Coordination](#).

Coordination

In most contexts where CVA is part of a humanitarian response, a CWG is likely in place. While the practical arrangements can vary depending on the context, the CWG is formally a sub-group of the Inter-Cluster Coordination Group (ICCG). According to its terms of reference, the ICCG is responsible for identifying and facilitating the coordination of multi-sectoral or multi-purpose cash transfers. Sector coordinators are expected to participate in these CWGs. For more information on CVA coordination, please consult CaLP's [coordination tip sheet](#).

The nutrition cluster/sector coordination team is responsible for the overall coordination of the assessment, planning, reporting, implementation and monitoring of CVA components of a nutrition response. It ensures that nutrition assessments and Humanitarian Needs Overview analysis consider economic barriers to the underlying determinants and whether CVA could play a role in addressing them. It supports determining the feasibility and adequacy of using CVA as part of the nutrition response. It supports the routine consideration of cash and voucher modalities in nutrition response analysis and ensures that adequate CVA responses are reflected in the nutrition component of the Humanitarian Response Plan. It provides or sources technical support for CVA interventions for nutrition partners and promotes the design and implementation of the CVA component based on current good practice. It ensures indicators related to the CVA component are integrated into the nutrition response monitoring system. It supports the documentation of lessons learned and promotes capacity and confidence building of local/national partners and local actors. Finally, it integrates the use of CVA into nutrition advocacy and resource mobilization activities.

Given that CVA touches upon the different underlying determinants for adequate nutrition, the nutrition sector needs to coordinate closely with the food security, WASH, health and protection sectors as well as the cash working group and relevant national actors on all aspects of the programme cycle. A lot of the information that is required to determine the feasibility and adequacy of CVA for nutrition outcomes is likely to sit with other sectors and actors. A lot of the expertise in designing, implementing and monitoring CVA lies with CWG and its partners. Furthermore, one of the roles of the CWG is to provide technical support to and advocating with clusters to ensure that each sector response plan includes a robust analysis of modalities, and of how cash and vouchers will be used to reach sector outcomes.

Information management

CVA components of a nutrition response aiming to achieve nutrition outcomes should be reported under the nutrition cluster/sector. To support the effective and standardized operational tracking of CVA, a [template](#) with recommended standard and optional reporting requirements for sectoral CVA was developed, in collaboration between the Global Clusters Coordination Group and our Global Clusters IM focal points. The template refers to inter-sectoral operational reporting requirements and does not affect the additional data required by clusters for their internal use. Nutrition clusters have been requested to integrate the CVA related columns into their reporting template. This will allow for sectoral CVA programming to be reported via the relevant cluster/sector, in line with existing processes for tracking in-kind assistance.

Risk analysis and mitigation

Risks related to CVA are identified during the feasibility assessment, considered during response options analysis, mitigated through programme design and other measures, and monitored during

implementation. Providing humanitarian assistance in humanitarian contexts involves a number of operational and institutional risks related to safety and dignity, access, data protection, social relations, household and community dynamics, fraud and diversion, and market impacts. Many of these risks are not specific to CVA and apply irrespective of the assistance modality being used. In fact, identifying risks that occur irrespective of the assistance modality can help in determining the causes and potential mitigation measures. Nonetheless, CVA, and especially cash transfers, are often perceived to be riskier than other modalities even though there is no evidence supporting this concern.

There are some risks that are specific to using CVA as part of a nutrition response:

- An important risk when providing cash transfers (and to lesser extent vouchers) is that the money is spent on goods and services that are not contributing to nutrition outcomes. Monitoring results of cash transfer interventions consistently show that vulnerable recipients use the cash transfers on priority needs. However, priority needs are not always consistent with improved nutrition outcomes for women and children within households. This risk can be mitigated to a large extent by pairing cash transfers with SBC interventions, thereby increasing the likelihood that the assistance is spent in a way that is women and child-centred. It is also important to keep in mind that recipients of in-kind assistance and vouchers often sell or barter vouchers and goods to address other priority needs that are not addressed by the assistance.
- Another important risk is the potentially harmful and unintended incentives associated with the provision of CVA. The risk of providing an incentive to caregivers to make or keep a child malnourished when providing CVA as part of treatment for malnutrition is not well understood but needs to be taken seriously when considering such an approach. Potential mitigation measures include avoiding continuous enrolment (if practical), providing CVA irrespective of the recovery of the child and to potentially reduce the transfer amount (see [Part 1](#) for additional information). There is anecdotal evidence from humanitarian contexts suggesting that CVA targeted towards pregnant and lactating women can lead to an increase in fertility rates. Evidence from development settings largely suggests that cash transfers targeting poor households with children do not increase fertility. In Africa, research from Kenya, Malawi, South Africa, and Zambia, demonstrates no increases in fertility as a result of national government cash transfer programmes (Palermo, 2016).

When considering a CVA component as part of a nutrition response, all relevant risks need be identified and measures to mitigate these need to be put in place. Most risks associated with CVA can be mitigated through project design and a strong accountability framework. The [Protection Risks and Benefits Analysis Tool](#) provides in-depth global evidence on the protection risks and benefits of cash transfers, divided into key protection areas. It outlines the key questions that practitioners should explore to reach a context-specific, participatory identification of protection risks and benefits of a given intervention. The [CVA and GBV compendium](#) helps to integrate GBV risk mitigation into CVA interventions and to integrate GBV prevention into multi-sector programming. Identified risks related to CVA including protection risks as well as the effectiveness of mitigation measures need to be monitored throughout the response.

2.2 How to apply a nutrition lens to a cash-based response

Most humanitarian cash transfers provided at the household level are implemented in the food security sector or as multipurpose cash transfers (MPC). MPCs have been rapidly expanding in humanitarian response over the past years and is today a common form of household cash assistance. They are usually not designed to contribute to nutrition outcomes and their impact on maternal and child nutrition is hardly documented. Nonetheless, they can be an attractive response modality from a nutrition perspective, as the transfer amount provided has the potential to address economic barriers across the underlying determinants. Household cash transfers alone, including MPCs, should not be expected to

contribute to nutrition outcomes of individual household members. However, different measures can be taken to increase the likelihood that they do. These measures include:

a. Integrating context-specific SBC with household cash transfers

As [Part 1](#) has demonstrated, there is relatively strong peer-reviewed and operational evidence that pairing household cash transfers with SBC can be an effective strategy to prevent child malnutrition. SBC can promote nutrition-sensitive and child/women-centred spending decisions, while the cash transfer allows caregivers to put some of their acquired knowledge and skills from SBC activities into practice. The integration of SBC is a key measure to increase the likelihood that household cash transfers contribute to nutrition outcomes. It is a must if household cash transfers aim to contribute to nutrition outcomes.

b. Appropriately reflecting nutrition in the minimum expenditure basket and transfer amount calculation

When an MEB is used to calculate the MPC transfer amount, it should be designed to meet the macro and micronutrient needs of households and individuals⁴⁹. It should further contain expenditures related to goods and services that can contribute to nutrition outcomes, such as health, hygiene, sanitation, water and transportation. The transfer amount of a cash-based response that aims to achieve nutrition outcomes should allow households to access nutrition relevant goods and services including a nutritious diet. Nutrition practitioners should advise on the composition of the MEB during its development and revision.

MEB and MPC transfer amounts are usually calculated based on an average household size or per capita. A more precise approach could take the number of at-risk household members into account (i.e. the number of PLW, children below two years of age, adolescent girls, etc.) and adjust the transfer amount, e.g. through an adequate top-up, reflecting their specific requirements of nutritionally vulnerable household members. UNICEF in Jordan for example provided a cash top-up in addition to the MPC of approximately US\$ 28 per month for every child within a household in order to increase child-specific spending and reduce negative coping (Abu Hadam et al., 2017).

c. Choosing nutrition sensitive targeting criteria

Targeting criteria for MPC are in most cases based on economic vulnerability indicators (if these can be reliably collected), such as income or expenditure, food security (e.g. number of meals per day), household composition (e.g. dependency ratio), asset ownership (e.g. livestock or land), and coping strategies. Targeting criteria for nutrition interventions on the other hand are either based on at-risk groups for preventive strategies or nutrition status for the treatment of malnutrition.

In contexts where malnutrition rates are high, targeting strategies for household cash transfers should pay specific attention to at-risk groups, such as PLW, children below five years of age, adolescent girls, the elderly or people living with HIV. To increase the nutrition impact of household cash transfers, these groups can be categorically targeted. Also, mixed targeting approaches combining categorical targeting based on at-risk groups and targeting based on economic vulnerability can be considered and explored.

d. Including nutrition objectives and indicators in the project design

Household cash transfers such as MPC allow beneficiaries to address priority needs across sectors. As such, when trying to constitute success, monitoring systems need to capture indicators from different sectors. The Grand Bargain Cash Workstream (2019) came up with a set of outcome indicators for the

⁴⁹ Sphere food assistance standard 6.1.: Design food and cash-based assistance to meet the standard initial planning requirements for energy, protein, fat and micronutrients.

MPC approach that includes both sectoral and cross-cutting indicators. Nutrition indicators were at the time not included due to the “complexity of nutrition outcomes”.

However, if MPC interventions are based on adequate analysis and designed with a strong nutrition lens (i.e. they incorporate the measures described in this chapter), they can be expected to contribute to nutrition outcomes, such as the improvement of children’s and PLW’s dietary diversity. Indicators such as MDD-W, MAD and MDD could be incorporated into MPC monitoring frameworks. However, household cash transfers alone (even if designed with a nutrition lens) should not be expected to impact indicators related to the nutrition status of at-risk groups (i.e. WHZ, HAZ or MUAC). This is unless MPC is paired with nutrition-specific interventions and part of a broader integrated response to comprehensively address the immediate and underlying determinants of malnutrition.

2.3 Recommendations

The recommendations included below are directed towards the nutrition sector at global and national level and other humanitarian actors. They focus on actions that are required at global and national level to more routinely consider and, if appropriate, use cash and voucher modalities and approaches in nutrition in emergencies. This chapter contains further recommendations on programmatic approaches and the design for CVA in nutrition response.

Recommendations to **nutrition cluster/sector** coordination teams:

- Closely collaborate with all relevant sectors including FSL, health, WASH and protection in the assessment of demand and supply side barriers to adequate nutrition, including economic barriers and factoring in seasonality.
- Make sure that economic barriers are considered in nutrition assessment whenever possible.
- Consult with the CWG at local and regional level and cash practitioners on CVA feasibility.
- Ensure that nutrition assessments can contribute to understanding the feasibility of CVA and its potential and limitation for improving nutrition outcomes.
- Encourage and support partners to systematically consider cash and voucher modalities and approaches in nutrition response analysis.
- Based on an understanding of context, needs, and CVA feasibility, identify and promote adequate opportunities to use CVA modalities and approaches at household and individual level as a component of integrated nutrition programmes.
- Closely collaborate with the food security cluster/sector on using CVA modalities for household assistance and/or individual feeding assistance as part of a nutrition response.
- Closely collaborate with the health cluster/sector on using CVA to improve access to health and nutrition services for the prevention and treatment of malnutrition.
- Provide overall coordination of the planning, reporting, implementation and monitoring of CVA components of nutrition interventions.
- Closely collaborate with the CWG and other sectors (notably FSL, WASH and health) in the establishment of nutrition relevant components of the MEB and promote the inclusion of the cost of nutritious foods for different age groups.
- Advocate for the calculation of the MFB and MEB to include the cost of a nutritious diet that meets the macro and micronutrient requirements of all household members.
- Advise the CWG and cash practitioners on how to apply a strong nutrition lens to the design and implementation of household cash transfers, including MPC.
- Work with relevant sectors and market actors to make sure that market monitoring systems collect sufficient data on nutrition relevant goods and services including nutritious foods.
- Promote the documentation and dissemination of lessons learned on the use of CVA for nutrition outcomes.

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- Promote CVA capacity and confidence building among local/national partners by raising awareness of the use of CVA and links to social protection and social safety nets.

Recommendations to **nutrition practitioners and partners**:

- Contribute to a common understanding of the barriers to adequate nutrition, including economic ones.
- Contribute to a common understanding of the feasibility and appropriateness of using CVA modalities and approaches for nutrition outcomes.
- Systematically consider cash and voucher modalities and approaches in the nutrition response analysis process.
- Select CVA approaches and design the CVA component of a nutrition response based on the recommendations on programmatic approaches and design (see below).
- Invest in monitoring and evidence generation of nutrition programmes with a CVA component.
- Proactively disseminate lessons learned in using CVA for nutrition outcomes.
- Seek opportunities to explore evidence gaps in operational contexts in collaboration with the scientific community.
- Build CVA capacities and confidence among nutrition practitioners by raising awareness about the use of the approach and its links to social protection and social safety nets.

Recommendations to the **GNC and the Global Technical Assistance Mechanism (GTAM)**:

- Provide leadership and coordination on further exploring the use of CVA for nutrition outcomes at the global level.
- Work with partners to review and update key nutrition tools and guidance at the global level in relation to assessment, response analysis, design, implementation, monitoring, preparedness and coordination to better reflect CVA considerations.
- Where necessary, work with partners to develop new tools supporting consideration of CVA in NiE.
- Promote the development and dissemination of capacity building materials on the use of CVA for nutrition outcomes.
- Work with partners and other sectors to coordinate evidence generation to fill the identified evidence gaps.
- Update the guidance note on the use of CVA for nutrition outcomes on a regular basis to reflect new evidence, experiences and best practice.

Recommendations to **cash practitioners and CWGs**:

- Provide advice and technical support to the nutrition sector on technical aspects of CVA feasibility, response analysis, design, implementation and monitoring and how CVA may complement nutrition interventions that are based on service provision.
- Consult the nutrition sector on the composition of the MEB/MFB, particularly in relation to cost of nutritious foods and foods for special age groups within the affected population.
- In collaboration with the nutrition sectors, explore how to apply a strong nutrition lens to the design and implementation of household cash transfers, including MPC.

Recommendations to **donors**:

- If the analysis of nutrition prevalence and causes warrants, consider funding longer-term and multi-year programmes with CVA components complementary to other nutrition sensitive and specific interventions in protracted humanitarian settings.

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- Consider funding research and evidence generation in relation to [identified research and evidence gaps](#).
- Recognize the opportunities and accept the limitations of using cash and voucher modalities for nutrition outcomes.

Recommendations on **programmatic approaches** and **design** for CVA in nutrition response:

- In most situations, CVA will need to be combined with other nutrition-sensitive and specific measures and factor in seasonality to impact on nutrition. Five main approaches to integrate CVA into nutrition responses emerge from existing evidence.
- The pairing of household assistance and individual feeding assistance is encouraged to ensure that at-risk groups access the nutrients they require. CVA modalities can be considered for both components with some limitations regarding individual feeding assistance.
- Cash transfers that aim to contribute to nutrition outcomes need to be accompanied with context-specific SBC activities. Value vouchers aiming to contribute to nutrition outcomes should be accompanied with context-specific SBC activities.
- When considering conditionality to enhance participation in SBC activities and visits to priority health services, the expected benefits of introducing the conditionality (i.e. improved participation or uptake) need to be weighed against estimated costs, resource requirements and other factors.
- A softer approach to conditionality can reduce costs and resource requirements and might be a more suitable approach in emergency settings.
- Cash transfers or vouchers can facilitate access to treatment of malnutrition by covering indirect cost related to transportation, food and accommodation (for in-patient care).
- CVA provided to caregivers who bring their child for SAM treatment as part of CMAM can improve treatment outcomes by reducing defaulting and improving recovery. Risks related to targeting based on nutrition status need to be anticipated in programme design and then monitored.
- Both MEB and MFB should be designed to meet the macro and micronutrient needs of households or individuals. They could further consider the household composition and specific nutritional needs of vulnerable household members such as PLW, children or adolescent girls.
- While transfer amount, duration and frequency of transfers depend on the objective of a CVA component, more generous transfers, a longer duration and more regular transfers are more likely to have a positive impact on nutrition.

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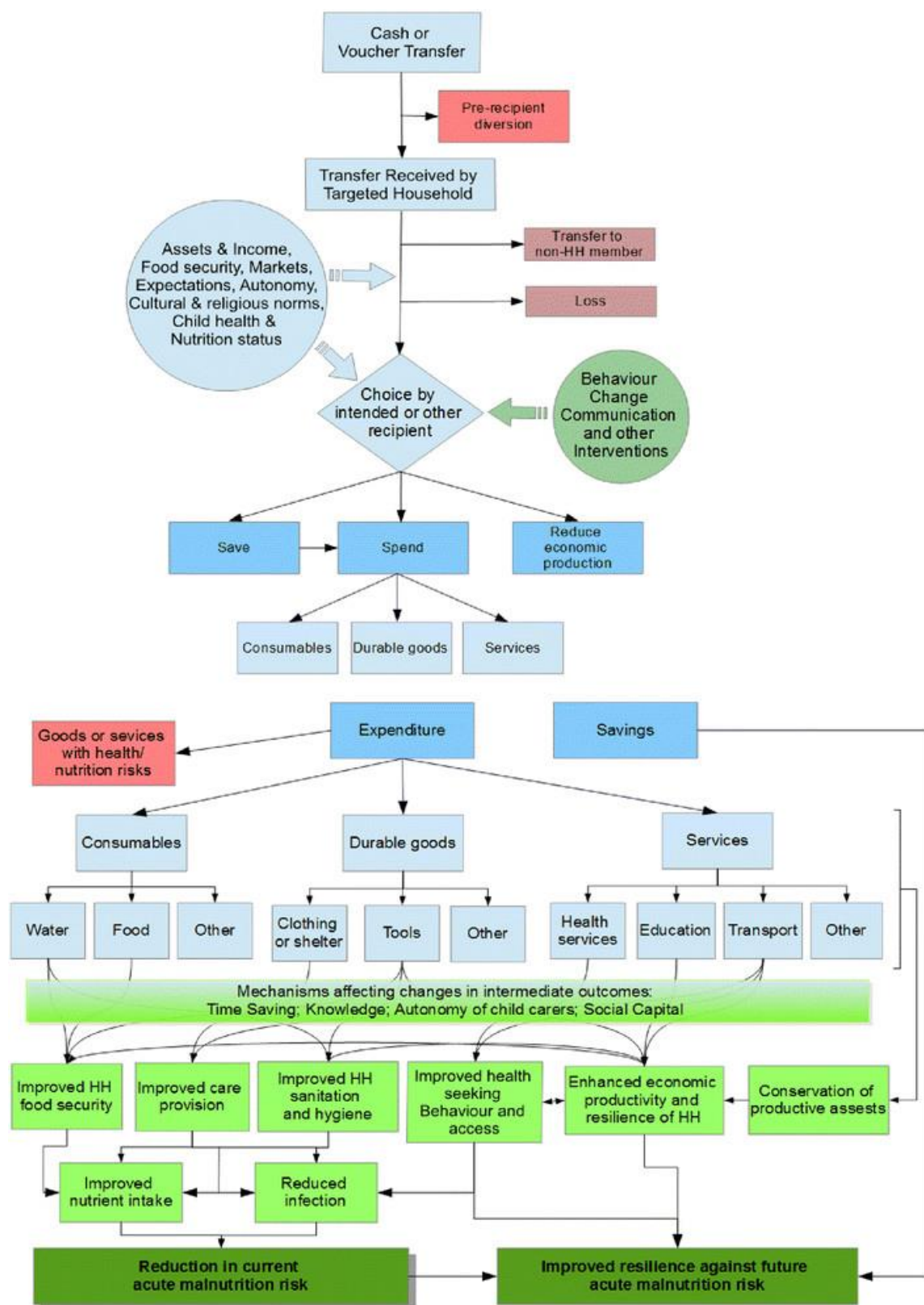
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Annex 1: REFANI Theory of Change



From Seal et al. (2017)

Note: An element that is missing in the theory of change is debt repayment. Following humanitarian shocks, household debt is often incurred to cover basic needs and cash transfers are often used to repay these debts.

Annex 2: Summary of Studies and Programmes

Peer reviewed studies are summarised in green boxes and operational examples are summarized in orange boxes. They are organized according to programmatic approaches.

Household assistance and individual feeding assistance

Research: Conditional cash transfer and/or lipid-based nutrient supplement targeting the first 1,000 days of life increased attendance at preventive care services but did not improve linear growth in young children in rural Mali: results of a cluster-randomized controlled trial	
Authors: Aubra et al. (2019)	Location: Mali
Intervention: evaluated the additional impact of the distribution of conditional cash transfers to mothers and/or lipid-based nutrient supplements (LNS) to children aged 6–23 months on mean HAZ, stunting (HAZ < -2), and on intermediate outcomes along the program impact pathways during the first 1,000 days of life. The cash and/or LNS component was conditional upon attendance of priority health services at community health centres (CHCs). The component was added to an ongoing health and nutrition programme (SNACK).	
Results: There were no impacts of the cash, LNS, or cash+LNS treatments, compared with the SNACK alone, on either HAZ or stunting.	
Learning: Implementation constraints and suboptimal participation in program activities may explain the lack of impact on child linear growth. This was particularly marked for the cash component where more than 34 per cent of women failed to receive any cash transfer. Although LNS had a higher coverage, on average children received the supplement only 10 times instead of the intended 18 times. Also, LNS was occasionally shared and the cash transfers, which was meant to be used to attend preventive health services, was reported to be used to buy food (>75 per cent) or clothes (around 40 per cent), and, to a lesser extent, to cover the children’s health expenses (around 25 per cent).	

Research: Preventing Acute Malnutrition Among Young Children in Crises: A Prospective Intervention Study in Niger	
Authors: Langendorf et al. (2014)	Location: Niger
Intervention: The study compared seven strategies used to prevent acute malnutrition in six to 23 month-old children, all providing general household assistance in the form of cash or in-kind food and/or specialized nutritious foods (LNS or SC+). These strategies were: HQ-LNS + cash; MQ-LNS + cash; SC+ plus cash; SC+ plus food; HQ-LNS alone; SC+ alone; Cash alone.	
Results: The study finds that preventive distributions combining a supplementary food and cash transfer had a better preventive effect on MAM and SAM than strategies relying on cash or supplementary food alone. The incidence of MAM was twice lower in the strategies receiving a food supplement combined with cash compared with the cash-only strategy or with the supplementary food only groups. The incidence of SAM was three times lower in the SC+/cash group compared with the SC+ only group. At the same time, the direct provision of nutritious supplementary food for a young child confers greater benefit than a comparable amount as cash in terms of “nutrition security” for young children	
Learning: The provision of supplementary foods to young children in conjunction with household support should remain a pillar of emergency nutritional interventions. Blanket distribution of nutritious	

supplementary foods to children under two years of age, associated with targeted cash transfer to the most vulnerable households, could be a cost-effective strategy in the short term.

Organisation: World Food Programme	Location: Somalia
Programme and duration: e-vegetable programme Fresh food vouchers, 2016-ongoing	Documents reviewed: NA
Intervention: WFP started to use fresh food vouchers to assist pregnant and lactating women in 2016. FFV (e-vegetables) are provided on top of the general food ration during pregnancy and until 6 months after the delivery (PLW). They aim to diversity diets and behaviour change. Voucher assistance is conditional on the attendance to Mother and Child Health and Nutrition (MCHN) centres, where women receive preventive health services (including antenatal and postnatal care, growth monitoring and immunization) as well as nutrition alongside SBC activities on health, nutrition and diet diversity.	
Results and learning: The latest Post Distribution Monitoring (PDM) from November 2019 on the e-vegetable programme for pregnant women enrolled in the MCHN intervention suggests 23.7 per cent of children 6-23 months consumed minimum acceptable diet that is higher than the national MAD rate of nine per cent (Somalia Infant and Young Child Nutrition Assessment, 2016). The survey results also revealed that 68 per cent of women met the minimum dietary diversity (MDD-W) threshold of having consumed more than 5 food groups out of 10 in the past 24 hours (excluding fortified foods).	

Organisation: AAH, CARE and WFP	Location: Haiti
Programme and duration: Fresh Food Vouchers, 2013	Documents reviewed: Learning review document (AAH, 2017)
Intervention: conducted a pilot project in Northern Haiti, where it replaced in-kind food rations with food vouchers. The objective of the project was to prevent malnutrition and promote growth by supplementing and improving the quality of the diet of PLW and children six-23 months. Food vouchers were composed of locally available and locally produced foods. The composition of the voucher was aligned with the in-kind ration and took into consideration the ideal nutritional intake for PLW and children 6-23 months. A fixed amount of money is included in the voucher for the purchase of fruits and vegetables. Caregivers of young children received a specific voucher with foods that are adapted for that age.	
Results and learning: Families preferred vouchers over in-kind rations and reported that they had access to better and fresher food and more diverse diets. The HDDs increased from 4.25 (baseline) to 4.36 (PDM 1) and to 6.83 (PDM 2). On the other hand, recipients reported that the food obtained through the vouchers was used in the first 10 days, possibility because of sharing with non-beneficiary households.	

Organisation: Action Against Hunger	Location: Bolivia, Haiti, Kenya, Occupied Palestinian Territories, Pakistan
Programme and duration: Different programmes	Documents reviewed: Meta-evaluation (AAH, 2012)
Intervention: AAH commissioned a meta-evaluation of five of its fresh food voucher programmes implemented between 2009-2011 during emergencies in Bolivia, Dadaab refugee camps in Kenya, Haiti, Pakistan and the occupied Palestinian Territories. The programmes were all paper value-	

vouchers exchanged for fresh foods in local markets. In the case of Bolivia, Dadaab and Haiti, the FFV was designed to complement GFD. In Pakistan, the voucher replaced GFD after markets demonstrated some degree of recovery. In the occupied Palestinian Territories, the voucher initially targeted those vulnerable to food insecurity who presumably had sufficient economic resources to meet staple food needs. Objectives ranged primarily from increasing dietary diversity and ensuring an adequate diet to reducing micronutrient malnutrition, preventing mortality or malnutrition, and other food security and livelihoods objectives, e.g. reducing negative coping mechanisms.

Results and learning: Fresh food vouchers increased dietary diversity in all programmes, but with mixed degree of result largely resulting from faults in design and implementation that can be better managed in the future. In the case of Haiti, dietary diversity only increased marginally (to pre-earthquake levels which were already poor) in part due to the lack of a general ration which may have led a significant portion of beneficiaries to use some of their voucher for staple foods. The importance of guaranteeing a staple food supply either through cash-based interventions and/or in-kind distributions is essential, and lack thereof may have resulted in an increase in acute malnutrition in some project areas during the FFV programme in Bolivia. That said, in three of the five countries where comparisons are possible, the relative cost effectiveness (change in food consumption) was significantly higher for FFV compared to in-kind staple food distribution only. FFV also correlated with lower rates of anaemia (Bolivia), increase in nutritional programme attendance (Dadaab), declines in acute malnutrition (Dadaab and Haiti), and income replacement and therefore reallocation of income to other livelihoods needs and protection of assets (occupied Palestinian Territories and Pakistan).

Organisation: WFP and UNHCR	Location: Kenya, Kakuma Camp
Programme and duration: Assistance to refugees in Kakuma camp, ongoing	Documents reviewed: Study by Ververs et al. (2019)
Intervention: UNHCR and WFP provided cash top-ups for dietary diversification in addition to in-kind food assistance to refugees. The food ration supplied 900–1,700 kcal per person per day, depending on the size of the household. The cash transfer was intended for dietary diversification.	
Results and learning: In 2017, a scurvy outbreak was observed in the camp. Ververs et al. (2019) who investigated the outbreak found that the cash transfer intended for dietary diversification was not used to purchase fresh foods but rather to complement the food rations with more calorically dense and cheaper staple foods to secure the missing calories. This led to vitamin C deficiency, i.e. scurvy, in adolescent and young adult male refugees who have comparatively high energy requirements ⁵⁰ . They conclude that simply providing an average amount of calories calculated on assumed household demographics is inadequate to meet nutritional requirements. More attention needs to be paid to household composition and size when determining food rations and transfer amounts.	

Organisation: ICRC	Location: Somalia
Programme and duration: Commodity vouchers plus SC to prevent deterioration in the nutrition situation, September 2017-May 2018	Documents reviewed: Learning document (ICRC, 2018)
Intervention: To prevent further deterioration in the nutrition situation and reduce malnutrition prevalence, the ICRC designed a two-phase intervention using an UCT, food vouchers and SNF. In the first phase (December 2017), a SMART Nutrition Survey was conducted to evaluate the nutritional status of the IDPs in a targeted location. The results showed that the prevalence of Global	

⁵⁰ The energy requirements for males aged 14–18 years and 18–30 years are 3,000–3,400 kcal per day and 2,550–3,900 kcal per day, respectively, based on moderate physical activity (males aged 14–18 years) and active to moderately active physical activity (men aged 18–30 years).

Acute Malnutrition required additional nutritional support for the population and all eligible households received an UCT of US\$ 200 plus 12 small boxes of BP5 for the 1st round (December 2017). For the second and third rounds (February and March 2018), all households with children below five received a food commodity voucher and Supercereal. In addition, children who were found suffer from SAM were referred for treatment at a mobile Outpatient Therapeutic Programme run by the Health Unit and the Somali Red Crescent. The combination of commodity vouchers plus SC distribution was later replicated in other regions in Somalia.

Results and learning: Two months after the third round of assistance, ICRC conducted a second SMART nutrition survey (May 2018) targeting the same population. The results showed an improvement of the GAM rate, especially for SAM. PDM from subsequent interventions using commodity vouchers and SC confirmed the positive impact on GAM prevalence. In the context of Somalia, food commodity vouchers have proven to be an effective tool to reduce the prevalence of malnutrition. This is particularly true where malnutrition is the result of an inadequate diet due to the loss or lack of income, and when the assistance is complemented with supplementary food, nutrition sensitization sessions and/or treatment of malnutrition.

Cash and Voucher Assistance paired with Social and Behavioural Change

Research: Food transfers, cash transfers, behaviour change communication and child nutrition⁵¹

Authors: [Ahmed et al.](#) (2019)

Location: Bangladesh

Intervention: The study implemented two randomized control trials in in two regions of Bangladesh (rural areas of the Northwest and Southwest region). The treatment arms include cash transfers, a food ration, or a mixed food and cash transfer, as well as treatments where cash and nutrition behaviour change communication (only in the North) or where food and nutrition SBC (only in the South) were provided. The core activity of the SBC component was a weekly, one-hour group session in each village with a trained community nutrition worker. These sessions covered six topics: importance of nutrition and diet diversity for health; handwashing and hygiene; diet diversity and micronutrients; breastfeeding; complementary foods for children six-24 months; and maternal nutrition. The programme applied a soft conditionality on their attendance.

Results: The study found that in the North, no treatment arm had a statistically significant effect on WHZ. Only cash plus nutrition SBC had a significant impact on nutritional status of children and its effect on HAZ was large. Improved diets in the cash and SBC arm, including increased intake of animal source foods, seem to be a key factor for these results. In the South, no treatment arm had a statistically significant effect on either HAZ or WHZ. The SBC did however result in improved knowledge of infant and young child nutrition, and this gain persists six-10 months after SBC activities ended.

Learning: Cash or food transfer programmes alone are likely to have limited impacts on child nutritional status, but given their cost-effectiveness and scalability, are promising platforms through which to leverage improvements in child nutrition, particularly with the addition of nutrition-specific complementary programming such as intense SBC.

Research: An Emergency Cash Transfer Program Promotes Weight Gain and Reduces Acute Malnutrition Risk Among Children 6-24 Months Old During a Food Crisis in Niger

Authors: [Bliss et al.](#) (2018)

Location: Niger, Tahoua region

⁵¹ The research contains preliminary material and research results and are circulated in order to stimulate discussion and critical comment. It has not been subject to a formal external review via IFPRI's Publications Review Committee.

<p>Intervention: looked at the impact of conditional cash transfers in combination with mandatory IYCF counselling for mothers in comparison with a control group. Program beneficiaries received three transfers over three months totalling US\$ 250 or approximately 65 per cent of Niger’s gross national per capita income. IYCF session topics included age-appropriate infant and child feeding, the importance of colostrum and breastfeeding, hand washing, and the use and mixing of oral rehydration salts. Cooking demonstrations showed participants how to prepare and integrate protein-rich foods and vegetable purees into meals for children</p>
<p>Results: The study found that dietary indicators improved, weight gain accelerated, and the prevalence of acute malnutrition in the cash group declined. The intervention was associated with a 1.27 kg greater overall weight gain and a 1.82 greater overall gain in WHZ. The odds of having acute malnutrition at the end of the intervention were 25 times higher among children in the comparison group than those in households receiving cash. Older children (those 12-24 months at baseline) benefitted the most from the cash intervention in terms of weight gain velocity.</p>
<p>Learning: The authors suspect that the use of conditionality and the sizable transfer amount were key features in achieving the positive results. Even though the intervention did not provide supplementary food, high adherence to the SBC activities may have fulfilled a similar role as food does in other programs and contexts</p>

<p>Research: Impact evaluation of different cash-based intervention modalities on child and maternal nutritional status in Sindh Province, Pakistan, at 6 months and at 1 year: A cluster randomised controlled trial.</p>	
<p>Authors: Fenn et al. (2017)</p>	<p>Location: Pakistan, Sindh province</p>
<p>Intervention: The study conducted a randomized control trial where they compared the effects of three different CVA modalities (single cash, double cash, fresh food vouchers) on nutritional outcomes in children under five years of age, measured at six months and at one year. The unconditional cash or voucher assistance was provided every month over six consecutive months. All programme participants also participated in SBC activities, which covered the causes of undernutrition, the benefits of exclusive breastfeeding, improved complementary feeding practices, food and water hygiene, handwashing, and sanitation.</p>	
<p>Results: The study found that all CVA modalities decreased odds of being stunted and improved linear growth at both six months and one year compared to the control group. As for wasting, only in the double cash arm were the odds of a child being wasted significantly lower compared to the control group, but only at six months. As an unintended outcome, children in the FFV arm had a significantly lower haemoglobin level compared to the control group. This may have been due to the restrictive nature of the voucher</p>	
<p>Learning: Large amounts of cash combined with SBC can benefit child growth and reduce wasting. The effect was only seen at six months suggesting that children remain vulnerable to wasting if the causes of food insecurity and high morbidity are not removed. Purchasing restrictions applied to FFV could have unintended effects, and their use needs to be carefully planned to avoid this.</p>	

<p>Research: The cash for nutrition intervention in Yemen: Impact evaluation study</p>	
<p>Authors: Kurdi et al. (2019)</p>	<p>Location: Yemen</p>
<p>Intervention: evaluated a conditional cash transfer program which started as a pilot in Al Hodeidah and was later expanded to other regions. The intervention targeted households with children under two years and pregnant women. The assistance was conditional on the attendance at monthly SBC activities and malnutrition screening. Programme recipients were required to attend these sessions,</p>	

but the programme took a soft approach to conditionality with emphasis on “case management,” meaning that community health educators reach out to non-attendees and encourage them to attend the next time.

Results: The study found significant positive impacts on the dietary diversity for children ages six to 23 months and women. The intervention decreased the share of children diagnosed with MAM or SAM and improved anthropometric indicators of children in the poorest third of households. The SBC activities were effective in improving key practices and increased the probability of early initiation of breastfeeding and exclusive breastfeeding by 15 per cent compared to the control group. In terms of women’s empowerment, women in households receiving cash were more likely to report that they can take their children if they are seriously ill to the health centre on their own.

Learning: Cash transfers combined with SBC in a conflict setting can have significant positive impacts on indicators of maternal and child nutrition. ‘Soft conditionality’ can be an effective alternative to unconditional or strictly conditional cash transfers in conflict settings, because it encourages high attendance at SBC sessions without excluding non-attendees.

Organisation: Save the Children	Country: Myanmar
Programme and duration: Maternal and Child Cash Transfer (MCCT) programme, 2016-2018	Documents reviewed: Endline report (Maffioli et al., 2019)
Intervention: The programme was implemented in three townships across Myanmar’s central dry zone and targeted pregnant women and mothers of young children. It comprised of monthly cash transfer to mothers in their last two trimesters of pregnancy until the child turns two years old (“first 1,000 days”) and SBC activity supplementing the cash transfers, covering a range of topics related to nutrition and child health. Villages in the three study townships were randomly assigned into three groups. In the first set of villages, women who were at least four months pregnant received both the cash transfers along with the SBC (cash+SBC). Another set of villages received only the cash transfers (cash-only), and a third set of villages did not receive any intervention (control).	
Results and learning: Overall, the cash+SBC intervention led to a reduction in the proportion of moderately stunted children. The intervention is particularly effective among vulnerable populations (low socio-economic status) and on children who were exposed for at least two years to the program, regardless of their gender. In contrast, the cash-only intervention did not seem to have an impact on the proportion of stunted children. The review does, however, find that cash transfers alone can help reduce moderate wasting. The review further finds that women assigned to the cash+SBC intervention spend significantly more money on food relative to the cash only and control groups. Cash+SBC interventions had a positive impact on both mothers’ and children’s dietary diversity. Also, mothers in the cash+SBC group have a higher knowledge on breastfeeding practices which led to a higher proportion of children (0-5 months old) receiving exclusive breastfeeding compared to the other groups. Regarding health seeking, the review finds that both cash+SBC and cash-only interventions led to an increase in usage of antenatal care, but no changes were found in postnatal care and delivery-related mothers’ behaviour. Also, women in both the cash+SBC and cash-only group improved in iron intake during the prenatal period.	

Organisation: Save the Children, Action Against Hunger	Location: Nigeria, Zamfara and Jigawa states
Programme and duration: Child Development Grant Programme (CDGP), 2013 to 2019	Documents reviewed: Baseline summary report, endline summary report (OPM, 2019)
Intervention: The programme aimed to address widespread poverty, hunger, and malnutrition, which affects the potential for children to survive and develop. The programme provided an UCT of	

NGN 3,500 per month (around US\$ 20) to over 90,000 pregnant women. Transfers were scheduled to begin during pregnancy and last until the child turned two years old, thereby targeting the first 1,000 days of the child's life. Alongside the cash transfer, communities in the programme were provided with education and advice about nutrition and health through an SBC component. The programmes tested two approaches to SBC: 1. 'low-intensity' SBC, delivered through posters, radio messaging, text messaging, health talks, and food demonstrations; and 2. 'high-intensity' SBC, delivered through support groups and one-to-one counselling for women receiving the transfer, in addition to the 'low-intensity' SBC.

Results and learning: The programme successfully led to a reduction in the prevalence of stunting among children. There was no corresponding impact on the prevalence of wasting, although the rate of wasting was considerably lower than the rate for stunting in this setting. This was accompanied by a strikingly positive impact on women's and men's knowledge and beliefs about healthy IYCF practices, as well as the reported adoption of such practices. The programme significantly increased exclusive breastfeeding rates and the uptake of vaccines, promoted increased dietary diversity of infants over six months and increased use of antenatal care services for pregnant mothers. The evaluation also found evidence of positive impacts on household food security, especially during the lean season, dietary diversity, and household expenditure. For several of the indicators measured, the positive impacts of the CDGP were found to have continued even after households had stopped receiving transfers. Overall, the findings point to the beneficial impact on child development of a programme combining household cash transfers with SBC that targets the first 1,000 days of a child's life.

<p>Organisation: Action Against Hunger</p>	<p>Location: Nigeria, Borno and Yobe states</p>
<p>Programme and duration: Protecting and promoting the food and nutrition security in the Yobe state, Phase II (2016-2017) Improving food and nutrition security in Borno state (2018-2019) Improving food and nutrition security of conflict affected communities in North East Nigeria (2019-2020)</p>	<p>Documents reviewed: Project proposal, final evaluation (AAH, 2019) Project proposal, endline report, final evaluation, Porridge Mum case study (AAH, 2017c) Project proposal</p>
<p>Intervention: Since 2016, Action Against Hunger (AAH) has implemented three subsequent projects aiming to improve food and nutrition security of crisis-affected populations and Borno and Yobe states. These projects followed a similar approach and combined general household assistance (i.e. the provision of food, cash and/or vouchers) to increase immediate food consumption for food-insecure households and nutrition behaviour change interventions targeting pregnant and lactating women (PLW) with a focus on adoption of optimal infant/young child feeding practices by caregivers.</p> <p>The transfer amount of the household assistance ranged between 17,000 to 21,000 NGN per household per month and was provided for 12 months. The amount represented between 70 to 100 per cent of the minimum food or expenditure basket.</p> <p>The implementation of the nutrition SBC approach varied between projects and states:</p> <p>In In Yobe state, 1,500 PLW benefited from IYCF counselling through care groups. The aim of the IYCF activities was to equip women with skills and knowledge on how to prepare healthy and nutritious meal from the locally available food for all children under five years of age and pregnant and lactating women in order to prevent children detected MAM during screenings from deteriorating into SAM and referred the SAM case to nearest outpatient therapeutic programme site before onset of medical complications, especially in view of the approaching lean season.</p>	

In Borno state, AAH continued with the Porridge Mum approach. AAH during the 2018-2019 project supported 100 porridge mum groups that comprised of a total of 1,500 PLW. Each group received a set of cooking utensils including a locally made fuel efficient stove, an electronic food voucher to purchase the ingredients for the daily cooking demonstration and a cash transfer to cover additional costs related to transportation and cooking. The food vouchers and cash transfer were administered by each group’s treasurer. Also, each group was trained on preparation and cooking of nutritious foods.

Results and learning: Project evaluations from Yobe and Borno found that the cash and voucher assistance helped households to improve diversify their diets. Also, cash transfers helped recipients to pay for immediate medical needs. The project evaluation (Yobe) revealed that the IYCF activities had a positive impact on the rate of exclusive breastfeeding, which increased from 26 per cent at baseline to 72 per cent at endline. The Borno evaluation found that cash transfers were more effective for increasing dietary diversity and quality, while food vouchers had a greater impact on per capita daily caloric intake. Also, the knowledge on complementary nutrition activities through porridge mum were highly satisfactory resulting in long-term impact and contributing to households positive coping mechanism. However, the evaluation also found that kitchen-based activities, i.e. the daily preparation of nutritious meals, were stopped at same time when AAH assistance stopped by end of March 2019. For the follow up project, AAH changed its porridge mum approach and reduced the number of cooking demonstrations and feeding sessions to twice weekly. Instead of providing food vouchers and cash transfers to the porridge mum group, AAH now provides food vouchers at NGN 5000 per month directly to PLW. With these monthly transfers, each PLW is expected to contribute to the cooking demonstration requirements of their groups.

Organisation: FAO	Location: Somalia
Programme and duration: Improving and sustaining food security in rural Somalia (emergency cash), 2019-2020	Documents reviewed: FFP project proposal
<p>Intervention: The project follows FAO’s cash plus approach and build on past projects using household cash transfers (through UCT or Cash for Work) and livelihood support. The programme aims to meet the immediate needs of shock-affected vulnerable communities while restoring their own food production. It combines household cash transfers based on 100 per cent of the minimum food basket, a livelihood support package tailored to livelihood group, technical training on different livelihood activity (e.g. good agricultural practices and nutrition SBC activities). The cash component is provided monthly for 3-6 months, depending on the duration of the lean season. The livelihood support package consists of:</p> <ul style="list-style-type: none"> • seeds for cereal (sorghum or maize), pulses and vegetables targeting farmers, • a vegetable kit and basic micro-irrigation supplies targeting women in IDP settlements, • feed blocks, milk containers and deworming for the animals targeting herders, • fishing gear and equipment targeting coastal communities. <p>SBC activities aim to improve food choices and utilization and include nutrition and food safety messages and cooking demonstrations. They are implemented through community nutrition champions who were previously trained as community trainers. The SBC trainings and activities focus on the different nutrition needs of people throughout the life cycle (i.e. from infancy to old age) as well as care practices, with an emphasis on women and children.</p>	
<p>Results and learning: Previous projects that provided household cash transfers in combination with an agricultural livelihood package achieve positive results household dietary diversity and production. Impact assessments to be done at the end of the implementation period will capture more nutrition sensitive indicators such as impact on-farm diversity, MDDW and MAD.</p>	

Conditional cash transfer to promote attendance to priority health services

Research: Program Impact Pathway Analysis Reveals Implementation Challenges that Limited the Incentive Value of Conditional Cash Transfers Aimed at Improving Maternal and Child Health Care Use in Mali	
Authors: Le Port et al. (2019)	Location: Mali
Intervention: assessed the incentive value of cash transfers in relation to community health centre (CHC) attendance. The study was embedded in a cluster-randomized impact evaluation of the program. The cash component provided mothers with a conditional cash incentive during visits to the CHCs for antenatal care, delivery, vaccination, and growth monitoring, and/or an LNS (Plumpy Doz). The size of the incentive ranged from US\$ 3-12 depending on the type of visit, estimated by program implementers to cover the cost for transportation and consultation fees, or the cost for delivery at the CHC.	
Results: The findings suggest that the LNS delivered in addition to cash provided a greater incentive than cash alone, as evidenced by the fact that among mothers of children 6–23 months of age (eligible for both cash and LNS), 72.3 per cent in the Snack + Cash arm had attended the CHC at least once compared with 84.7 per cent of mothers in the Snack + Cash + LNS arm. Our results showed that the LNS was also perceived by mothers as a benefit and an incentive for caregivers to attend growth-monitoring visits, while cash was perceived as a benefit of attending the CHC but not as an incentive. Mothers clearly viewed LNS as more important for improving their children’s health and preventing malnutrition.	
Learning: Implementation constraints related to remoteness and inaccessibility of health centres may have undermined the incentive value of the cash transfers in the SNACK programme. These constraints affected both the ability of frontline workers to deliver the cash according to protocol, and the participation of beneficiaries in the programme and their likelihood of receiving the cash when attending the CHCs. Furthermore, the study remarks that cash may not have been the best incentive to boost attendance at CHCs in this context and the transfer amount may have been too low to provide an incentive mothers to attend CHCs given transportation and other constraints.	

Research: Cash for Improved Nutrition in Somalia (CINS) – preliminary results	
Authors: UCL Institute for Global health and Concern Worldwide	Location: Somalia
Intervention: The CINS study was conducted in IDP camps in the Afgooye Corridor, an area that contains the largest IDP settlements in Mogadishu. The study used a twotwo factorial randomised cluster trial design, where IDP camps were designated as clusters. A total of 23 clusters/camps were selected and included in the study. All households with children aged less than five years (n=774) within the study clusters were selected to receive US\$ 70 in the first three months (humanitarian cash) and US\$ 35 for another six months (safety net cash).	
The 23 clusters were initially randomised to receive either conditional or unconditional cash. The randomisation was then repeated to allocate the clusters to receive either mHealth or no mHealth. The conditionality was for caregivers to take any children below five years of age to the local health clinic for a health screening, where they were issued with a health record card. The mHealth component consisted in weekly voice messages, delivered directly to the caregivers’ mobile phone. The voice messages covered the following topics: vaccinations; IYCF; WASH; identifying serious illness & health seeking; prevention, recognition and treatment of acute malnutrition; and maximizing health and nutrition for all household members.	

Results: The CCT intervention was associated with a strong and significant increase in the coverage of EPI vaccination and a reduction in measles infection. The mHealth intervention did not have any measurable impact on knowledge of health and nutrition topics among mothers/caregivers of children aged below five years. It did however lead to an increase in household expenditure on food and an improvement in the child dietary diversity score, as well as significantly reducing the risk of mortality in children aged below five years. Unexpectedly, the CCT was associated with an increased risk of acute malnutrition, and the mHealth intervention appeared to reduce measles vaccination coverage in children aged 9-59 months and was associated with an increased the risk of measles infection.

Learning:

- Integrated cash plus approaches are important to achieve key health and nutrition outcomes in humanitarian contexts such as Somalia.
- Conditional cash transfers can improve the uptake of life saving vaccination services.
- Linking cash transfers to health facility access can create demand for service provision and enhance reach.
- mHealth interventions can increase household expenditure and improve child dietary diversity.

Organisation: Consortium (AAH, UNICEF, WFP)	Location: Nigeria, Borno and Yobe states
Programme and duration: Integrated Nutrition Programme plus (INP+), 2017 to 2019 INP+ multisectoral pilots, 2017-2019	Documents reviewed: Project proposal Baseline report, midline report
<p>Intervention: The INP+ included a whole range of nutrition sensitive and specific interventions, including maternal dietary supplementation, micronutrient supplementation, breastfeeding and complementary feeding promotion, dietary supplementation for children, CMAM, Long Lasting Insecticide–treated Nets distribution, and cash transfers. The cash component provided a conditional cash transfer of NGN 5,000 per month to cover the additional nutritional requirements of PLW and the children during pregnancy and until the child turns two (first 1,000 days window of opportunity). The assistance was conditional on the initial enrolment at the health centre. Once enrolled, PLW were actively encouraged to access health services, such as antenatal care or vaccinations, and their attendance was monitored ('soft conditionality'). PLW were also referred to mother to mother support groups during their enrolment and actively encouraged to participate in SBC sessions ('soft conditionality').</p> <p>The INP+ multisectoral pilots was implemented in Shani and Nagere local government areas (LGA) from July 2017 to March 2019 adopted a similar approach as the INP+ but included additional sectoral interventions such as WASH support and livelihood support for PLW.</p>	
<p>Results and learning: Overall, the INP+ led to increased uptake and utilization of basic health care services. The enrolment of PLW at the health centres seem to positively impact health seeking following the enrolment. Also, the enrolment in mother to mother support groups and active encouragement of PLW's participation in these groups (soft conditionality) improved the participation of women in the health/nutrition education session at the community level.</p> <p>The midline survey for the INP+ multisectoral pilot shows that indicators such as under-five mortality rate, exclusive breastfeeding, minimum dietary diversity and minimum acceptable diet for children, household dietary diversity and access to safe and clean water supply improved across the surveyed LGAs as compared to the baseline. The conditional cash component increased antenatal care attendance, which resulted into the increase in the proportion of women who received Iron and folate supplementation in pregnancy. The midline survey further found that stunting improved across board irrespective of whether the LGA is an intervention site or not. Population-based anthropometric</p>	

measurements (GAM) for children aged zero – 59 months across the interventions LGAs appear not to have improved. In terms of negative consequences, some participants in focus group discussions (which were conducted as part of the mid-term survey) stated that the cash assistance causes disharmony in the family at the initial period of implementation especially in Nangere LGA, because their wives suddenly became rich and resisted sharing the money with them.

Organisation: World Vision International	Location: Bangladesh
Programme and duration: Cash-based Programming in South-Western Bangladesh, 2015-2016	Documents reviewed: Case study (WVI , 2019)
Intervention: The programme provided conditional cash transfers to pregnant and lactating women who live below the lower poverty line for 15 months during their pregnancy and after the birth of their child. These cash transfers were conditional on three antenatal care check-ups during pregnancy, one postnatal check-up, monthly growth promotion and monitoring sessions and attendance at SBC sessions after birth. Women reported that they did not find it difficult to meet the conditions for receiving cash assistance. Furthermore, the project applied a certain flexibility when it came to the conditionality: if a mother missed sessions for a non-emergency reason, they would not be paid that month, but they were still eligible to receive the full fifteen payments if they attend future sessions. The monthly transfer amount of 2200 taka (US\$ 27.50) was considered sufficient to meet the food-related needs of the mother and child, but not the rest of the family.	
Results and learning: The programme led to an increase in attendance of women at health centres and improved health outcomes for children and mothers according to cash recipients and health staff. The use of conditionality helped to encourage nutrition outcomes by making attendance at health or education sessions a requirement for cash recipients. The project led to an increase in dietary diversity, quality and quantity of diets. This was because of increased purchasing power as well as increased knowledge on how best to feed their children to meet their nutritional needs.	

Household Cash and Voucher Assistance and Severe Acute Malnutrition treatment

Research: Effects of unconditional cash transfers on the outcome of treatment for severe acute malnutrition (SAM): a cluster-randomised trial in the Democratic Republic of the Congo	
Authors: Grellety et al. (2017)	Location: DRC
Intervention: The study conducted a cluster-randomised controlled trial in children with uncomplicated SAM who received treatment according to the national protocol and IYCF counselling with or without a cash supplement. All participating caregivers from the intervention group with one or more children with SAM received an UCT of US\$ 40 value each month during treatment and follow-up for a total of six months (US\$ 240 in total). The objective of the study was to test whether cash transfers can improve the outcome of children treated for SAM	
Results: The study finds that the hazard ratio of reaching full recovery from SAM was 35 per cent higher in the intervention group than the control group. Non-response and defaulting were lower when the households received cash. All nutritional outcomes in the intervention group were significantly better than those in the control group. After six months, 80 per cent of cash-intervened children had re-gained their mid-upper arm circumference measurements and weight-for-height/length Z-scores and showed evidence of catch-up. Less than 40 per cent of the control group had a fully successful outcome, with many deteriorating after discharge. There was a significant	

increase in diet diversity and food consumption scores for both groups from baseline; the increase was significantly greater in the intervention group than the control group

Learning: The study shows that giving cash in impoverished communities can be effective in improving the outcome of children treated for SAM and provides a safety net that prevents relapse and allows for continued catch-up in weight and MUAC up to six months from admission. The results demonstrate that cash transfers are a viable and more easily implemented alternative to a supplementary feeding programme following discharge.

Organisation: Consortium (AAH, UNICEF and WFP)	Location: Nigeria
Programme and duration: integrated basic nutrition programme (INP) from 2016 to 2017	Documents reviewed: Learning review (ACF, 2017b)
Intervention: the INP provided cash transfer to caregivers of children who were admitted with SAM for treatment. Following registration, household monthly cash transfers of NGN 21,000 were provided over 6 months. The programme aimed to address underlying financial causes of child malnutrition and mitigate the risk of relapse. Households were registered on a continuous basis over the course of one year and were provided with monthly cash assistance for 6 months following enrolment. The transfer amount was based on the cost of the minimum food basket for a household.	
Results and learning: The programme seemed to have contributed to several unintended consequences: it led to large increase in SAM admission and there was some anecdotal evidence that caregivers would make or keep their child malnourished to be eligible for the assistance. Both health workers and programme staff reportedly accepted bribes to enrol children who did not meet the criteria. There were rumours that services were sometimes denied to children whose caregivers could not pay. Based on these experiences, ACF suggests the following lessons: 1) to avoid using nutrition status as targeting criteria; 2) to systematically ensure independent verification of household eligibility; 3) to determine a contextually appropriate transfer amount; and 4) to ensure sufficient internal controls including monitoring and accountability systems are available for communities to share anonymous feedback.	

Organisation: ICRC	Location: Somalia
Programme and duration: Cash transfers for caregivers of SAM children, July 2015-July 2018	Documents reviewed: NA
Intervention: The project provided UCT to caregivers whose children were treated for SAM in stabilization centres (in-patient) in Baidao and Kismayo. The objective of the cash transfer was to cover transportation costs, stabilize household food security following discharge and prevent relapse of children into SAM. Caregivers do not get assisted if they quit the stabilization centre before the treatment is finalized or if they return for treatment. They were eligible to three cash payments of US\$ 100 each commencing once the child has completed treatment and has been formerly discharged.	
Results and learning: To what extent the programme was able to achieve its objective is not clear. ICRC decided to conduct a study/evaluation on March 2018 (after two years and half the beginning of the activity) to review the outcomes and the pertinence of the programme and address the questions that have been raised inside the organization. Unfortunately, for security reason leading to lack of access of the international staff in Somalia, ICRC could not start the study and had to stop the cash transfer component in July 2018.	

Organisation: UNICEF	Location: Somalia
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Programme and duration: Safety Net Cash Programme, 2019-2020	Documents reviewed: Concept note
Intervention: The programme implemented by UNICEF started in 2019 and planned to provide caregivers of children with SAM with monthly cash transfers of US\$ 20 over nine months following their enrolment at the treatment centre. The aim of the cash transfer was to enhance the impact of therapeutic care and prevent children from relapsing into acute malnutrition. The programme also included SBC and counselling around optimal maternal and child feeding, and care practices targeted towards beneficiary households and the communities that host them. Due to operational and funding constraints, the programme was cut short and only provided three cash transfers (the last payments are ongoing).	
Results and learning: Due to operational constraints related to COVID-19, regular monitoring activities had to be cancelled or postponed.	

Studies that could not be assigned to a programmatic approach

Research: Unconditional Cash Transfers Do Not Prevent Children's Undernutrition in the Moderate Acute Malnutrition Out (MAM'Out) Cluster Randomized Controlled Trial in Rural Burkina Faso.	
Authors: Houngbe et al. (2017)	Location: Burkina Faso, Tapao province
Intervention: The study conducted a two-arm randomized controlled trial ('MAMout') in which the poorest household received monthly UCT during the lean season from July to November over two years (2013-2014). The monthly allowance of XOF 10,000 (equivalent to US\$ 17) was transferred through mobile phone.	
Results: Children in the intervention group had a lower risk of self-reported respiratory tract infections than children in the control group. The mean dietary diversity score in children and caregivers was higher as compared to the control group. Children and mothers were more likely to have consumed legumes, nuts, oils, fat and animal source foods, and had higher intake in vitamins. Qualitative investigations revealed that the money was also used to access health care and there were positive perceived changes in relation to gender equality and improvement in women's status. Nonetheless, the cash transfer did not result in a significant decrease in the incidence of acute malnutrition among children.	
Learning: The lack of impact on acute malnutrition can be potentially explained by different factors. The positive effect of the intervention on diet quality might have been too small to affect child anthropometry. The transfer amount might have been too low to cater to both the child's specific needs and the needs of the entire household. The authors conclude that cash alone was in this context not a successful strategy to address acute malnutrition and the intervention might have benefited from complementary measures such as SBC.	

Research: Findings from a cluster randomised trial of unconditional cash transfers in Niger.	
Authors: Sibson et al. (2018)	Location: Niger, Tahoua department
Intervention: The study conducted a two-armed cluster-randomised controlled trial in which the poorest households received either the standard UCT (four transfers between June and September, which is considered the 'lean season' in Niger) or a modified UCT (six transfers from April to September). The cumulative amount of cash received by the groups was equal, i.e. 130,000 FCFA. Eligible individuals (pregnant and lactating women and children six-<24 months old) in beneficiary households in both arms also received supplementary food between June and September.	

Results: Despite improvements of household expenditure and food security for all beneficiaries (including falling household food insecurity access scores, coping strategies index scores, and rising diet diversity and food consumption scores), the anthropometric status of children in households receiving either UCT or supplementary food was unchanged by endline and remained above the 10 per cent emergency threshold. At the same time, the prevalence of child sickness increased, because of a large increase in fever/malaria. This increase was observed despite an increase in bed net use and a fall in acute respiratory infection.

Learning: In both arms and samples, the baseline prevalence of GAM remained elevated at endline, despite improved food security, possibly driven by increased fever/malaria in children. Non-food related drivers of malnutrition, such as disease, may limit the effectiveness of UCTs plus supplementary feeding to prevent malnutrition in this context.

Research: The Role of Unconditional Cash Transfers During a Nutritional Emergency in Maradi Region, Niger: A Pre-Post Intervention Observational Study.

Authors: [Fenn et al.](#) (2014)

Location: Niger, Maradi region

Intervention: The study conducted a pre–post intervention observational study involving two rounds of data collection on the same cohort of ‘poor’ and ‘very poor’ households enrolled by Save the Children in an unconditional cash intervention that lasted from April to September 2012.

Results: The study showed that the living standards of ‘poor’ and ‘very poor’ households improved, as indicated by a reduction in poverty-related indicators and an improvement in household food security. Furthermore, anthropometric outcomes for children aged six–36 months improved significantly, despite a decline in child health and women’s well-being and autonomy. However, it was not possible to attribute the improvements in childhood nutrition status to the cash transfer.

Learning: It is plausible that giving UCT during an emergency can help safeguard living standards of the very poor and poor.

Research: A cash-based intervention and the risk of acute malnutrition in children aged 6–59 months living in internally displaced persons camps in Mogadishu, Somalia: A non-randomised cluster trial.

Authors: [Grijalva-Eternod et al.](#) (2018)

Location: Somalia, Mogadishu

Intervention: The study implemented a non-randomised cluster trial in IDP camps, located in peri-urban Mogadishu. The intervention group received a monthly UCT of US\$ 84 for five months, a one-off distribution of a non-food-items kit, and the provision of piped water free of charge. The control group did not receive anything.

Results: Diet diversity appeared to improve in children from households receiving the cash transfers and an apparent improvement in diet and food security was also observed in their mothers or primary carers. However, the study did not observe an associated reduction in the risk of children becoming acutely malnourished in camps receiving cash transfers.

Learning: It is unclear why the intervention did not appear to reduce the risk of malnutrition in children. Future work is necessary to understand whether modifications to this intervention, such as adding specific nutritious foods or SBC, could positively affect its ability to prevent children from becoming acutely malnourished.

Research: Cash and voucher assistance and children's nutrition status in Somalia

Authors: Doocy et al. (2020a, 2020b)

Location: Somalia

Intervention: The study examined the impact of CVA on prevention of child and maternal acute malnutrition in 2017/2018 in the context of the Somalia food crisis. Changes in diet and acute malnutrition were measured over a four-month period among children age six–59 months and pregnant and lactating women from households receiving household transfers of approximately US\$ 450 (over four months) delivered either as food vouchers or a mix of in-kind food, vouchers, and cash.

Results: The study found that household food security was similar for both intervention groups at endline; however, households receiving mixed transfers consumed meals more frequently. Children in households receiving mixed transfers also had more diverse diets at the end of the study period; however, the magnitude of change in dietary diversity over the study period was similar for children in mixed transfers and vouchers. Acute malnutrition prevalence was higher among children in households that received vouchers at both baseline and endline. The change over time in both mean MUAC and acute malnutrition prevalence was similar for both interventions, suggesting that mixed transfers and food vouchers had similar preventive effects on child nutrition status.

Learning: Alongside other evidence regarding beneficiary preferences for cash and lower implementation costs compared with vouchers, evidence supports continuing use of cash and voucher assistance in Somalia and considering expanded use of cash transfers.