



# R4ACT

RESEARCH 4 ACTION

## Impacts of CASH on NUTRITION outcomes

From available scientific evidence to informed action



Evidence review by Bridget Fenn



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# Acronyms

<b>ACF</b>	Action Against Hunger
<b>BCC</b>	Behaviour change communication
<b>BMI</b>	Body mass index
<b>CBI</b>	Cash-based interventions
<b>CBT</b>	Cash-based transfer
<b>CCT</b>	Conditional cash transfer
<b>CEA</b>	Cost-effectiveness analysis
<b>CT</b>	Cash Transfer
<b>CRCT</b>	Cluster randomised controlled trial
<b>CTP</b>	Cash transfer programme
<b>CMAM</b>	Community management of acute malnutrition
<b>DALY</b>	Disability adjusted life years
<b>EAP</b>	East Asia and the Pacific
<b>ENN</b>	The Emergency Nutrition Network
<b>HAZ</b>	Height-for-age Z-score
<b>LAC</b>	Latin America and the Caribbean
<b>LMIC</b>	Low and middle-income countries
<b>MEB</b>	Minimum expenditure basket
<b>PLW</b>	Pregnant and lactating women
<b>SA</b>	Southern Asia
<b>SAM</b>	Severe acute malnutrition
<b>SP</b>	Social protection
<b>SSA</b>	Sub-Saharan Africa
<b>ToC</b>	Theory of Change
<b>UCT</b>	Unconditional cash transfer
<b>UNICEF</b>	United Nations Children’s Fund
<b>WASH</b>	Water, sanitation, and hygiene
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organisation
<b>WHZ</b>	Weight-for-height Z-score

*A glossary referring to the technical terms used in the report can be found in Annex 5.*

# Preface

A review of the current state of evidence on cash for nutrition outcomes was commissioned by Action Against Hunger and the World Food Programme as an essential preliminary step to develop a set of recommendations on how to support the use of cash transfers for enhanced nutrition outcomes in humanitarian and development programmes. The evidence presented in this report was reviewed and summarized by Bridget Fenn.

The report was circulated to a select group of stakeholders (14 in total) who were invited to participate in the 'Research 4 Action' pilot process aimed at facilitating the uptake of scientific evidence. This process included a one day workshop in November 2017 during which currently available evidence was discussed and recommendations were established. The recommendations from this stakeholder group developed during the workshop are outlined in Section 2.3.

Action Against Hunger and the World Food Programme wish to thank Bridget Fenn and the workshop participants for making this report possible.

# Section 1: Assessing the potential impact of cash transfers on nutrition outcomes

## 1.1 INTRODUCTION

Undernutrition is a persistent global public health challenge; the 2017 Global Nutrition Report<sup>1</sup> notes that 88% of countries suffer from a significant burden of two or three forms of malnutrition. Among children under the age of five, 52 million children are acutely undernourished and 155 million are stunted. To tackle the global burden of undernutrition, nutrition-sensitive interventions have been identified with a high potential to efficiently prevent undernutrition in all its forms<sup>2</sup>. Among them, cash transfers are a key program modality that could allow scaling-up of interventions.

Following the presentation of the Grand Bargain agreement at the 2016 World Humanitarian Summit, the use of cash transfers has become a key component of humanitarian assistance. There is strong evidence and consensus that cash transfers are efficient and effective in covering basic needs. Cash transfers offer dignity, choice and flexibility to affected populations and therefore play a key role in reaching nutrition security for all.

Humanitarian actors and policy-makers increasingly recognize the need for more evidence-based interventions to support their programmes and policies<sup>3</sup>. Currently, the overall body of evidence for CBIs on nutrition outcomes in humanitarian settings is limited; a lack of robust studies further narrows the power of the available evidence to affect decision-making for maximising impacts.

However, the number of studies and reviews addressing the impact of cash transfers on nutrition is growing, and multiple efforts are being made to build on this evidence.

With more evidence available from development settings, the question arises as to whether this evidence can be applied in humanitarian settings. While there are similarities between development programmes and humanitarian responses involving cash, the differences, largely driven by context, remain important. Additionally, the types of interventions, and how they are implemented, are diverse, resulting in a wide range of variables to consider when synthesising evidence of the impact of cash transfers on nutrition.

The exercise of collating the available scientific evidence to inform programmes and policies is necessary to respond to major questions regarding the use of cash transfers in nutrition programmes: Do cash transfers have an impact on nutrition outcomes? Can they be scaled-up and systematized in humanitarian contexts? How can evaluators and implementers work together to not only conduct a successful programme but also build on the evidence-base, especially around 'how' cash-based interventions (CBIs)<sup>4</sup> work? This report serves as a starting point to answer some of these questions.

## 1.2 OBJECTIVES

The main objective of this report is to provide a user-friendly summary of available evidence linking cash to nutrition outcomes. It served as the basis for further discussion by a selected panel of experts to generate recommendations at the Research 4 Action workshop held in Paris on 14th November 2017. To facilitate this process, the meeting followed the steps below:

1. **'What we know'** – Presentation of the key findings on the effects of cash-based transfers on nutrition outcomes, as well as evidence gaps (including programme design and implementation).
2. **'What should be done'** – Presentation of the recommendations, prepared in advance, by each invited organization, with a focus on operational impacts and policy implications. Discussion and revision or addition of recommendations by workshop participants.
3. **'How can these recommendations be translated into action'** – Workshop participants brainstormed on ways of translating recommendations into programme and policy action.

1 Development Initiatives, 2017. Global Nutrition Report 2017: Nourishing the SDGs. Bristol, UK: Development Initiatives.

2 Ruel, M, Alderman, H and the Maternal and Child Nutrition Study Group. Nutrition-sensitive interventions and programs: how can they help accelerate progress in improving maternal and child nutrition? Lancet. 2013;382(9891):536–551.

3 Blanchet et al. Evidence on public health interventions in humanitarian crises. Lancet. 2017;390(10109):2287–2296.

4 The term can be used interchangeably with Cash Based Assistance, Cash Transfer Programming (CTP), Cash-Based Transfers and Cash and Voucher Programming

5 Helene Clark, ActKnowledge in Vogel, 2012, DFID report

## 1.2 THEORY OF CHANGE

*'Theory of change is a dynamic, critical thinking process, it makes the initiative clear and transparent - it underpins strategic planning. It is developed in a participatory way over time, following a logical structure that is rigorous and specific, and that can meet a quality test by the stakeholders. The terminology is not important, it is about buying into the critical thinking.'*<sup>5</sup>

Theory of Change (ToC) is increasingly regarded as an essential tool in designing and appreciating the complex network of factors influencing project outcomes and impact. A ToC is essential to understanding the important pathways and mediating factors that together underpin the success, or failure, of any programme.

The pathway between cash transfers and nutrition outcomes is extremely complex, and flexibility is required in the process of developing a successful ToC, within any given setting. There is thus no universally applicable ToC for cash and nutrition; any programme must develop a tailored ToC which carefully considers each of the potential pathways leading to the desired outcomes. To facilitate summarizing and categorizing current evidence, this report refers to the Theory of Change developed by Bailey and Hedlund in 2012<sup>6</sup> (Annex 3), based on the UNICEF conceptual framework on the causes of malnutrition.

To fully capture the complex nature of pathways between cash and nutrition outcomes, ToCs also need to consider the social processes and factors involved (for example barriers and facilitators, or perceptions) following the flow of cash from distribution to use, and

considering the context in which the programme is implemented. The individual pathways within the ToC should be explored in-depth to facilitate understanding of the potential for success or risks of failure of a programme in meeting its goals. For instance, although it seems logical that significant improvements in dietary intake and child sickness (two of the main drivers of malnutrition) should lead to significant improvements in anthropometric status, this is not always the case. During development of a ToC, stakeholders engage in discussion and represent their analysis through diagrams and visuals as part of an ongoing process developed across the programme life cycle, from inception to impact evaluation. An adapted version of this method was used to support a dynamic exchange between the participants of the R4ACT workshop, which resulted in a list of priority recommendations for research as well as programme and policy action.

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<sup>6</sup> Bailey, S and Hedlund, K. The impact of cash transfers on nutrition in emergency and transitional contexts: A review of evidence. Humanitarian Policy Group. 2012.

# Section 2: What does the evidence say?

## 2.1 DESCRIPTION OF STRENGTH OF EVIDENCE

Most of the evidence in this report focuses on what works. There has been much less documentation on why an intervention works and the challenges in implementation within a given setting. It is this information that would help to increase the generalisability of research findings.

Very few studies highlight negative effects; generally, where there was a statistically significant impact observed, that impact was positive.

This report includes reviews that have used evidence from robust studies, and therefore no further examination of the quality of the studies was conducted. To enable the assessment of the strength of evidence, the size of the body of evidence (number of studies included) and consistency of evidence (number of studies pointing to similar conclusions, usually positive unless otherwise stated) were used to generate the five categories.

Evidence is presented beginning with the impact of cash transfers on child nutritional status and proceeds to the immediate and then underlying determinants of nutrition outcomes (Table 1). This is followed by evidence from additional factors that may influence the multiple pathways between cash and nutrition, such as programme design, implementation and costs (Table 2). In tables 1 and 2, the studies mentioned under the indicator are those that directly measured the

indicator in question. The key findings refer to trends, based on best evidence to date drawn from the studies that were reviewed, but do not necessarily refer to the conclusions of individual studies. The researcher made additional notes which can be seen in italics under the key findings column.

**Strength of body of evidence according to size and consistency:**

●●●● = STRONG

●●● = MODERATE

●● = GROWING










● = LIMITED

⊘ = NO OR VERY LITTLE EVIDENCE

**TABLE 1: EVALUATION OF THE STRENGTH OF EVIDENCE ON OUTCOMES AND DETERMINANTS OF NUTRITION STATUS**

Indicators (with reference to literature in annex)	Strength of evidence	Key findings (with reviewer’s notes in italic>)
Wasting 2, 3, 4, 5, 6-13, 16	●●	<p>⇒ Limited but growing number of studies with statistically significant results – studies that are significant show positive impacts on reduced risk of being wasted (mainly by WHZ) in both emergency and development programmes</p> <p>⇒ Emerging evidence of positive impacts on WHZ with complementary programmes e.g. BCC, supplementary food, access to CMAM</p>
Stunting 2, 3, 4, 5, 7, 9, 10, 14	●●	<p>⇒ Growing number of studies with statistically significant results – studies that are significant show positive impacts on HAZ score</p> <p>⇒ These results have mainly been driven by CCTs with evidence from development programmes, especially from the LAC region; however, more evidence is emerging from humanitarian and short-term programmes (e.g. Pakistan [UCT and vouchers], Togo [CCT])</p>






<p>Underweight</p> <p>3, 4, 8, 9</p>		<p>⇒ Evidence of statistically significant improvements in underweight is more limited than measures for wasting or stunting</p> <p>⇒ Evidence mainly from longer-term programmes</p> <p><i>General note on nutritional status indicators: Improvement in nutritional status was not consistent across studies. It is important to consider whether the lack of significant results was due to programme design or the intervention implementation (including the interaction with the context), or to methodological differences in impact evaluations.</i></p>
<p>Micronutrient status</p> <p>2, 5, 6, 9</p>		<p>⇒ Inconsistent evidence in improvement in micronutrient status</p> <p>⇒ Growing evidence on access to micronutrients</p>
<p>Child dietary intake</p> <p>5, 9-13, 16</p>		<p>⇒ A small amount of inconsistent evidence is available regarding dietary diversity at the individual child level; most available evidence is at household level</p> <p>⇒ Limited evidence (one study) has shown cash (UCT) to be better than vouchers for improving child dietary diversity in a humanitarian context</p> <p>⇒ Growing evidence of increase in expenditure on food for children seen with CBIs</p>
<p>Child health status</p> <p>2, 3, 4, 5, 9, 12, 13, 16</p>		<p>⇒ More evidence of positive impact from CCTs in development settings</p> <p>⇒ Pathways of impact are unclear</p> <p><i>Note: Very limited evidence on treatment of child disease. This is difficult to measure accurately as cash is likely to improve health thus resulting in reduced perceived need for treatment.</i></p>
<p><b>Household Food Security:</b></p>		
<p>Food consumption/Dietary diversity</p> <p>1, 2, 3, 4, 6-9, 11 -13</p>		<p>⇒ Consistent positive impact of CBIs</p> <p>⇒ Most of the current evidence suggests no significant difference between type of cash transfer, although there is some evidence that UCTs could be better than vouchers in humanitarian contexts (e.g. Pakistan), and that vouchers could be better in development contexts (e.g. Ecuador)</p> <p>⇒ Both UCTs and CCTs, including vouchers, may be better than food transfers (i.e. HH food baskets) for improving dietary diversity</p>
<p>Caloric intake</p> <p>1, 6</p>		<p>⇒ Food transfers (i.e. HH food baskets) may be better than CBIs at increasing caloric intake, depending on the programme and the context</p>

<p><b>Health environment</b></p> <p>Preventative health care (e.g. ANC, ITN, deworming, growth monitoring)</p>		<p>⇒ Evidence mainly from CCTs</p> <p><i>Note: Lack of evidence in humanitarian settings, which may be due to complex determinants of health and lack of quality supply.</i></p>
<p><b>WASH</b></p> <p>4, 6, 9</p>		<p>⇒ Limited evidence as WASH is a recent objective of CBIs</p>
<p><b>Care practices/characteristics:</b></p>		
<p>Feeding behaviours, health practices and psychosocial care</p> <p>4, 7</p>		<p>⇒ No evidence mainly due to heterogeneity of indicators used</p>
<p>Physical health, empowerment, stress/mental health</p> <p>4, 7, 9</p>		<p>⇒ No evidence mainly due to heterogeneity of indicators used</p>
<p>Individual dietary intake (caregiver)</p> <p>7, 9, 12-15</p>		<p>⇒ Maternal health not a focus in the reviewed reports.</p> <p><i>Note: Whilst reference is made to maternal health there is a lack of evidence on impact.</i></p>
<p><b>Household economy:</b></p>		
<p>Increase in income/ protection of assets</p> <p>1, 6, 9</p>		<p>⇒ Evidence mainly from development settings</p> <p><i>Note: Strong logic but data (usually self-reported) difficult to collect. Dependent on amount of cash grant and immediate need of household.</i></p>
<p>Household expenditures and/or food expenditures</p> <p>1-7, 9, 12,13</p>		<p>⇒ Largely consistent evidence that food security programmes, especially CBIs, increase expenditures on food (although impact is dependent on context, implementation and intervention design)</p> <p><i>Note: It is difficult to determine how cash transfers might affect usual HH expenditures that would occur without the receipt of cash (i.e. whether or not HHs save money from normal incomes, whether usual costs are offset by transfers, etc.) and how these changes may impact nutrition.</i></p>
<p>Coping strategies (food based)</p> <p>1, 9, 12, 13</p>		<p>⇒ No evidence due to heterogeneity of indicators used</p>
<p>Multi-sectorial (other); e.g. education, shelter, early marriage</p> <p>1, 5, 6</p>		<p>⇒ Evidence mainly from CCTs</p>

**TABLE 2: EVALUATION OF THE STRENGTH OF EVIDENCE ON PROGRAMME DESIGN, IMPLEMENTATION AND COSTS**

Currently there is more evidence available on the impact of CBIs on nutrition outcomes and causes (as seen in Table 1) than for programme design and implementation factors. Many of the reviews note the heterogeneity in programme design and implementation, which makes extracting definitive conclusions on best interventions for impact on nutrition outcomes difficult. Table 2 outlines key design and implementation elements for cash transfer programmes. Although there is limited evidence available to date, theories of change suggest that these factors might have a potential impact on nutrition outcomes.

**Strength of body of evidence according to size and consistency:**

-  = STRONG
-  = MODERATE
-  = GROWING
-  = LIMITED
-  = NO OR VERY LITTLE EVIDENCE

Key elements of programme design and implementation (with reference to literature in annex)	Strength of evidence	Key findings
<p><b>Complementarity</b> (Cash + complementary interventions/services) 2, 3, 7</p>		<p>⇒ Complementary programmes are deemed necessary (e.g. nutritional status and behaviour change communication) in any setting due to the multiple underlying causes of undernutrition</p> <p><i>Note: A lack of such programmes may explain why, although we see improvements in child dietary intake and/or health access, we do not always see improvement in anthropometric status</i></p>
<p><b>Purpose of the cash transfer</b> (e.g. multi-purpose; multi-sector; sector-specific; item-specific)</p>		<p>⇒ No evidence due to lack of documentation</p> <p><i>Note: Not detailed per se in reviews, although purpose of the transfer is an essential element of cash programming.</i></p>
<p><b>Transfer recipient</b> (Women; men; household) 3, 7</p>		<p>Inconsistent limited evidence suggests:</p> <p>⇒ Negative impact on child WHZ if given to men</p> <p>⇒ Positive impacts on access to health care if given to women</p>
<p><b>Conditionality of Cash</b> (UCT; CCT including cash for work; restricted transfer) 3, 4, 5, 6, 7, 16</p>		<p>⇒ Evidence mainly from development settings</p> <p>⇒ No difference on anthropometry comparing CCT and UCT</p> <p>⇒ Emerging studies in humanitarian settings showing improvement in wasting and stunting with conditionality (e.g. Niger, Togo)</p>

<p><b>Modality (sub-modality)</b></p> <p>(Cash; cash voucher; commodity voucher; service voucher; e-voucher)</p> <p>1,3,4,6,7,9</p>		<p>⇒ Cash and vouchers may be better than food transfers (i.e. HH food baskets) at increasing dietary diversity</p> <p>⇒ Limited evidence (one study) has shown cash (UCT) to be better than vouchers for improving dietary diversity in a humanitarian context</p> <p><i>Note: Restricted Vouchers offer the opportunity to enhance consumption of food items that will have a beneficial impact on nutrient intake, as long as these food items are available and of good quality. Voucher programmes can be designed based on knowledge of nutrient gaps in a particular context.</i></p>
<p><b>Cash delivery mechanism</b></p> <p>(Direct cash payment; delivery through an agent; card (as prepaid, smart, e-voucher); mobile money; bank account; other)</p> <p>1, 2, 3</p>		<p>⇒ No effects seen on WHZ comparing different cash delivery mechanisms</p> <p>⇒ Mixed evidence on what is more effective depending on the indicator measured; e.g. compared to a UCT paid in hand, mobile transfers may be more effective for asset protection but less so for household dietary diversity</p> <p>⇒ Some evidence shows that electronic transfers are better (and preferred by recipients) to physical transfers</p>
<p><b>Cash transfer value</b></p> <p>(Differences in amount; based on MEB/ food basket/proportion of the minimum wage or SP amount/ other)</p> <p>3, 4, 7, 9</p>		<p>⇒ Most evidence comes from CCTs</p> <p>⇒ Consensus that the amount of CT needs to have a significant contribution to the household economy (e.g. transfers of between 15% and 30%) if it is to have an impact on nutritional status</p> <p>⇒ Higher transfer amounts showed positive effects on HAZ and WHZ and access to preventative health care</p>
<p><b>Targeting</b></p> <p>(Socio-economic criteria; U5 / PLW; other)</p> <p>3, 4, 7</p>		<p>⇒ Sex and age (of child and carer) need to be considered – although mixed results from limited number of studies, disaggregation is highlighted for future studies</p> <p>⇒ Some consensus on targeting younger children from poorest households, especially those with less access to services</p>
<p><b>Duration</b></p> <p>(Short term programme: 3 to 6 months; multiannual (un)predictable transfers)</p> <p>3, 4, 7, 9, 12</p>		<p>⇒ Limited evidence on the duration of an intervention although there is strong logic that longer duration would be associated with improved child anthropometric outcomes and increase use of healthcare</p> <p>⇒ It is likely that improvements in acute malnutrition are transient</p>

<p><b>Timing</b></p> <p>(Earlier initiation (pre-lean season, prior to known nutrition crisis); during lean season; other)</p> <p>7, 12</p>	⊘	⇒ Strong logic – although recent evidence shows no impact
<p><b>Frequency</b></p> <p>(Larger one-time sum; regular payments)</p> <p>7</p>	⊘	<p>Inconsistent evidence suggests:</p> <p>⇒ Smaller regular payments are more likely spent on children</p> <p>⇒ Larger one-off payments are likely spent on productive assets</p>
<p><b>Supply-side</b></p> <p>(health services, education)</p> <p>4, 7</p>	⊘	<p>⇒ Increase in availability and access to health services and education</p> <p>⇒ More relevant for CCTs than for other CBIs</p>
<p><b>Communication</b></p> <p>(Labelling of CBI for specific use)</p> <p>5, 7</p>	⊘	⇒ Context and programme specific (e.g. longer term programmes)
<p><b>Sustainability/resilience</b></p> <p>7, 9</p>	⊘	<p>⇒ Impact on acute malnutrition is transient</p> <p>⇒ Impact on stunting from a short-term programme may continue after intervention ended</p>
<p><b>Behaviour responses (acceptance)</b></p> <p>7, 9, 11</p>	⊘	⇒ Qualitative studies with very context-specific conclusions
<p><b>Grievance mechanisms</b></p> <p>(Hotline; complaint boxes; other)</p> <p>9</p>	⊘	⇒ Transparency in programme implementation and a clear understanding among beneficiaries can lead to better nutrition outcomes
<p><b>Monitoring and graduation</b></p> <p>6</p>	⊘	⇒ Effective monitoring and graduation systems are crucial, in order to see the evolution of nutrition benefits
<p><b>Link with SP program</b></p> <p>(Part of the SP; transfer alignment with SP; other)</p>	⊘	⇒ Context-specific and depends on on-going government programmes

<p><b>Unintended effects</b></p> <p>(Time burden (on recipients); reinforcement of gender norms; change in household dynamics; gender-based and/or intimate partner violence; increase in fertility; reduced labour supply; inflation of prices; inflation/deflation of wages; cash exchange rate unfavourable; other)</p> <p>1, 4, 7</p>	<p>●</p>	<p>⇒ Limited evidence due to heterogeneity of indicators used; evidence that is available does not suggest unintended consequences but this is context-specific (e.g. higher BMI and obesity in the <i>Oportunidades</i> programme)</p>
<p><b>Costs</b></p> <p>(Cost-efficiency; cost benefit; DALY; multiplier effects)</p> <p>1, 6, 7, 9, 10, 12, 13</p>	<p>●</p>	<p>⇒ Cash transfers and vouchers may be more cost-efficient than in-kind food distribution</p> <p>⇒ More evidence for cost-effectiveness of CBIs on food security</p> <p>⇒ Cash and vouchers have positive economic multiplier effects (compared to in-kind food)</p>

## 2.2 KEY FINDINGS SYNTHESIS

This report highlights evidence gaps on the impact of cash transfers on nutrition outcomes, and reaffirms the importance of context as a key critical factor of the effectiveness of an intervention. The findings can be used to assist in the formulation of informed questions to design the most impactful interventions.

The major findings of the evidence review are summarized in the below graphic:



### NUTRITIONAL STATUS

Growing body of evidence that:

- Where studies are significant they show **positive impacts on WHZ and HAZ**
- Impacts on **stunting** are mainly driven by **CCTs** in development programmes although there is growing evidence of impact in humanitarian settings and shorter-term programmes
- CT have a **positive impact on diversity and dietary intake** and are often better than food transfers (i.e. HH food baskets) at increasing dietary diversity

Limited evidence but strong logic that:

- **Complementary programs (Cash+)** are necessary in any setting due to multiple causes of undernutrition

No strong evidence of a **difference between CCT and UCT** on anthropometric outcomes



### HEALTH

Growing body of evidence that:

- CCTs (often in development contexts) have a **positive impact on health environment and preventive health care**



### FOOD SECURITY

Moderate body of evidence that:

- CT increase expenditures on food and increasing evidence that

Growing body of evidence that:

- CT increases **expenditures on food for children**
- **Cash and vouchers may be better than food transfers** at increasing dietary diversity, but not calorie intake.



### IMPLEMENTATION

Growing body of evidence that:

- The amount of cash needs to **significantly contribute** to the household economy to have an impact on nutritional status
- Cash transfers and vouchers may be more cost-efficient than in-kind food transfers
- Positive impacts driven by development settings; lack of evidence on conditions in humanitarian settings

## 2.3 METHODOLOGY AND RECOMMENDATIONS EMANATING FROM THE RESEARCH 4 ACTION WORKSHOP

The evidence detailed in section 2.1 served to support discussions among the 14 participants of the R4ACT workshop, including decision-makers and technical (nutrition and/or cash) experts from a broad range of institutions including governments, the United Nations, non-government organizations, technical platforms, academia and donors (see list in Annex 4). The number of participants was purposely limited to keep the process flexible and dynamic, foster constructive discussion and facilitate transversal collaboration between different actors with diverse profiles. Consensus methodology was used throughout the recommendation drafting process.

The evidence detailed in section 2.1 was shared with all the participants prior to the workshop. Participants were asked to draft three suggestions on what they considered should be done in light of these findings.

The workshop began with a discussion of the evidence and key findings. Participants then worked in groups to review the suggestions formulated before the workshop and prioritized them by vote to identify the five most strategic and relevant topic areas for further consideration. The working groups then drafted and voted on sets of recommendations related to the five topic areas.

Once the recommendations were finalized, the working group developed a work plan to translate these recommendations into practical actions to be monitored in 2018.

### KEY TOPIC 1

#### **Generation of evidence on nutrition-sensitive outcomes through research and evaluation**

Recommendations established:

- Advocate for funding to capture programme learning on impacts of CBIs on nutrition outcomes
- Conduct research focusing on the pathways of impact between CBT and nutrition, including inquiry around design and implementation features
- Standardize indicators and robust methods for monitoring and evaluating the nutrition sensitivity of CBIs

### KEY TOPIC 2

#### **Maintain nutrition focused cash based interventions through longer term social safety nets and other programmes**

Recommendations established:

- Advocate for enhanced nutrition focus in operations, policy, and research on shock-responsive social protection systems and safety nets
- Support national governments to design nutrition-sensitive social protection systems, leveraging humanitarian CBIs
- Develop appropriate exit strategies for cash programmes with specific nutrition objectives, linked to SP programmes where feasible

### KEY TOPIC 3

#### **Definition of the optimal package(s) of assistance involving cash to maximize nutrition outcomes across contexts**

Recommendations established:

- Improve understanding of how complementary interventions involving cash can improve nutrition outcomes
- Increase understanding and document good practices on optimal context specific package of assistance and services

### KEY TOPIC 4

#### **Make current cash interventions more nutrition-sensitive across contexts**

Recommendations established:

- Advocate for increased donor support on upstream and downstream activities
- Provide support and capacity building to programmers across sectors to implement nutrition-sensitive cash-based programmes
- Promote the use of cash in programmes with nutrition as a primary objective, beginning at design stage

### KEY TOPIC 5

#### **Improving multi-sectorial coordination between stakeholders to support the use of cash for achieving nutrition outcomes**

Recommendations established:

- Enhance existing coordination between nutrition, food security, health and cash
- Build the capacity of nutrition experts on cash-based programming

# Annex 1: Existing body of evidence on cash and nutrition

These reviews were selected during a planning meeting between ACF and WFP held in July 2017.

## REVIEW CHARACTERISTICS

The reviews are ordered in terms of quality with systematic reviews first (high quality), followed by reviews of systematic reviews (high-to-moderate quality), then literature reviews (moderate quality).

High quality denotes the inclusion of research studies meeting set criteria for quality, identified by each reviewer.

Moderate denotes a mix of high, moderate and low quality studies according to research criteria. Two of the seven studies are defined as systematic reviews; one is a review of systematic reviews; two are a mix of impact evaluations and systematic reviews and include studies with other quantitative methods.

The remaining two are comprehensive literature reviews giving a broad sense of evidence and gaps from the available literature.

**THE SYSTEMATIC REVIEWS** consider studies from 2000 onwards (1,2). Studies included were robust experimental (e.g. randomised controlled trials) or quasi-experimental (non-randomised controlled trials) including difference-in-difference, regression discontinuity design, instrumental variables or ordinary least squares regression analyses. One of the reviews examines the processes

involved in the UNICEF conceptual framework of malnutrition and costs (1). In terms of anthropometric outcomes, there are between them only seven studies included.

**THE 'REVIEW OF REVIEWS'** cover a wide range of settings, both humanitarian and development. Two of these reports have specific nutrition objectives (4,5), while the other (3) includes an analysis of design and implementation features. These reports use recent robust evidence.

**THE LITERATURE REVIEWS** include one which addresses the different transfer modalities used across the humanitarian sector and focuses on different sectors (6), whilst the other has a nutrition focus as well as a consideration of evidence gaps (7). Both include (mainly) published papers in humanitarian settings.

Ref	Review	Year Published	Context	Countries/ Regions	Research design (#studies/reviews)	Transfer types	Objectives	
	<b>SYSTEMATIC REVIEWS</b>							
[1]	Cash-based approaches in humanitarian emergencies - 31e	2016	Humanitarian emergency	Afghanistan, Bangladesh, Belize, Bosnia and Herzegovina, Burundi, Chile, DR Congo, Ecuador, Ethiopia, Haiti, India, Indonesia, Kenya, Japan, Jordan, Lebanon, Lesotho, Niger, Malawi, Mozambique, Occupied Palestinian Territory, Pakistan, the Philippines, Somalia, South Sudan, Sri Lanka, Sudan, Swaziland, Turkey, Uganda, Vietnam, Yemen, Zambia, Zimbabwe	Experimental or quasi-experimental (5); cost-efficiency; observational (10), qualitative and mixed methods (108)	UCT, Voucher and CCT	1) To assess and synthesise existing evidence on the effects of cash-based approaches on individual and household outcomes in humanitarian emergencies 2) To assess the efficiency of different cash-based approaches and identify factors that hinder and facilitate programme implementation	
[2]	Pega et al - Unconditional cash transfers for assistance in humanitarian disasters: effect on use of health services and health outcomes in low- and middle-income countries.	2015	Humanitarian emergency	Nicaragua & Niger	Cluster randomised controlled trial (1); controlled before-and-after studies (2)	UCT	1) To assess the effects of UCTs in improving health services use, health outcomes, social determinants of health, health care expenditure, and local markets and infrastructure in LMICs 2) To compare the relative effectiveness of UCTs delivered in-hand with in-kind transfers, conditional cash transfers, and UCTs paid through other mechanisms	
	<b>SYNTHESIS OF SYSTEMATIC/LITERATURE REVIEWS &amp;/OR OTHER STUDIES</b>							
[3]	Cash transfers: what does the evidence say? – ODI	2016	Development, transitional and humanitarian emergency	LAC (27), SSA (11), SA (2), EAP (1)	Randomised controlled trial (21); Quasi-experimental (20)	UCT, CCT,	1)To retrieve, assess and synthesise the existing body of evidence on the impacts of cash transfers and their design and implementation features	

Ref	Review	Year Published	Context	Countries/Regions	Research design (#studies/reviews)	Transfer types	Objectives
[4]	deGroot et al - Cash Transfers and Child Nutrition: Pathways and Impacts - UNICEF	2017	Development & humanitarian emergency	Mainly SSA and LA – includes Brazil, Burkina Faso, Colombia, Ecuador, Ethiopia, Ghana, Honduras, Kenya, Lesotho, Liberia, Malawi, Mexico, Morocco, Mozambique, Nicaragua, Niger, Somalia, South Africa, Tanzania, Tunisia, Uganda, Zambia, Zimbabwe Also - Bangladesh, India, Philippines, Sri Lanka	*Systematic reviews (6); meta-analysis (1)	UCT or CCT (cash only)	1) To provide a comprehensive overview of the impacts of CT programmes on the immediate and underlying determinants of child nutrition
[5]	Child Outcomes of Cash Transfer Programming – Save the Children	2017	Development & humanitarian emergency	LMIC	Experimental & quasi-experimental, other quant & qual methods (peer and non-peer-reviewed)	Unrestricted & restricted UCTs and CCTs, labelled UCT/CCTs, cash (plus)	1) To fill the evidence gap by reviewing a comprehensive list of indicators around outcomes for children in health, food security, nutrition, protection, and education
<b>LITERATURE REVIEWS</b>							
[6]	The Other Side of the Coin: The Comparative Evidence of Cash and In-Kind Transfers in Humanitarian Situations – World Bank	2016	Humanitarian emergency	Bangladesh, Cambodia, DRC, Ecuador, Ethiopia, Malawi, Mexico, Niger, Sri Lanka, Uganda, Yemen	Experimental or quasi-experimental (14) comparative studies	Cash (non-specific), vouchers, food in-kind	1) A comparative analysis - To review the existing evidence on the performance of alternative transfer modalities across humanitarian sectors, including cash transfers, vouchers, and in-kind assistance (food and non-food)
[7]	REFANI Literature Review	2015	Humanitarian emergency	LMIC – not specific	Published papers & studies (multiple)	UCT, CCT, vouchers	1) To identify existing evidence on the use of Cash Transfer Programmes (CTPs) and the impact on acute malnutrition in humanitarian contexts 2) To identify key gaps that remain in our collective knowledge base

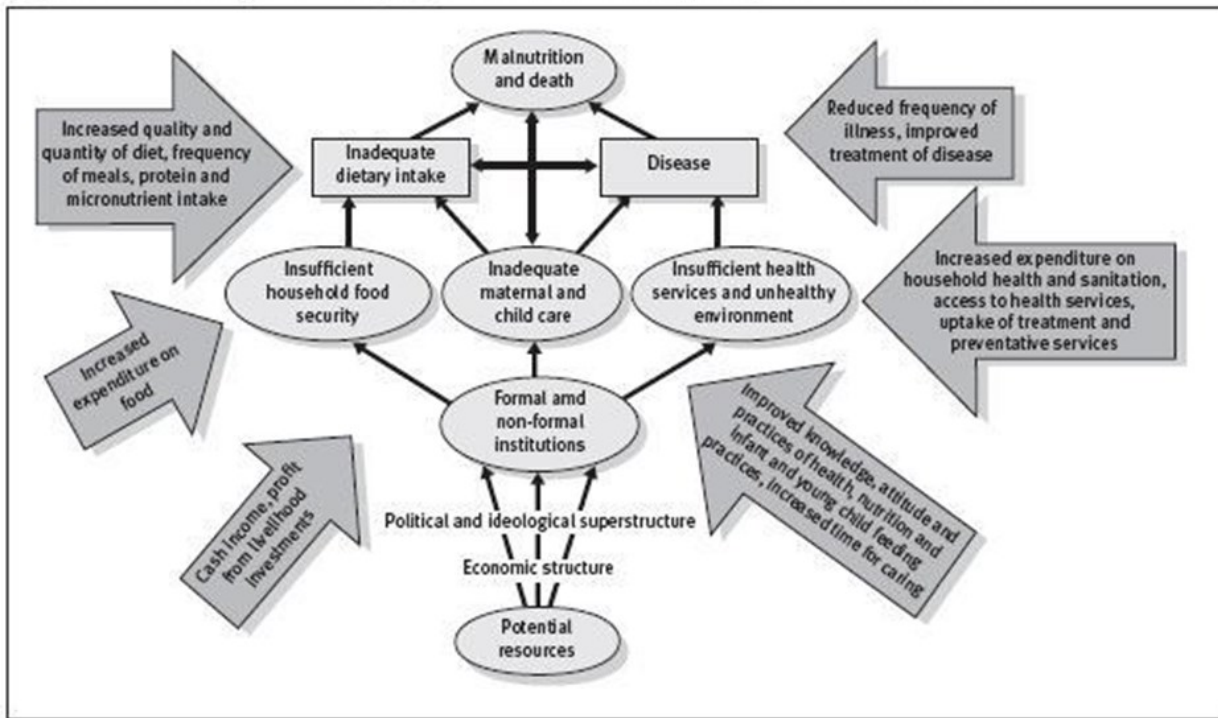
## Annex 2: New and emerging evidence on cash and nutrition

Since the reviews in Annex 1 have been published, a number of high-quality studies concerning the impacts of cash on nutrition in a number of different contexts have been produced (Annex 2), some published in peer-reviewed journals and others still under review. All of the studies have an experimental design (one is quasi-experimental [16]) and were conducted in humanitarian or food insecure settings. Target groups include pregnant and lactating women and children <59 months. All CBIs are UCTs; one study uses value vouchers (9).

Ref	Evidence	Country	Context	Study Population	Research design	Programme objective	Intervention duration/year	No. of arms	Intervention
<b>PUBLISHED</b>									
[8]	Greilley E et al 2017	DRC	Humanitarian emergency	Children 6-59 months with severe acute malnutrition	crCT	Treatment	6 months (2015)	2	UCT vs no cash (both arms have access to CMAM)
[9]	Fenn et al 2017 REFANI	Pakistan	Humanitarian emergency	Children 6-48 months (at baseline) & mothers/carers	crCT plus CEA	Prevention	6 months (2015)	4	UCT (2 differing amounts) or voucher (restricted, value) vs no cash/voucher (all arms had access to the ACF WINS* programme)
[10]	Houngbe F et al 2017 MAM'Out	Burkina Faso	Food insecure	Children < 36 months	cCRT	Prevention	24 months (2013-14)	2	Seasonal UCT vs no cash
[11]	Tonguet-Papucci et al 2017 MAM'Out								
<b>TO BE PUBLISHED (UNDER REVIEW)</b>									
[12]	REFANI UCL/ CONCERN	Niger (1)	Humanitarian emergency	Children aged 6-59 months and their mothers or carers	crCT	Prevention	4 & 6 months (2015)	2	Earlier and longer seasonal UCT vs seasonal cash
[13]	REFANI UCL/ CONCERN	Somalia	Humanitarian emergency	Children aged 6-59 months and their mothers or carers	Controlled trial (not randomised)	Prevention	5 months (2016)	2	UCT vs no cash (both arms had access to NFI kits, free piped drinking water)
[14]	IRD/WB/UNICEF	Togo	Food insecure	Mothers (1000 days) & children 6-59 months with SAM	crCT	Prevention & improvement	30 months (2014-6)	2	UCT vs no cash (both arms received home visits and BCC)
[15]	WFP	Mali	Food insecure	Mothers (1000 days) & children 6-24 months	crCT	Prevention & improvement	36 months (2014-6)	4	SNACK* + UCT; SNACK + Plumydoz; SNACK + UCT + Plumydoz vs SNACK activities only. *Santé nutritionnelle à Assise Communautaire à Kayes – Community Nutrition and health program in kayes
[16]	Cornell/CONCERN	Niger(2)	Humanitarian emergency	Children 6-36 months	Quasi-exp	Prevention	3 months (2012)	2	CCT vs no cash: conditional education sessions

# Annex 3: Theory of change

Figure 2: Potential ways that emergency cash transfers could impact upon causes of malnutrition



From: Bailey, S and Hedlund, K. (2012) *The impact of cash transfers on nutrition in emergency and transitional contexts: A review of evidence*. HPG Commissioned Report. Accessible at:

<https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7596.pdf>

# Annex 4: List of participants

**AAH-Action Against Hunger-** Amador Gomez

**AAH-Action Against Hunger-** Céline Sinitzky

**CaLP -The Cash Learning Partnership-** Stefan Bumbacher

**CashCap-Cash and Markets Standby Capacity Project-** Mamta Khanal Basnet

**FAO-Food and Agriculture Organization** - - Etienne Juvanon Du Vachat

**ICRC-International Committee of the Red Cross-** Valérie Captier

**John Hopkins University** – Shannon Doocy

**Ministry of Health Nigeria-** Dr. Chris. Osa. Isokpunwu

**Save the Children** - Megan Gayford

**UNHCR-United Nations High Commissioner for Refugees** - Valerie Gatchell

**USAID-U.S. Agency for International Development** - Elisabeth Bontranger

**WFP-World Food Programme** - Fatiha Terki

**WFP-World Food Programme** - Antoine Renard

**Absents:** Abigail Perry – **DFID (Department for International Development)**, Domitille Kaufmann - **FAO**

**Speaker:** Bridget Fenn- Independent research consultant

**Moderator:** Jeremy Shoham – **ENN (Emergency Nutrition Network)**

**Organizers:** Myriam Aït-Aïssa, **AAH**, Stephanie Stern – **AAH**, Mica Jenkins – **WFP**

**Observers:** Simon Pickard - **ELHRA (Enhancing Learning and Research in Humanitarian Assistance)**, Kate Ogden – **WFP**, Tamsin Walter, **ENN**

# Annex 5: Glossary

*Acknowledgement: 'Cash' is the unofficial word usually used for CBI, CBT, and/or cash transfer modality. During the workshop we used 'cash' as shorthand for CBI, CBT, cash modality etc. unless otherwise specified.*

*Definitions come from the CaLP Glossary, World Bank, WHO, the Global Nutrition Report and ACF glossary of terminology.*

**Dietary diversity:** number of food groups consumed over a given reference period.

**Anthropometric outcomes:** In this report refers to wasted, stunted and underweight.

**Cash Based Intervention (CBI)/Cash Based Assistance (CBA)/Cash Transfer Programming (CTP)/Cash Based Transfers (CBT):** refers to all programs where cash (or vouchers for goods or services) is directly provided to beneficiaries. In the context of humanitarian assistance the term is used to refer to the provision of cash or vouchers given to individuals, household or community recipients; not to governments or other state actors. CBI covers all modalities of cash-based assistance, including vouchers. This excludes remittances and microfinance in humanitarian interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash). The term can be used interchangeably with Cash Based Assistance, Cash Transfer Programming (CTP), Cash-Based Transfers and Cash and Voucher Programming.

**Cash Plus/Cash+:** refers to complementary programming where CTP is combined with other modalities or activities. Complementary interventions may be implemented by the same agency/agencies providing CTP, or potentially by other agencies working in collaboration. Examples might include provision of training and/or livelihood inputs, or behaviour change communication programmes.

**Cluster Randomized Controlled Trial (cRCT):** Like an RCT except randomization is done on groups e.g. geographic regions, villages, hospitals, clinics etc.

**Conditionality:** refers to prerequisite or qualifying conditions that a beneficiary must fulfil to receive a cash transfer or voucher, i.e. activities or obligations that must be fulfilled before receiving assistance. Conditionality can in principle be used with any kind of cash, voucher or other type of assistance, depending on its objectives and design.

- **Conditional (Cash) Transfer:** requires beneficiaries to undertake a specific action/activity (e.g. attending school, building a shelter, attending nutrition screenings, undertaking work, trainings, etc.) in order to receive assistance; i.e. a condition must be fulfilled before the transfer is received. Cash for Work/Assets/Training are all forms of conditional transfer.

- **Unconditional Cash Transfer:** are provided to beneficiaries without the recipient having to do anything in return in order to receive the assistance.

**Cost Effectiveness:** is the extent to which the program has achieved or is expected to achieve its results (outcomes/impacts) at a lower cost compared with alternatives. Source: World Bank

**Cost Efficiency Analysis:** is the comparison of the administrative cost of a cash transfer programme relative to the amount disbursed.

**Delivery Mechanism / Payment mechanism:** Means of delivering a cash or voucher transfer (e.g. smart card, mobile money transfers, cash in envelopes, etc.), through Delivery instrument/ Payments instruments, which are the technology used by the delivery mechanism\*.

**Experimental designs:** Studies that use a randomized approach to investigate the effects of a particular treatment or intervention on participants. They refer to Randomized Control Trials (RCT) and Cluster Randomized Controlled Trials (cRCT). Micronutrient deficiencies: Iron, folic acid, vitamin A, zinc, iodine below healthy thresholds.

**Minimum Expenditure Basket:** is defined as what a household needs – on a regular or seasonal basis – and its average cost over time. The MEB can be a critical component in the design of interventions including Multipurpose Cash Grants/Assistance (MPG/MCA), with transfer amounts calculated to contribute to meeting the MEB.

**Modality:**

- **Assistance modality:** refers to the form of assistance – e.g. cash transfer, vouchers, in-kind, service delivery, or a combination. This can include both direct transfers to household level, and assistance provided at a more general or community level e.g. health services, WASH infrastructure.
- **Cash modality:** refers to the different types of cash or voucher transfer – e.g. conditional (cash for work, etc.), unconditional, restricted, unrestricted, multipurpose, etc. A single transfer can generally be categorized in terms of several of these variables e.g. a conditional, unrestricted transfer.
- **Delivery modality/ Delivery sub-modality:** refers to the different types of cash or voucher delivery technology – e.g. paper, virtual- and mechanism chosen – e.g. mobile technology, smart technology, etc. A single transfer can generally be categorized in terms of several of these variables e.g. a virtual money through mobile money technology transfer\*.

**MUAC:** Mid-Upper Arm Circumference. It is a measurement taken at the mid-point of the upper arm. It is an indicator of mortality risk associated with acute malnutrition to be used for a child of 6 to 59 months of age.

**Multiplier Effect:** are the indirect effects of cash transfers whereby increased expenditure by recipients contributes to income growth for non-recipients, expansion of markets for local goods, or increased demands for services. The 'economic multiplier' is the estimated number by which a change in some other component of aggregate demand is multiplied to give the total amount by which the national income is increased as a result of direct and indirect benefits from that change in demand.

**Multipurpose Cash Grant/ Multipurpose Cash Assistance:** are defined as a transfer (either regular or one-off) corresponding to the amount of money a household needs to cover, fully or partially, a set of basic and/or recovery needs. They are, by definition, unrestricted cash transfers. The MPG/MCA can contribute to meeting a Minimum Expenditure Basket (MEB) or other calculation of the amount required to cover basic needs, but can also include other one-off or recovery needs.

**Quasi-experimental designs:** Studies with an experimental group and a control group, but where there is no random assignment to groups. Works in situations where random assignment may not be ethical, but results are not as strong as in a randomized controlled trial.

**Randomized Controlled Trial (RCT):** Sometimes called the "gold standard" of research studies. Participants are randomly assigned to either an experimental group(s) (which receives the intervention(s)) or a control group (which receives either no treatment, a placebo, or the "usual care"). These different groups can then be compared.

**Restriction:** refers to limits on the use of a transfer after it has been received by a beneficiary. Restrictions may describe either the range of goods and services that a transfer can be used to purchase, or the places where a transfer can be used, or both. The degree of restriction may vary – from the requirement to buy specific items, to buying from a general category of goods or services, or to achieve an agreed output (e.g. to repair a shelter, or start-up a livelihood activity). Restriction is distinct from conditionality, which applies only to prerequisite conditions that a beneficiary must fulfil before receiving a transfer.

- **Restricted (cash) transfer:** requires the beneficiary to use the assistance provided to purchase particular goods or services. This includes vouchers, which are restricted by default, and cash transfers where receipt of subsequent transfers is contingent on spending previous transfers on particular goods or services.
- **Unrestricted Transfer:** can be used entirely as the recipient chooses i.e. there are no direct limitations imposed by the implementing agency on how the transfer is spent. Cash transfers are by default unrestricted, unless they require beneficiaries to spend their cash on particular goods or services in order to receive subsequent transfers.

**Safety Nets / Social Safety Nets:** consist of non-contributory transfers, such as in-kind food, cash or vouchers, targeting the poor; they can be provided conditionally or unconditionally. They are a subset of broader social protection systems.

**Social Assistance:** consist of repeated, unconditional, predictable transfers of cash, goods or services provided on a long term basis to

vulnerable or destitute households or specific individuals (e.g. the elderly, pregnant women), with the aim of allowing them to meet basic needs or build assets to protect themselves and increase resilience against shocks and vulnerable periods of the life cycle. Usually refers to government assistance provided in cash.

**Social Protection:** are all the actions carried out by the state or privately, to address risk, vulnerability and chronic poverty. Social protection refers to comprehensive systems including safety nets, social assistance, labour market policies, social insurance options (e.g. contributory pensions, health insurance), and basic social services (e.g. in education, health and nutrition).

**Stunting:** Adaptation to chronic malnutrition reflecting the negative effects of nutritional deprivation on a child's potential growth (low height for age), over time. Measured by height-for-age Z-scores.

**Undernutrition:** Undernutrition is a condition in which the body's requirements are unmet due to under consumption or to impaired absorption and use of nutrients. Measured by weight for age z-scores.

**Voucher/Coupon/Token/Stamps:** is a paper, token or e-voucher that can be exchanged for a set quantity or value of goods, denominated either as a cash value (e.g. \$15) or predetermined commodities or services (e.g. 5 kg maize; milling of 5kg of maize), or a combination of value and commodities. They are redeemable with preselected vendors or in 'fairs' created by the agency. Vouchers are used to provide access to a range of goods or services, at recognized retail outlets or service centers. Vouchers are by default a restricted form of transfer, although there are wide variations in the degree of restriction/flexibility different voucher-based programmes may provide. The terms vouchers, stamps, or coupons are often used interchangeably.

- **Commodity voucher:** are exchanged for a fixed quantity and quality of specified goods or services at participating vendors. Commodity vouchers share some similarities with in-kind aid in that they restrict and specify the assistance received, but it is accessed at local markets through traders.
- **Fresh Food voucher:** are exchanged for a specified fresh food at participating vendors. Fresh food vouchers are generally commodity vouchers but can also be value vouchers with a restricted use to some fresh food vendors and goods.
- **Value voucher:** has a denominated cash value and can be exchanged with participating vendors for goods or services of an equivalent monetary cost. Value vouchers tend to provide relatively greater flexibility and choice than commodity vouchers, but are still necessarily restricted as they can only be exchanged with designated vendors
- **Wasting:** Commonly used to describe acute malnutrition, it indicates a severe loss of weight (low weight for height). Measured by weight-for-height Z-scores or mid-upper arm circumference.