Learning Brief

Cash and Voucher Assistance for Nutrition in Emergencies

A summary of programmatic challenges and promising practices

Prepared by the Global Cash & Voucher Assistance for Nutrition Outcomes Global Working Group

Based on a report by
Key Aid Consulting
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@Ashiqullah Mandozai / Save the Children : Afghanistan April 2022

Background

The use of cash and voucher assistance (CVA) has expanded rapidly in humanitarian contexts – more than doubling in value (3.3 to 7.9 billion USD) between 2016 and 2022.[1] Interest in using CVA to improve a range of nutrition outcomes in crisis settings has also grown significantly, but evidence and documentation of practice in this area remains generic and sparse.[2] In 2020, the Global Nutrition Cluster (GNC) developed the Evidence and Guidance Note on the Use of CVA for Nutrition Outcomes in Emergencies (the 'Evidence and Guidance Note').[3] In 2021, a global working group on CVA for Nutrition was established (under the GNC Technical Alliance), and, soon after, the working group commissioned a review of current practice and capacity gaps among programmes using CVA for nutrition.

There are many pathways by which CVA can influence nutrition. These pathways differ by context but can generally improve the nutrition of women and children by:

1. Improving dietary diversity and/or food consumption of all household members;
2. Improving feeding and caring practices of nutritionally vulnerable groups (largely children under-two and pregnant or breastfeeding women);
3. Improving utilization of health and nutrition services by nutritionally vulnerable groups;
4. Sustaining food and income throughout the year, reducing negative coping strategies.

As outlined in the Evidence and Guidance Note, practitioners designing programmes to improve nutrition must understand these pathways to determine the role CVA could play. Developing a theory of change or conceptual framework to map these pathways in each context for different target groups is an important first step. Two such frameworks are provided as examples: (Annex 1) the theory of change for the Research on Food Assistance for Nutrition Impact (REFANI) project (also included in the Evidence and Guidance Note)[4] and (Annex 2) an impact pathway adapted from FAO's Nutrition and Cash-based Interventions technical guidance.[5] Both frameworks offer a starting point for adaptation to elaborate the specific pathway to good nutrition in each context.

1 Global Humanitarian Assistance Report 2023. Development Initiatives, 2023. https://devinit.org/resources/global-humanitarian-assistance-report-2023/#exec-summary

2 *Ibid*

3 Global Nutrition Cluster, et al. Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies (2020).

4 Global Nutrition Cluster, et al. Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies (2020).

5 FAO, Nutrition and Cash-based Interventions. Technical Guidance to improve nutrition through cash-based interventions (2020)

Purpose and methodology of review

The purpose of the review was to explore the degree to which practitioners have been able implement the guidance outlined in the Evidence and Guidance Note, identify key challenges and some promising practices that are emerging to address those challenges.

Key Aid Consulting undertook the review and engaged with practitioners working in both nutrition and in CVA programming in emergency contexts. The review covered roughly 15 countries, nine of which were 'deep dive' countries.[6] A total of 77 key informant interviews (KII) were completed, largely with staff from the UN and NGOs. In total, 81 documents from 114 projects were reviewed. A summary of the key projects reviewed from the deep dive countries can be found in Annex 5.

INTENDED AUDIENCE AND NOTE ON THE FINDINGS

This brief is intended for anyone designing nutrition programmes in emergency contexts, especially those considering a CVA component. It aims to bridge the gap between the nutrition and CVA sectors, a gap that has often impeded integrated programme design in the past. The promising practices may be most useful to nutrition practitioners, but the brief also provides valuable perspectives for CVA practitioners, offering guidance on ways to adapt integrated and multipurpose cash assistance to optimise positive nutrition outcomes.

The review set out to provide an update on the 'state of play' in the rapidly growing area of using CVA to improve nutrition outcomes in humanitarian contexts. It did not set out to contribute new evidence on the effectiveness of CVA for nutrition or to recommend best practices. The brief presents challenges and related promising practices based on the experience of a sample of country-level practitioners with additional inputs from global actors. The promising practices identified do not offer a comprehensive solution to all the challenges. They offer a glimpse of what has been tried and a basis for future programme design and research.

Nutrition outcomes were defined for this review as nutritional status typically measured through weight-for-height score (WHZ), height-for-age z-z-score (HAZ), mid-upper arm circumference (MUAC), weight-for-age z-score (WAZ) and micronutrient status. The review also included CVA interventions aiming to improve outcomes related to dietary intake of individuals, including minimum dietary diversity for women (MDD-W), minimum acceptable diet (MAD), minimum dietary diversity (MDD) and minimum meal frequency for children.

FINDINGS

The findings are presented in alignment with the five phases of the humanitarian project cycle, which the Evidence and Guidance Note uses to lay out seven steps for using CVA for nutrition in humanitarian response (Figure 2). Under each phase, key challenges are presented for each step, followed by promising practices that were largely reported by stakeholders with some additional perspective from the CVA-Nutrition

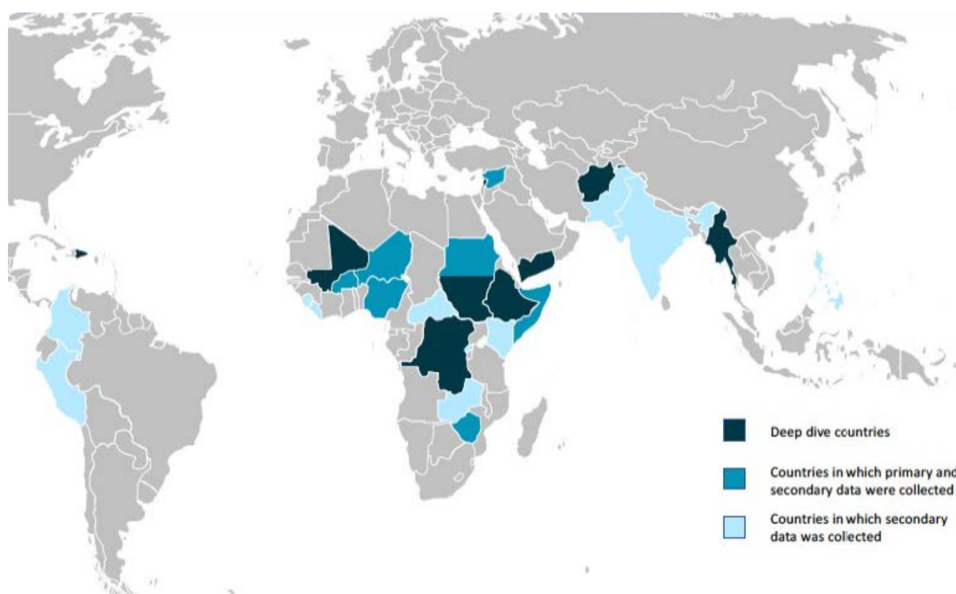


Figure 1. Geographical scope of the review
Source: Key Aid Consulting

6 Afghanistan, DRC, Ethiopia, Haiti, Lebanon, Mali, Myanmar, South Sudan, Yemen

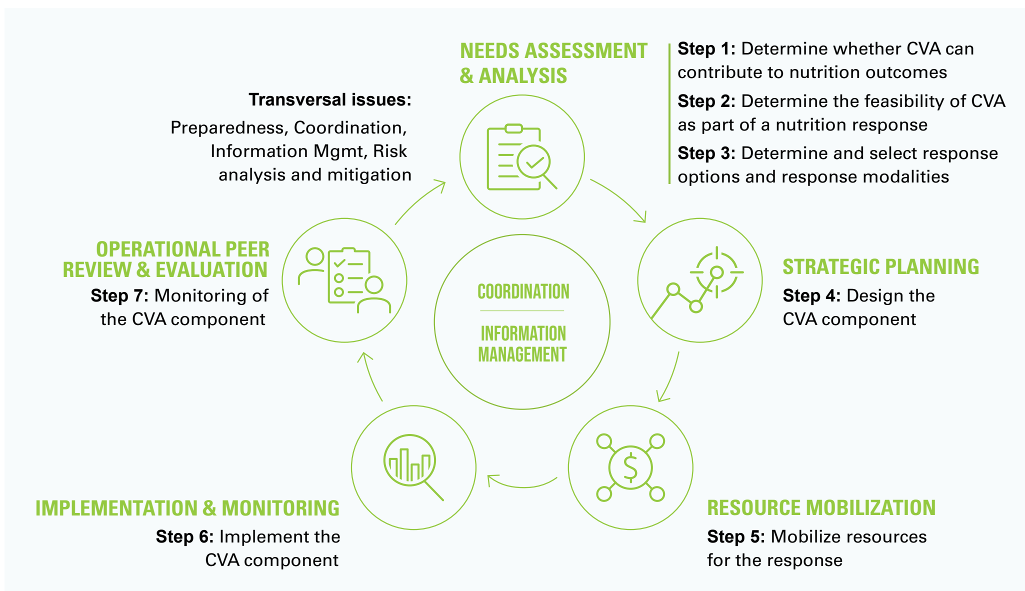


Figure 2. Project cycle phases and steps per the Evidence and Guidance Note on the Use of CVA for Nutrition Outcomes in Emergencies (2019)

Working Group members drafting this brief. A total of 18 challenges were identified; the greatest number (8) were under Strategic Planning and Design. Many of the promising practices reinforce those already laid out in the Evidence and Guidance Note.

A list of the gaps in knowledge and skills relating to CVA for nutrition programming that were identified during the review are described in Annex 3. A summary of the 18 challenges and related promising practices is included in Annex 4.

The Evidence and Guidance Note outlines five approaches by which CVA can help improve nutrition as show in Table 1. The review found that this typology of approaches was still useful to broadly categorise the programmes included in the review. However, it was evident that many programmes used a combination of approaches and added complementary activities, such as social and behaviour change (SBC) interventions, highlighting the complexity of CVA for nutrition responses.

Table 1. Five approaches to improve nutrition with CVA from the Evidence and Guidance Note

Approach	Outcome
1. Combine household assistance with individual feeding assistance	**Household CVA:** • Improve households food security and dietary diversity • Protect nutritional status **Individual CVA** • To prevent deterioration in nutritional status of at-risk groups • To reduce the prevalence of MAM in children under five • Support dietary diversification
2. Combine household cash or vouchers with social and behaviour change interventions	• Improve household food security and dietary diversity • Protect nutritional status • To prevent deterioration in the nutritional status of at-risk groups
3. Provide conditional cash transfers to incentivise attendance to priority preventative health services	• Improve household food security and dietary diversity • Protect nutritional status • To prevent deterioration in the nutritional status of at-risk groups
4. Provide cash or vouchers to facilitate access to treatment of malnutrition	• Improve attendance to priority health services • Cover indirect costs and reduce opportunity costs of seeking health services • Improve households food security and dietary diversity • Protect nutritional status
5. Provide household cash or voucher assistance to caregivers of children with severe acute malnutrition	• Improve treatment outcomes: reducing defaulting, non-response to treatment and relapse • Improve household food security and dietary diversity • Protect nutritional status

FINDINGS BY PROJECT CYCLE STEP

1. Needs assessment and situation analysis

Four challenges and promising practices were identified under needs assessment and situation analysis:

Challenge 1.1. Assessing the nutrition situation and the appropriateness of using CVA requires time and expertise to collect and analyse a broad and complex range of information. Understanding the burden of malnutrition and its drivers in an emergency context is challenging in itself. When considering a CVA component, practitioners must also confirm whether CVA could contribute to improving nutrition outcomes and how (Step 1 of CVA for nutrition project cycle in the Evidence and Guidance Note). Lack of time and expertise to do this well were identified as key barriers by both nutrition and CVA practitioners (Afghanistan, DRC, Ethiopia, Haiti and Lebanon). Respondents reported feeling overwhelmed by this enormous task. In particular, they cited the difficulty in collecting anthropometric data to determine the prevalence of malnutrition, which many understood was necessary to make sound decisions. They also expressed reluctance to rely on secondary nutrition data because it was out of date, unreliable or, in some instances, inaccessible due to data protection regulations.

Promising practice 1.1.

Optimise use of secondary data. Much data is already being collected in many countries via the cluster or sectoral groups. Examples that were shared included the Joint Market Monitoring Initiative (Ethiopia and South Sudan) and the Food Security and Nutrition Monitoring System (South Sudan). Post distribution monitoring data can also help understand how cash is spent to inform transfer values or complementary interventions. Stakeholders should agree where secondary data may be 'good enough' and only collect primary data if it is really needed. Anthropometric data may not be required to make key decisions in all settings.

Challenge 1.2. Deciding if financial barriers are a key determinant of malnutrition and if CVA should be prioritised to improve nutrition. Practitioners from different sectors noted it was often difficult to come to strong consensus that CVA could and should be one of the priority response options to address malnutrition. While the Evidence and Guidance Note provides a sizeable list of assessment tools to determine the potential contribution of CVA to nutrition outcomes, many require considerable time, expertise and resources to carry out, and several are only available in English.

Promising Practice 1.2.

Focus on the information required to understand if/ how CVA could improve nutrition. To keep the analysis manageable, it may help to focus on the potential pathways from cash to improved nutrition. Programme teams should ask themselves and key informants if CVA could address the underlying drivers of malnutrition along those pathways in the target context for the identified target groups or if other pathways may be more important. When considering the pathways from cash to improved nutrition, remember that 'markets' for health and water service provision do not operate in the same way as markets for food and other goods. As such, CVA cannot 'fix' dysfunctional services or damaged infrastructure, and other complementary interventions may be required.

Key questions to ask when trying to understand if/ how CVA could improve nutrition:
Are financial barriers a major obstacle to improving nutrition?

- Are services relevant to improving nutrition available, accessible and at what cost?
- Are nutritious foods available in the markets to buy? (for fresh food vouchers a more detailed assessment of vendor capacity is required, see below)
- What additional market systems may need to be assessed (and monitored)?
- What is the preferred modality of households and what are potential risks of each?

To help answer these questions, programme teams could start with the practical tools available for general CVA assessments, particularly market assessments, and adapt them to be more nutrition sensitive to capture the above.

Challenge 1.3. Capacity to assess CVA feasibility to inform the choice of CVA response modality is often limited in nutrition programming teams. Nutrition practitioners reported limited capacity to determine the feasibility of cash versus voucher or in-kind assistance in each emergency situation (Step 2 in the CVA for nutrition project cycle). Respondents reported lacking skills to carry out market analysis, community preference assessments and financial service provider assessments. Although a number of tools are available for this, some are not widely known, and practitioners outside the cash community did not feel comfortable

using them ‘off the shelf’ without training and support.[7] The standard CVA assessment tools also lack a level of nutrition sensitivity e.g. they should be monitoring markets not only for availability of food but availability of nutritious food.

Promising Practice 1.3.

Engage relevant cash and nutrition experts with different skills – even if only for part of the assessment process. Joint assessments were undertaken in several countries under the umbrella of the nutrition and food security clusters and the Cash Working Group. Partnering with local organisations was cited as critical to understand market functionality and community dynamics (Myanmar, South Sudan and Zimbabwe). Tapping into HQ technical support of different agencies was also helpful (DRC).

Challenge 1.4 Assessing the appropriateness and feasibility of using food vouchers – especially fresh food vouchers (FFV). According to respondents, one of the most challenging aspects is assessing the capacity of local food vendors to supply nutritious foods on time (Lebanon, Syria, DRC, Myanmar and Nigeria). In conflict settings, vendor selection must also take into account potential tensions between vendors and voucher users and how this may affect acceptability and access for recipients, which requires additional analysis and time. In South Sudan, for example, voucher recipients living in camps following displacement expressed distrust of the food sold by some local traders, voicing fears of food contamination.[8] Finally, when assessing the feasibility of fresh food vouchers, it is often difficult to ensure households have the capacity to store fresh food products at home (Lebanon).

While many of these challenges also apply to providing cash assistance, when implementers choose food vouchers as their modality, they assume a greater responsibility for ensuring contracted vendors can supply nutritious foods on time and make them accessible to all participants in a conflict-sensitive manner. This additional accountability for vendor performance may lead discourage practitioners from choosing food vouchers, even in contexts where they are an appropriate modality.

Promising practice 1.4.

If considering fresh food vouchers, plan sufficient time to carry out a detailed feasibility assessment. In particular, time must be taken to determine the capacity of retailers to deliver fresh, nutritious food products of sufficient quality and quantity in a timely manner; to ensure the range of available vendors will be accessible and acceptable to all target households (especially in conflict-affected populations); and the capacity of households to store fresh foods (see Box 1 on vendor assessment criteria used in Ethiopia).

Example Box 1.
Fresh Food Vouchers: Selecting vendors in Amhara Region, Ethiopia

The WFP Country Office responded to the government request to support efforts to address malnutrition, a key national priority. The needs assessment highlighted that stunting and micronutrient deficiencies in the country are strongly linked to the consumption of inadequate nutritious diets. The use of restricted cash-based transfer, such as value vouchers, was therefore introduced to complement the cash provided with PSNP to address the lack of dietary diversity. A market assessment was conducted in the interested areas to ensure availability of nutritious foods, including foods rich in Vitamin A and iron. Other sectoral assessments, including the information and communication technology and financial sectors, confirmed the feasibility of using e-vouchers.

As part of WFP standard process, the selection of vendors was based on pre-defined criteria that were discussed and agreed on with key stakeholders. The criteria used includes the following:

- Retailers must be able to provide fresh food items (vegetables, fruit, egg and/or milk)
- Retailers must be operating in the selected markets, based on the final recommendations from sectorial assessments.
- Retailers must possess valid licenses from the government authorizing them to operate the business or be willing to obtain a licence with the exception of recognized small-scale enterprises.
- For retailers who have been engaged with WFP in the FFV programme before, only those with cumulative good performance are considered in the selection process.

7 The Evidence and Guidance note suggests the Cash Delivery Mechanism Assessment tool from UNHCR, but other tools that have emerged (among others) include the Market Functionality Index from WFP (2020) and the Modality Decision Tool Nutrition Addendum from USAID (2021)

8 Yunusu E, Sibanda G, and Markham, M. Cash-Based Programming to Address Hunger in Conflict-Affected South Sudan: A Case Study. (2016)

2. Strategic planning and design

Eight challenges and promising practices were identified under strategic planning and design:

Challenge 2.1. Deciding which districts and communities to prioritise for CVA and the optimal timing of the transfer to have the greatest nutritional impact. It emerged that some practitioners were unsure if the Integrated Phased Classification (IPC) was sufficient to target or prioritise districts for assistance if the objective was improved child or maternal malnutrition because the IPC focuses mostly on food security (not the other underlying causes of malnutrition). Some practitioners also wondered if there was a particular period when CVAs should be delivered to maximise nutritional impact and how to consider context-specific seasonal factors when planning CVA disbursements.

Promising practice 2.1.a.

Use a mix of socioeconomic and nutrition data to target geographical areas/ communities at highest risk of malnutrition (note, targeting individual households is a different process). Nutrition surveys such as SMART surveys, which estimate the prevalence of acute malnutrition, may be useful to target Districts or other sub-national units (depending on the level of disaggregation). The Integrated Phased Classification for Food Insecurity (IPC) and Cadre Harmonisé in the Sahel can help identify areas of a country with high levels of food insecurity, but practitioners should interpret the prioritisation with caution. While nutrition data is often now included in the IPC, food security data predominates, potentially causing other factors that may be driving malnutrition to be overlooked. Thus, programmes will likely need to complement the IPC / Cadre Harmonisé targeting process with additional information including aggregated health facility data, nutrition screening data, estimates of health and nutrition service coverage and key informant interviews. This will help identify pockets of malnutrition to target with CVA for nutrition programmes.

Promising practice 2.1.b.

Target disbursement of CVA to occur during the period when populations - particularly children - are most vulnerable to malnutrition (for example, the lean season). Seasonality plays a significant role in nutrition vulnerability in many contexts. Matching the CVA distribution times to the periods just before cases of malnutrition normally peak was considered an important strategy by several respondents (Mali and Somalia). Programmes may wish to focus the CVA disbursements to that period or simply increase the value of ongoing transfers during those peak periods.

Challenge 2.2. Deciding on the modality: cash and/ or vouchers and/or in-kind support (Step 3 in the CVA for nutrition project cycle). This is especially important when the needs assessments and analysis of CVA feasibility and risk were not well coordinated or weak or their findings were contradictory. Reaching stakeholder agreement regarding the best modality and/or accepting the necessary trade-offs per modality can be difficult, particularly when decisions must be made in short timeframes.

Promising Practice 2.2.

Build flexibility into the response regarding the modality used (cash or voucher or in-kind support) and adapt the modality as needed. Being able to move between cash, voucher and in-kind assistance or a combination has allowed organisations in several countries to adapt to changes in the cost of a nutritious diet linked to currency fluctuations or changes in market functionality. (Afghanistan, Burkina Faso, Myanmar, Nigeria and Zimbabwe). This could include coupling cash distribution with in-kind supplementary food, such as lipid based nutrition supplements or a locally produced fortified flour, for pregnant and breastfeeding women and children under-two during the lean season (Mali, Niger and Burkina Faso).

Challenge 2.3. Calculating the transfer value to meet nutritional needs is complex and the resulting value is often high, making it difficult to deliver with existing resources. Several practitioners felt they lacked the practical tools and methods to estimate a nutritionally-sensitive transfer amount beyond the standard minimum expenditure basket (MEB) calculation. The Cost of the Diet approach can provide detailed profiles of a nutritious diet based on locally available foods and preferences and nutritional requirements for households with different compositions (e.g. with young children and pregnant women) as well as the cost in local markets.[9] However, practitioners reported that the time, technical know-how (and funding) required to carry out a

9 Save the Children. Cost of the Diet, a practitioners guide V2 (2014)

Cost of the Diet study were often not feasible and limited its use. The Nut Val software was cited as a simple and accessible tool to identify the components of a nutritionally adequate diet. However, Nut Val is software and not a comprehensive method and therefore does not include guidance or tools to assess the availability and cost of foods in local markets and consumption preferences. Without this information the estimated MEB will remain largely theoretical and not fit for the context.[10]

More importantly, the estimated value of a nutrition-sensitive transfer is often considerably higher than the standard food MEB. This often makes it difficult to reach consensus on the final transfer value and to secure sufficient funding to deliver it without reducing the targeted number of recipients.

Promising Practice 2.3.

Advocate for the development of simple tools to estimate a transfer value that takes nutritional needs of vulnerable groups (e.g. young children) into account, but remember the transfer value is only one of many ways to optimise the nutritional impact of CVA. The transfer value should be set relative to nutrition objective(s) (e.g. diet adequacy, basic needs, access to treatment or improvement of treatment outcomes), and nutrition experts should be engaged in the development of the MEB. If the objective is to improve access to a commodity or service, it is important to include the costs related to access them safely (e.g., transportation costs, accommodation if journeys are long or unsafe) based on a market assessment. Given it is often difficult to cover all the people in need with a fully nutrition-sensitive transfer amount with given resources, it is important to consider implementing other complementary (potentially less costly) activities alongside the transfer. These may include social and behaviour change communication to influence how the money is spent and food system and/or market development activities to increase the affordability and availability of nutritious foods.

Example Box 2.
Current practices to estimate transfer values to meet the cost of a nutritious basket

- In Somalia, within the Somalia Cash Consortium, CARE conducted a Cash Plus and Nutrition Outcomes study (2020)[11], and based on this is working with cash working group partners to review the transfer values appropriate to ensure nutritional adequacy where CVA is used for nutritional outcomes. The IRC is also advocating for calculating the transfer value in a way that covers not only survival needs but also an adequate and diversified diet.
- In *Ethiopia*, UNICEF uses the Joint Monitoring Market Initiative (JMMI) as a benchmark to assess the price of food commodities for households and set the transfer values, which in the end tends to be higher than the Productive Safety Net Program (PSNP) value (which is linked to the national wage value).
- In *Mali*, the new government policy provides guidelines for transfer amounts and standards for cross-sectoral cash assistance to allow the different actors to align their services (including for nutrition).
- In *Afghanistan*, in 2021, the food security and agriculture cluster adopted a revised MEB to make the basket more adapted to food security and nutrition needs. Sugar was removed; lentils were added, and quantities for wheat flour, rice, and vegetable oil were revised.
- In *Myanmar and Nigeria,* Save the Children conducted a Cost of the Diet analysis to design the transfer value for the three-year Maternal and Child Cash Transfer programme (Myanmar) and for the Child Development Grant Programme (Nigeria), which was finally adopted by both Governments as part of their social protection system.

10 See other tools that are available or becoming available such as the **Fill the Nutrient Gap developed by WFP**, although this tool and process must be led by WFP and usually at national level, missing data at micro-level and not freely available for non-WFP users.

11 Care and USAID. **Cash Plus and Nutrition Outcomes study. 2020.**

Challenge 2.4. Assessing risks linked to conditionality. Respondents worried that conditionality could pose risks to already vulnerable households, particularly if conditionality is linked to unreliable services. They were concerned that even when CVA conditionality was linked to services that were available, accessing them required both time and financial means for travel which vulnerable households often could not afford (South Sudan and Mayanmar). Assessing this risk and determining if, and when, conditionality might be appropriate often proved difficult. While the concept of 'soft conditionality' was generally understood, respondents felt there was little guidance as to what exactly it means and when it could be used.

Promising Practice 2.4.

Opt for unconditional cash transfers as a rule, but consider 'soft conditionality' where CVA recipients are encouraged but not required to meet a condition (e.g. to access a service or attend a behaviour change communication session) in order to receive the CVA. Conditions should not be applied and enforced when the conditioned services are not available or not affordable for recipient households. The potential risks associated with conditional cash transfers and putting additional burden on already vulnerable recipients (often women) are well documented. Soft conditionality is an option, which means explaining to recipients that they are expected to fulfil a certain condition, but in case of non-compliance, the transfer will still be provided. In addition, programmes should follow up and encouragement recipients to fulfil the conditionality in the next round.

Challenge 2.5 Essential health, WASH and other services are often not easily accessed and/ or of poor quality, limiting the potential impact of CVA. Practitioners felt that even when assessments showed CVA had potential to improve nutrition by helping overcome financial barriers (such as access to nutritious foods), the hierarchy of factors driving malnutrition were not always as clear-cut and often changed rapidly in emergencies. Even where programmes had factored the costs of accessing services (e.g. service fees or transport costs) into the transfer value, they often worried about the availability and quality of services, especially when illness was a major driver of malnutrition.

Promising Practice 2.5.a.

Combine CVA with complementary interventions that improve delivery of essential services required to ensure good nutrition (also referred to as a 'Cash-plus' approach). As noted a above, it is important that CVA programmers understand that 'markets' for essential services do not operate in the same way as markets for goods. Additional resources may be required to ensure that CVA recipients using the transfer to access health or WASH services will receive quality preventative and curative services when they arrive. This will likely require cash 'plus' system strengthening efforts and direct support to essential service providers (e.g. the Ministry of Health) and often rehabilitation of water or sanitation infrastructure in many contexts. This must be well resourced and planned and based on a more detailed assessment of service functionality, if initial assessments suggest that CVA alone may be insufficient to improve nutrition.

Promising Practice 2.5.b.

Where programmes are physically delivering cash, bring distribution points closer to vulnerable groups and locate them in a safe space – ideally, at or near key service points to encourage uptake of complementary services (with careful planning to ensure the service can accommodate additional demand). This includes health facilities where essential maternal and child health services are delivered and sites where SBC activities are carried out. It is critical, however, that the programme assesses the capacity of those facilities/ services to absorb additional demand from CVA recipients. Concerted efforts may be needed to strengthen the capacity of health facilities to accommodate a potential increase in caseload and deliver cash or voucher assistance in a safe way. Where colocation was not possible, mapping and optimising referral to functional service points was recommended at a minimum.

Challenge 2.6. Complementary social and behavioural change activities are important to improve nutrition but are often difficult to design and implement effectively in crisis settings. Behaviour change communication is considered important to 'nudge' recipients to use cash for key goods and services that could improve child and maternal nutrition. However, developing targeted messages that can influence behaviour requires a strong analysis of what specific goods and services are available, how much they cost, and the language and images that may be most effective in convincing recipients to take up the behaviour. Changing complex behaviours such as breastfeeding or complementary feeding practices for infants and young children often requires more time and more intensive social

and behaviour change activities such as one-to-one counselling or mother support groups, which are even more difficult to set up in emergencies, especially when populations may be mobile.

Promising Practice 2.6.

Understand and build on existing, pre-crisis social behaviour change platforms and behaviour change communication materials; keep messages targeted to just a few behaviours; and try to disseminate messages via the same channels as the CVA. Rapid consultations with government and NGO actors can help identify existing communication materials and volunteers or community networks that previously channelled behaviour change messaging. Narrow down the set of messages to key behaviours, focusing on those that the CVA is most likely to enable. Where CVA is distributed as mobile money, work with mobile money operators or voucher vendors to determine if simple messages can also be disseminated via mobile phones. Alternatively, key messages can be communicated via interactive sessions, drama or printed materials at physical cash distribution points. Ensure behaviour change communication is well sequenced and coordinated with CVA distributions to best influence decisions on expenditure.

Challenge 2.7. Designing a fresh food voucher intervention requires additional skills to select and manage vendors. In particular, respondents cited the complexity of contracting and paying multiple vendors; determining which fresh foods can/ cannot be purchased with the vouchers; and ensuring vendors were able to provide a diversity of fresh foods in sufficient quantities throughout the year without vendors resorting to price increases linked to the increased demand for fresh foods.

Promising Practice 2.7.

Consider the potential benefits of fresh food vouchers – including stimulating markets for fresh foods – carefully versus the extra time and skills before deciding for or against them. Fresh food vouchers can yield positive results over the medium to longer term by improving demand and supply for fresh foods win local markets over time. While cash assistance has some potential to do the same, fresh food vouchers allow for more active engagement with vendors to improve and monitor their capacity to deliver fresh foods (and to find alternative vendors if they fail to deliver them). It is important to remember, however, that strong behaviour change communication on the importance of fresh foods and how to store and prepare them may be required to ensure they are consumed and the demand is sustained.

Example Box 3. The importance of monitoring availability of nutritious foods for fresh food vouchers: REFANI research in Pakistan.
In Pakistan, Action Against Hunger distributed fresh food vouchers with a cash value of 1,500 PKR (approximately US$14), which could be exchanged for specified fresh foods (fruits, vegetables, milk, and meat) in nominated shops. Whilst there was a significant increase in the consumption of animal protein, the type of meat consumed was not specified. Qualitative evidence suggests that the only meat available for the fresh food vouchers was chicken, which is low in iron. This led to a comparatively negative performance of vouchers compared to other modalities towards improving child and maternal nutritional status.

Challenge 2.8. Choosing a delivery mechanism that optimises nutritional impact. While respondents valued mobile transfers because they offer a greater level of privacy, they also worried that mobile money may pose limitations for some vulnerable groups, by, for example, requiring the recipient to have an official ID and SIM card (a particular barrier for women). They also felt mobile cash meant significantly fewer opportunities for direct contact with CVA recipients, which they worried may be particularly important to achieve nutrition outcomes. In particular, they were concerned about losing opportunities for face-to-face behaviour change communication sessions at distribution sites and for taking regular anthropometric measurements to monitor nutrition outcomes and refer for treatment as needed.

Promising Practice 2.8.

Choose the delivery mechanism based on an assessment of feasibility and risk – including nutritional risk - in each context for each target group. This is the case for all CVA programmes and is no different for CVA for nutrition programmes. A simple list of risks and feasibility issues for each modality for each target groups (different target groups may face different risks or barriers) should be drawn up and discussed with key stakeholders. Consideration should be given to the risks associated with less regular contact with CVA recipients, but it is important to remember that those same CVA recipients may be receiving behaviour change communication and being targeted for malnutrition screening via complementary activities. The mobile money platform could also be used for behaviour chance communication/ nudges to CVA recipients. Mobile money may indeed offer a greater level of privacy, which may be particularly important if there are any sensitivities around the targeting criteria used for CVA, such as pregnancy or having a child who is malnourished, but needs to be assessed in each context.

3. Advocacy and resource mobilization

Two challenges and promising practices were identified under advocacy and resource mobilisation:

Challenge 3.1. Donors and some practitioners are still hesitant to commit significant resources to CVA to achieve nutrition outcomes because they perceive the evidence as insufficient or inconclusive. This seems to be primarily a challenge of perception as cash transfers for nutrition have been recently identified as one of 18 interventions with evidence of effectiveness, on par with more direct interventions delivered via the health system (e.g. vitamin A supplementation) or direct provision of food supplements (lipid based supplements).[12, 13] However, the evidence for use in emergency response may not be as strong.

Promising Practice 3.1.

Build on global momentum for CVA generally and global commitments for nutrition (e.g. via Nutrition for Growth) to convince donors to invest in more operational research and programming using CVA. ECHO has signalled its interest in supporting Cash Plus modalities in its recently published Cash Policy (2022).[14] USAID Advancing Nutrition is also working to gather lessons learned on CVA for supplemental nutritious assistance.[15]

Challenge 3.2. Donor preferences are strongly influencing if and how CVA is being used for nutrition outcomes, potentially limiting further expansion and generation of evidence. In the absence of wider consensus on how CVA can/ cannot be expected to improve nutrition, individual donor preferences are influencing response analysis and modality choice.

Promising Practice 3.2.

Mobilise CVA and nutrition actors to articulate practical research priorities and collaborate to generate evidence to inform CVA and nutrition programming. An initiative is currently underway to map research gaps since publication of the Evidence and Guidance Note, led by the Emergency Nutrition Network (ENN). Strong examples from the past include the Research on Food Assistance for Nutritional Impact (REFANI) project (2014 – 2017) and investments in impact evaluations by UNICEF, Save the Children and others (CAR, DRC, Rwanda). Several agencies have conducted or are conducting research on CVA for nutrition in emergencies (Action Contre La Faim, Croix Rouge Française, Concern, GOAL, Mercy Corps, Save the Children). Building basic nutrition-sensitive indicators and data collection into routine programmes using CVA can help build a pool of relevant data.

4. Implementation

Three challenges and lessons learned were identified in implementation:

Challenge 4.1 Using nutrition vulnerability criteria to target households and individuals and understanding the risks of targeting households based on a child's nutritional status. Respondents reported a lack of clarity on how to use nutrition vulnerability information to target households for cash. There was particular concern regarding the hypothesised risk of targeting households based on the presence of a child with acute malnutrition as this might create an incentive to keep children malnourished. While some evidence on this risk has been documented in DRC and Nigeria, no respondents said they had seen any evidence of this risk in their programmes.[16]

Promising Practice 4.1.a.

Collaboratively define vulnerability criteria to target households within those communities also using a mix of socio-economic factors and categories of nutritionally vulnerable individuals. Nutrition vulnerability is often defined by age and/or being within a vulnerable stage of the life cycle when nutrient needs are high to support rapid growth or reproduction. In practical terms, this often means targeting households that have a woman member who is pregnant or breastfeeding an infant under six months or has a child under two (or in some cases five) years of age. Respondents also reported using existing lists of vulnerable households, such as social protection or safety net registers (Ethiopia, Somalia, Kenya, Tanzania). A final verification exercise with communities to ensure the identified households are indeed the most nutritionally vulnerable is also essential. A 'blanket' approach, in which all households in a nutritionally vulnerable area are targeted for CVA is possible but requires significant resources or usually a reduction in the number of communities targeted.

12 Save the Children. Child Development Grant Programme: Strengthening social protection systems in Nigeria (2022)

13 Scott, N., Delport, D., Hainsworth, S. et al. Ending malnutrition in all its forms requires scaling up proven nutrition interventions and much more: a 129-country analysis. BMC Med 18, 356 (2020).

14 DG ECHO DG Thematic Policy Document No. 3 Cash Transfers (2022)

15 See USAID, Share Your Experience Using Cash, Voucher, and In-Kind Specialized Assistance in Nutrition Programming (April 2022)

16 Duerr Andre on behalf of the Global Nutrition Cluster, CASHCAP, Case Study: Documentation of experiences using CVA for nutrition outcomes in Nigeria. 2020

Promising Practice 4.1.b.

Do not use the presence of a malnourished child in the family as a singular criterion to target vulnerable households for CVA, unless the child is enrolled in a wasting treatment programme and the purpose is to improve treatment outcomes. Programmes providing CVA to children already enrolled in a treatment programme to improve treatment outcomes or prevent relapse is a different type of intervention and is outlined in the Evidence and Guidance note. Using the presence of a malnourished child as the only or main criteria in a community targeting exercise to identify households for CVA is not recommended because it could motivate households to cause their child to become or continue to be malnourished. Instead, use a mix of criteria with the presence of a malnourished child being just one but not the sole criterion. Ideally, the list of children enrolled in treatment services at the local health facility could be used to cross check targeting – the household of each child could be followed up to assess them against the CVA eligibility criteria (even if it does not include presence of a household member with malnutrition) as it is likely (but not guaranteed) they may fit the criteria.

Promising Practice 4.1.c.

Build strong referral pathways between CVA and nutrition treatment programmes and other services to increase focus on the most nutritionally vulnerable. While mapping and strengthening referral pathways is a general good practice across humanitarian programming, it is particularly important for CVA-nutrition programming. Children admitted to malnutrition treatment services should be referred to the CVA program for assessment against a larger set of CVA eligibility criteria during enrolment periods, and all children identified as wasting/ having acute malnutrition during CVA targeting must be referred to the nearest health facility for treatment.

Challenge 4.2. Verifying nutritional vulnerability, particularly pregnancy or breastfeeding status, is not always straightforward and often not culturally appropriate. In some settings, women might not feel comfortable declaring that they are pregnant or breastfeeding due to local traditions, and more objective methods to verify when a woman is pregnant (e.g. antenatal cards or urine tests) or breastfeeding, may not be feasible or appropriate for the same reason. As such, target recipients may be missed or target numbers inflated (e.g. if based only on self-reporting). Due to these complexities, respondents from two country programmes (Syria and Lebanon) decided not to use pregnancy or breastfeeding status as an eligibility criteria. Further, as is the case with all CVA programmes, a one-off targeting approach may miss people who later become vulnerable (in this case, become pregnant or breastfeeding).

Promising practice 4.2.

Be sure to understand local norms around sharing pregnancy and breastfeeding status before deciding to use it as an eligibility criteria and determine how it can be carried out routinely in a respectful and systematic manner. While a specific practice to address this did not emerge directly from the consultations, the above is an important principle when targeting pregnancy and breastfeeding women. A further related learning mentioned by respondents is that programmes targeting nutritionally vulnerable women, it is best to have a 'woman plus' approach where women are the main target group but additional services other than cash are offered to household members and spouses. This will avoid potential conflicts that may arise within the household because of CVA.

Challenge 4.3. Nutrition practitioners are often not aware of the many challenges (and solutions) that CVA programmes face until budgets and resources have already been allocated – especially in countries where investment in CVA preparedness has been limited. These include working with financial service providers and their varied capacities, mobile network coverage when using mobile money, and distributing cash in the context of inflation or volatile exchange rates, among many others. Roles and responsibilities between CVA and nutrition practitioners are also often vague, which limits effective oversight of implementation and monitoring of outcomes.

Promising Practice 4.3.

Nutrition actors must work closely with CVA practitioners and engage them early when planning for a CVA for nutrition programme. Orienting nutrition actors on the basics of CVA programming can also help teams be better prepared to co-design CVA for nutrition programmes when the need and opportunity emerges. Engaging in CVA preparedness to establish operational capacities before or as soon as a crisis strikes is common practice among CVA practitioners. Nutrition actors need to be aware of the considerable efforts and time required to become CVA operational and work directly with their CVA counterparts to ensure all those measures are in place. Where CVA capacity is not immediately available in the team or operational area, nutrition practitioners will need to advocate to bring in this capacity and be realistic about timelines and funding required to do so. See Annex 3 for an outline of key areas identified for capacity development, particularly for nutrition practitioners.

5. Monitoring, Evaluation and Learning

One challenge and promising practice was identified for monitoring, evaluation and learning:

Challenge 5.1 Defining success of CVA for nutrition and agreeing the indicators and tools to measure it. Given the lack of documented impact of CVA on nutritional status to date and the short time period for emergency CVA responses, respondents struggled to identify the most appropriate and realistic nutrition indicators to use. CVA practitioners also felt that they may not have the skills to measure standard nutrition indicators.

Promising Practice 5.1.

Use a mix of outcome and output indicators to assess the impact of CVA along the specific pathways by which the programme activities aim to improve nutrition for each target group. This could include measuring child or maternal nutritional status and/or the underlying factors that contribute to malnutrition, including food security, health and nutrition practices and access to essential health and WASH services. As outlined under the needs assessment and design sections above, developing a proposed theory of change or impact pathway to clarify how the programme will use CVA and complementary interventions to improve nutrition is a critical first step. This is important for all programmes but especially for CVA because a lack of cash in the household is often not the only barrier to good nutrition, meaning complementary activities will be required. The set of basic indicators outlined for nutrition in the Multipurpose Cash Outcome Indicators and Guidance developed by the Grand Bargain Workstream[17] is a good place to start. Please also see the FAQ on Cash and Voucher Assistance for Nutrition in Emergencies: Frequently Asked Questions for nutrition (available soon on the Global Nutrition Cluster website) for examples of indicators that can be used.

17 Grand Bargain Workstream in coordination with CALP. Multipurpose Cash Outcome Indicators and Guidance (2022).

Conclusions and way forward

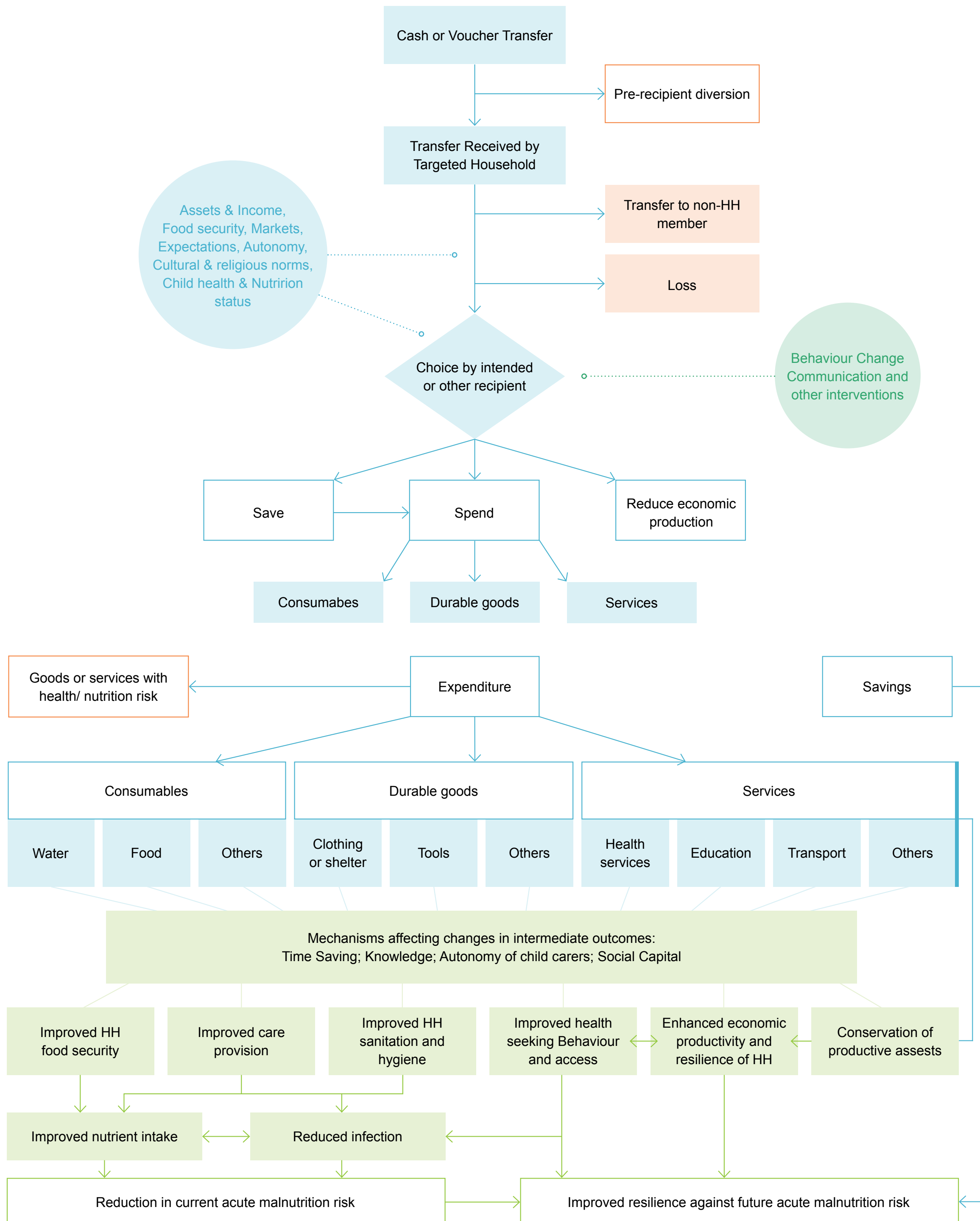
CVA can facilitate access to nutritious foods in humanitarian contexts where markets are functional and nutritious foods are available. CVA also has the potential to improve the nutritional status of women and children through multiple pathways, such as facilitating access to health, nutrition and water services - where those services are already available and functioning (e.g. by helping cover fees or transport costs). CVA may also help parents create more time to feed and care for their children by reducing pressure to seek income-generating opportunities.

However, malnutrition is usually driven by multiple, intersecting factors, many of which cannot be addressed simply by providing households with cash. In most contexts, CVA must therefore be adapted and combined with interventions that can address the other non-financial barriers to good nutrition. This includes targeting CVA to those who are the most nutritionally vulnerable – usually women of reproductive age and children under-two living in locations with high levels of nutrition risk factors. It may require comprehensive support to health and nutrition service delivery and/or sanitation and water infrastructure in target communities. Finally, social and behaviour change activities may also be needed to promote essential feeding and caring practices for children and women, including 'nudging' carers to use the cash received on goods and services that are likely to improve nutrition.

Practitioners across the humanitarian sector have recognised the important role CVA can play in improving nutrition and have been experimenting with how they deliver it to optimise nutritional impact. This review aimed to capture the most common challenges practitioners have faced when trying to implement the approaches laid out in the Evidence and Guidance Note and what they have done to try to address those challenges. It is essential that practical learning continues to be documented as it emerges and is used in coordination with more structured research to determine how to use CVA to improve nutrition in different contexts. Collaboration across cash and nutrition sectors is critical to optimising the impact of programmes on nutrition. It is becoming clear that in most contexts, financial barriers are only one of many hurdles on the path to good nutrition - cash is an essential piece in the puzzle, but not the only one.

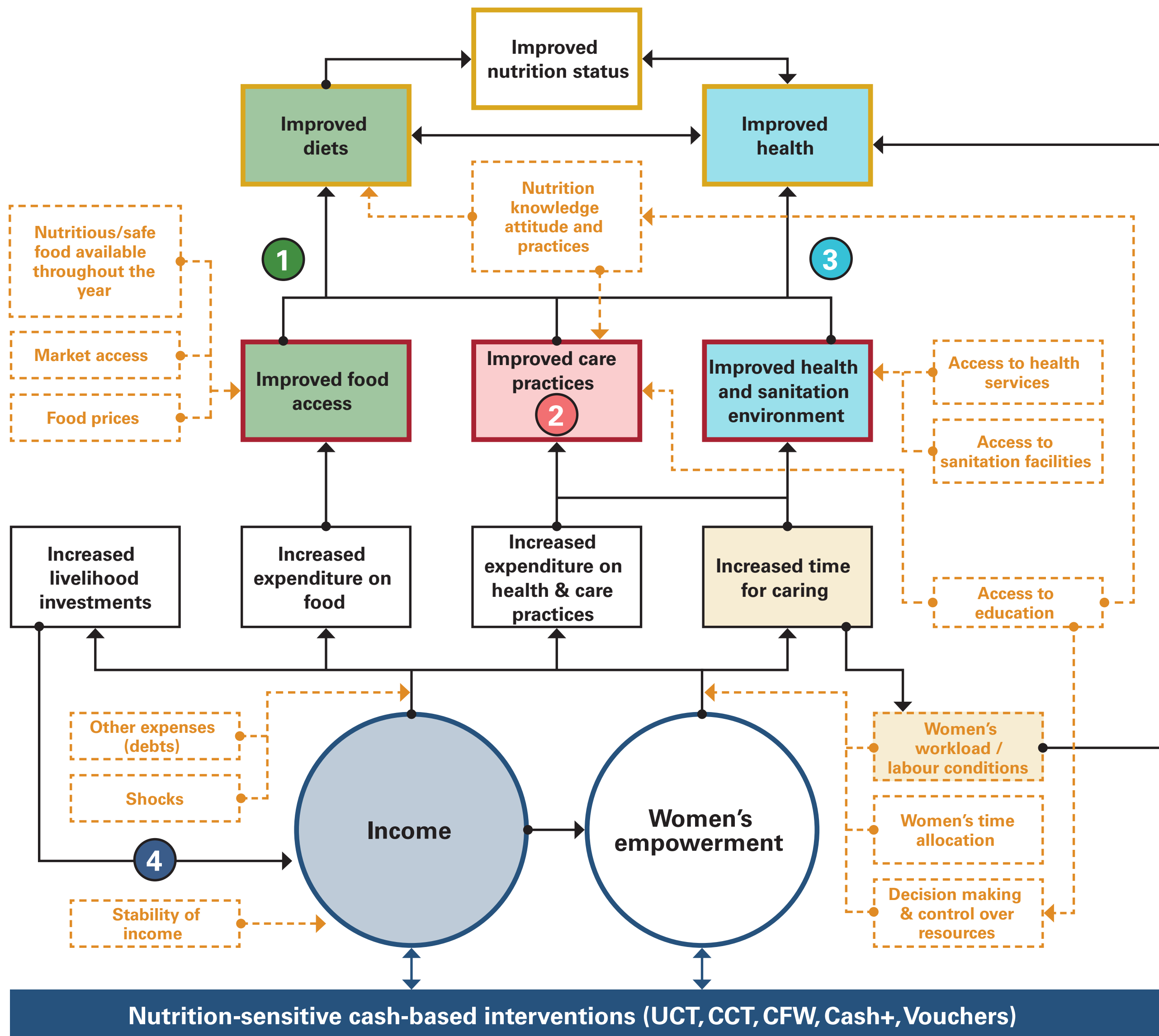
Annexes

ANNEX 1. EXAMPLE THEORY OF CHANGE FOR CVA IMPACT ON NUTRITION FROM RESEARCH ON FOOD ASSISTANCE FOR NUTRITIONAL IMPACT (REFANI) PROJECT[18]



18 Global Nutrition Cluster, et al. **Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies** (2020).

ANNEX 2. EXAMPLE IMPACT PATHWAY ADAPTED FROM FAO'S TECHNICAL GUIDANCE TO IMPROVE NUTRITION THROUGH CASH-BASED INTERVENTIONS (2020)[19]



UCT – unconditional cash transfer; CCT – conditional cash transfer; CFW – cash for work

19 FAO, Technical Guidance to improve nutrition through cash-based interventions (2020)

ANNEX 3. SUMMARY OF KNOWLEDGE AND SKILL GAPS IDENTIFIED, PARTICULARLY FOR NUTRITION PRACTITIONERS

<table>
<tr><th>Project cycle phase</th><th>Topics</th></tr>
<tr><td rowspan="2">General</td><td>Translate tools to languages other than English</td></tr>
<tr><td>Make resources easily accessible to both sectors. Be sure everyone knows where to find existing tools & training resources</td></tr>
<tr><td>1. Needs Assessment and Situation Analysis</td><td>CVA feasibility assessment training/ support on:
• Market analysis
• Community preference assessments
• Financial service provider mapping/ assessment
Nutrition situation analysis with a market lens</td></tr>
<tr><td>2. Strategic Planning and Design</td><td>Designing CVA programmes
• Guidance/ support on deciding best modality to meet nutrition outcomes
• Guidance/ support on deciding best delivery mechanism</td></tr>
<tr><td>3. Advocacy and Resource Mobilisation</td><td>Orientation on CVA for Nutrition for senior managers:
• Current evidence for CVA for nutrition
• Ways to integrate CVA and nutrition programming
• Relative costs of using different modalities/ activities (for accurate budgeting)</td></tr>
<tr><td rowspan="2">4. Implementation</td><td>Special focus on all CVA for nutrition skills for local and smaller organisations who may have limited exposure to CVA.
• Orientation on nutrition fundamentals for Cash Working Groups in country
• Orientation on CVA for Nutrition Cluster Coordinators/ Co-Leads in country</td></tr>
<tr><td>Managing inflation (navigating inflation, dollarization and changing financial regulations)</td></tr>
<tr><td>5. M&E</td><td>Which indicators to use at outcome and output level when implementing CVA for nutrition, particularly what CVA related indicators are appropriate.</td></tr>
</table>

ANNEX 4. SUMMARY OF CHALLENGES AND PROMISING PRACTICES USING CVA FOR NUTRITION

Project Cycle Phase	Challenge	Promising Practice
Needs assessment and situation analysis	**1.1.** Assessing the nutrition situation and the appropriateness of using CVA requires time and expertise to collect and analyse a broad and complex range of information.	**1.1.** Optimise use of secondary data.
	1.2. Deciding if financial barriers are a key determinant of malnutrition and if CVA should be prioritised to improve nutrition.	**1.2.** Focus on the information required to understand if/ how cash could improve nutrition.
	1.3. Capacity to assess CVA feasibility to inform the choice of CVA response modality is often limited in nutrition programming teams	**1.3.** Engage relevant cash and nutrition experts with different skills – even if only for part of the assessment process.
	1.4. Assessing the appropriateness and feasibility of using food vouchers – especially fresh food vouchers.	**1.4.** If considering fresh food vouchers, plan sufficient time to carry out a detailed feasibility assessments.
Strategic planning and design	**2.1.** Deciding which districts and communities to prioritise for CVA and the optimal timing of the transfer to have the greatest nutritional impact	**2.1.a**. Use a mix of socioeconomic and nutrition data to target geographical areas/ communities at highest risk of malnutrition. **2.1.b.** Target disbursement of CVA to occur during the period when populations - particularly children - are most vulnerable to malnutrition (e.g. the lean season).
	2.2. Deciding on the modality: cash and/or vouchers and/or in-kind support in situations that are rapidly changing.	**2.2.** Build flexibility into the response regarding the modality used (cash or voucher or in-kind support) and adapt the modality as needed.
	2.3. Calculating the transfer value to meet nutritional needs is complex and the resulting value is often high, making it difficult to deliver with existing resources.	**2.3.** Advocate for simple tools to estimate a transfer value that takes nutritional needs including for young children into account, but remember the transfer value is only one of many ways to optimise the nutritional impact of CVA
	2.4. Assessing risks linked to conditionality	**2.4.** Opt for unconditional cash transfers as a rule, but consider 'soft conditionality' where CVA recipients are encouraged but not required to meet a condition (e.g. to access a service or attend a behaviour change communication session) in order to receive the CVA.
	2.5. Essential health, WASH and other services are often not easily accessed and/ or of poor quality, limiting the potential impact of CVA.	**2.5.a.** Combine CVA with complementary interventions that improve delivery of essential services required to ensure good nutrition – also referred to by some as a 'Cash Plus' approach **2.5.b.** Where programmes are physically delivering cash, bring distribution points closer to vulnerable groups and locate them in a safe space – ideally, at or near key service points to encourage uptake of complementary services (with careful planning to ensure the service can accommodate additional demand).
	2.6. Complementary social and behavioural change activities are important to improve nutrition but are often difficult to design and implement effectively in crisis settings.	**2.6.** Understand and build on existing, pre-crisis social behaviour change platforms and behaviour change communication materials; keep messages targeted to just a few behaviours; and try to disseminate messages via the same channels as the CVA.
	2.7. Designing a fresh food voucher intervention requires additional skills to select and manage vendors.	**2.7.** Consider the potential benefits of fresh food vouchers – including stimulating markets for fresh foods - carefully versus the extra time and skills before deciding for or against them
	2.8. Choosing a delivery mechanism that optimises nutritional impact.	**2.8.** Choose the delivery mechanism based on a feasibility and risk assess in each context for each target group.

Project Cycle Phase	Challenge	Promising Practice
3. Advocacy & resource mobilisation	**3.1.** Donors and some practitioners are still hesitant to commit significant resources to CVA to achieve nutrition outcomes because they perceive the evidence as insufficient or inconclusive.	**3.1.** Build on global momentum for CVA generally and global commitments for nutrition (e.g. via Nutrition for Growth) to convince donors to invest in more operational research and programming using Cash Plus modalities
	3.2. Donor preferences are strongly influencing if and how CVA is being used for nutrition outcomes, potentially limiting further expansion and generation of evidence.	**3.2.** Mobilise CVA and nutrition actors to articulate practical research priorities and collaborate to generate evidence to inform CVA and nutrition programming
Implementation	**4.1.** Using nutrition vulnerability criteria to target households and individuals and understanding the risks of targeting households based on a child's nutritional status	**4.1.**a. Collaboratively define vulnerability criteria to target households within those communities also using a mix of socio-economic factors and categories of nutritionally vulnerable individuals. **4.1.**b. Do not use the presence of a malnourished child in the family as a singular criterion to target vulnerable households for CVA, unless the child is enrolled in a wasting treatment programme and the purpose is to improve treatment outcomes. **4.1.**c. Build strong referral pathways between CVA and nutrition treatment programmes and other services to increase focus on the most nutritionally vulnerable.
	4.2. Verifying nutritional vulnerability, particularly pregnancy or breastfeeding status, is not always straightforward and often not culturally appropriate	**4.2.** Be sure to understand local norms around sharing pregnancy and breastfeeding status before deciding to use it as an eligibility criteria and determine how it can be carried out routinely in a respectful and systematic manner.
	4.3. Nutrition practitioners are often not aware of the many challenges (and solutions) that CVA programmes face until budgets and resources have already been allocated – especially in countries where investment in CVA preparedness has been limited.	**4.3.** Nutrition actors must work closely with CVA practitioners and engage them early when planning for a CVA for nutrition programme. Orienting nutrition actors on the basics of CVA programming can also help teams be better prepared to co-design CVA for nutrition programmes when the need and opportunity emerges.
M&E	**5.1.** Defining success of CVA for nutrition and agreeing the indicators and tools to measure it.	**5.1.** Use a mix of outcome and output indicators to assess the impact of CVA along the specific pathways by which the programme activities aim to improve nutrition for each target group

ANNEX 5. LIST OF PROJECTS REVIEWED AND EXPLORED WITH STAKEHOLDERS FROM THE NINE DEEP DIVE COUNTRIES

Country	Project name	Time period	Actors	Link to relevant document
Afghanistan	Cash Plus transportation & accommodation incentives / SAM	2021	Nutrition Cluster members	
	Multipurpose cash transfer designed with nutrition lens	2021	WFP	
	School feeding programme	2017 – 2022	WFP	
	Voluntary repatriation cash grant	2002 – present	UNHCR	**MPCA Afghanistan case study (CALP 2018)**
	Afghanistan emergency response mechanism to meet the emergency	2011 – present	NRC, DRC, PIN, ACF, Solidarities, DACAAR, ACTED	**Afghanistan Emergency Response Mechanism Case Study (CALP 2017)** **MPCA Afghanistan case study (CALP 2018)**
DRC	Partnership to tackle malnutrition in DRC	2022	Give Directly	**Project description on Power of Nutrition website**
	Assistance for conflict affected households	2017	Action Against Hunger	**Case study on ACF website**
	Approche intégrée de lutte contre la malnutrition chronique dans le Sud-Kivu	2016 – TBC	WFP, UNICEF, FAO	**Project description on UNICEF website**
	Save the Children cash-plus project (cash added to SAM treatment) in DRC	2015 – 2016	Save the Children, Prog. National de Nutrition (Pronanut)	**Cost-Efficiency and Cost-Effectiveness Study of UNICEF "Cash Plus" Interventions in Lebanon & DRC (UNICEF 2020)** **Also see research study below**
	Research study: Effects of unconditional cash transfers on the outcome of treatment for severe acute malnutrition: A cluster-randomised trial in the DRC	2015 – 2017	Health centre staff and Save the Children	Journal Article: **Effects of unconditional cash transfers on the outcome of treatment for severe acute malnutrition (SAM): a cluster-randomised trial in the DRC (Grellety et al 2017, BMC Medicine)**
	Enhanced Responses to Nutrition Emergencies (ERNE)	2020 – 2023	Concern	

Country	Project name	Time period	Actors	Link to relevant document
Ethiopia	Fresh Food Vouchers	2019 – TBC	WFP	**Impact Evaluation of WFP's Fresh Food Voucher Pilot Programme in Ethiopia** (WFP 2019)
	Fresh food vouchers for refugees		ACF	
	The integrated nutrition social cash transfer (IN-SCT) pilot project	2015 – 2017	Gov. of Ethiopia, UNICEF, Irish Aid & Institute of Development Studies (IDS)	**IN-SCT Pilot in Ethiopia: Perceptions & Feedback from Clients & Service Providers (IDS 2017)** **Gender and cash transfers: implications of intrahousehold decision making on nutrition of women and children in Ethiopia (Lumbasi L, CALP, 2018)**
	Health and nutrition response for women and girls in SNNPR and Somali Region	2019	Save the Children	
	Integrated community-based management of acute malnutrition, cash and WASH response in Korahe Zone of Somali Region, Ethiopia.	2019	Save the Children	
	Ethiopia, Fresh Food Voucher Programme	2017 – 2019	WFP	**Impact evaluation report for WFP Fresh Food Vouchers Ethio;pia (2019)**
	Graduation with resilience to achieve sustainable Development (GRAD)	2011 – 2016	CARE, Gov. of Ethiopia, Local organisations	**GRAD project final narrative report (USAID, et al 2016**) **GRAD programme learning brief (CARE, 2018)**
	Enhanced Responses to Nutrition Emergencies (ERNE) in Ethiopia	2020 – 2023	Concern	
Haiti	Réponse et préparation à la sècheresse à travers la restauration des moyens de subsistance et le renforcement de la résilience, département du Nord-Ouest et dans l'Haute Artibonite	2018 – 2019	COOPI	**Project description on COOPI website**
	The use of nutrition vouchers to prevent malnutrition and improve the quality off diet	2017 – 2018	Action Against Hunger	**Use of nutrition vouchers learning brief (AAH, 2017)**
	Review of cash-based interventions during Hurricane Matthew response in Haiti	2016	Mercy Corps	**Review report: Moving forward with cash in Haiti (Mercy Corp, 2018)**
	Food For Peace market-based emergency food assistance programs	2010 – 2016	ACF, WFP, CARE, WV, CRS	**Review of Food for Peace Market-based emergency assistance programs – Haiti Case Study (Tango Intl, 2018)**
	Food security & agriculture in rural area: distribution of unconditional 100USD in addition to seed and input vouchers		WFP	

Country	Project name	Time period	Actors	Link to relevant document
Lebanon	UNICEF Cash + Nutrition approach		UNICEF	
	Impact of Multipurpose Cash Assistance on outcomes for children in Lebanon	2015	Save the Children	**Report on impact of multipurpose cash assistance on outcomes for children in Lebanon (Save the Children, 2015)**
	Cash Plus nutrition awareness		Save the Children	
	MPCA for food security		ACF	**Action Against Hunger Lebanon website with case studies**
	Food and basic assistance for refugees, school meals	NA	WFP	**WFP Lebanon country website**
	Support of Syrian refugees In Lebanon	2011 – present	WFP	**Food Restricted voucher or unrestricted cash - how to best support Syrian refugees in Jordan and Lebanon (WFP, 2017)**
Mali	Réponse à la CRIse ALimentaire au CEntre Sahel : support nutritionnel et relèvement (CRIALCES)	2017 – 2024	WFP	**CRIACLES project fact sheet (WFP, 2022)**
	Santé nutritionnelle à assise communautaire dans la région de Kayes (SNACK)	2011 – 2016	WFP	**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 (SNACK programme)** (IFPRI, 2019)
	Resourcing family for better nutrition: Cash distribution coupled with in-kind enriched flour distribution		Save the Children	
Myanmar	Universal maternal cash transfer program for pregnant women and their children (Cash only; Cash + SBCC)	2016 – 2019	Government of Mayanmar, Save the Children	**The impact of maternal cash transfers on child malnutrition in Myanmar (Poverty Action Network, 2019)**
	Maternal and child cash transfers for improved nutrition	2021	World Bank	**Project description on World Bank website**
	Maternal and child cash transfer (MCCT) programme	2013 – present	Save the Children	**Endline report for randomised control trial on interventions under the LEGACY programme** (Save, 2019)
	Nutrition support to the vulnerable persons	2020	Rakhine Women Union	
	Cash intervention for food (COVID-19 Response)	2020 – 2021	Action Contre la Faim	
	Cash for food at four IDP camps in Mrauk U	2020 – 2021	Christian Aid	

Country	Project name	Time period	Actors	Link to relevant document
South Sudan	CVA to SAM/MAM Children	2020	Save the Children	
	South Sudan safety net project (SSSNP)	2020	World Bank	**SSSNP project description on World Bank website**
	World Vision emergency assistance	2015-2016	World Vision	**Cash-based programming to address hunger in conflict affected South Sudan: a case study (World Vision, 2016)**
	Nutrition-sensitive voucher schemes	2017-2018	FAO, UK/ NI Rep of Norway	**Nutrition-sensitive voucher schemes in South Sudan (FAO, 2020)**
	Enhanced responses to nutrition emergencies (ERNE)	2020 - 2023	Concern	
Yemen	Conditional cash grants (post SAM/ MAM treatment)	2019-2022	Save the Children	
	Unconditional cash transfers for food security and nutrition outcomes		YFCA	
	Cash for nutrition intervention in Yemen	2015-2017	Yemen Social Fund for Development	**The cash for nutrition intervention in Yemen: impact evaluation study report (IFPRI, 2019)** **Policy Brief - Responding to Conflict: Does "Cash Plus" work for preventing malnutrition (summary of impact evaluation above) (IFPRI, 2019)**
	Integrated health, nutrition and child protection project in Hajjah	2019 - 2021	Save the Children	**In Yemen, cash assistance contributes to positive nutritional outcomes (Save the Children, 2022)**
	Multipurpose cash transfers & community support projects on household & community resilience, Amran and Abyan Governorates	2017	CARE & ACF	**The gendered dimension of MPCA supporting disaster resilience (CARE, ACF, 2019)**

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