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ACCESSING LOCAL FOODS THROUGH CASH OR VOUCHER ASSISTANCE TO PREVENTING WASTING & MANAGING MODERATE ACUTE MALNUTRITION

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FOREWORD

This document is a **concise and simplified version** of the full report based on an extensive **evidence review of how Cash and Voucher Assistance (CVA) can improve access to locally available nutritious foods to prevent wasting and support the management of Moderate Acute Malnutrition (MAM)**. It provides a high level overview designed primarily for **Action Against Hunger (ACF) technical partners**, and therefore does not present the full depth of analysis included in the comprehensive report.

A **longer, fully detailed version**—covering complete methodology, findings, in depth analyses and references—is available **upon request only**. Scientific partners or any stakeholders requiring a thorough understanding of the evidence base and methodological details may request access to the full version from the Action Against Hunger team.

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LIST OF ACRONYMS

CCT	Conditional Cash Transfer
CVA	Cash and Voucher Assistance
FFV	Fresh Food Vouchers
GNC	Global Nutrition Cluster
IDDS	Individual Dietary Diversity Score
KII	Key Informant Interview
LBW	Low Birth Weight
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD-C	Minimum Diet Diversity for Children
MDD-W	Minimum Diet Diversity for Women
MUAC	Middle Upper Arm Circumference
PBWGs	Pregnant and Breastfeeding Women and Girls
SBC(C)	Social and Behavior Change (Communication)
SFF	Specially Formulated Food
UCT	Unconditional Cash Transfer

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TABLE OF CONTENTS

Executive summary 8
Introduction 10
Methodology and limitations 12

1. KEY FINDINGS 16

1.1 "CVA for food" impact on the prevention of wasting and risk of poor growth and development 16
Prevention of wasting and risk of poor growth and development among children under 5 16
Prevention of wasting among Pregnant and Breastfeeding Women and Girls (PBWGs) 18
1.2 "CVA for food" impact on the management of Moderate Acute Malnutrition 18
1.3 "CVA for food" impact on Low Birth Weight and Child Mortality 19
Low Birth Weight 19
Child Mortality 20
1.4 "CVA for food" impact on Individual Diet Diversity 20
Individual Diet Diversity among children under 5 20
Individual Diet Diversity among Pregnant and Breastfeeding Women and Girls (PBWGs) 22

2. CONCLUSIONS 23

3. RECOMMENDATIONS 25

3.1 Evidence Gap and Research Recommendations 25
A more representative research to understand specific population groups and regions needs 25
Filling the research gap on management of MAM through CVA via the food route 25
Access to "local" and "nutritious" food: how to assess, what to assess? 27
Does modality matters? Comparing cash, commodity vouchers and value vouchers 27
Assessing the specific contribution of SBC and other "complementary components" 28
3.2 Operational Recommendations 28
Context Analysis and understanding the impact pathways 29
Targeting Strategies 29
Timing and Duration of Interventions 29
Transfer Value and Market Considerations 29
Integration of Complementary Components 29
Physical and Technological Barriers 29
Monitoring, Evaluation, and Sustainability 30
Coordination and Multi-sectoral Collaboration 30

References 31
Appendices 37

GLOSSARY OF KEY TERMS

KEY TERM	DEFINITION
CASH AND VOUCHERS ASSISTANCE	Refers to the direct provision of cash transfers and/or vouchers for goods or services to individuals, households, or group/community recipients. In the context of humanitarian response, CVA excludes payments to governments or other state actors, remittances, service provider stipends, microfinance and other forms of savings and loans. (CALP)
CONDITIONAL/ UNCONDITIONAL (CASH) TRANSFERS	Refers to prerequisite activities or obligations that a recipient must fulfil to receive assistance. Conditions can be used with any kind of transfer (cash, vouchers, in-kind, service delivery) depending on the intervention design and objectives. Some interventions might require recipients to achieve agreed outputs (which can include purchasing specific goods or services) as a condition of receiving subsequent tranches. Examples of conditions include attending school, building a shelter, attending nutrition screenings, undertaking work, training, etc. Cash for work/assets/training are all forms of **conditional transfer**. **Unconditional transfers** are provided without the recipient having to do anything to receive the assistance, other than meet the intervention's targeting criteria (targeting is separate from conditionality). Conditionality is distinct from restriction (how assistance is used) and targeting (criteria for selecting recipients. (CALP)
VOUCHER	A paper voucher or e-voucher that can be exchanged for a set value, quantity and/or type of goods or services, denominated either as a currency value (e.g., $15), a predetermined range of commodities (e.g., fruits and vegetables) or specific services (e.g., a medical treatment), or a combination of value and commodities. They are redeemable with preselected vendors or service providers or in 'fairs' created by the implementing agency. (CALP)
COMMODITY VOUCHER	Commodity vouchers can be redeemed at participating vendors for goods or services selected by recipients from a pre-determined list of items/services of specified types and quality. They may provide some choice in terms of vendors and market locations. (CALP)
VALUE VOUCHER	A value voucher has a denominated currency value and can be redeemed with participating vendors for goods or services of an equivalent monetary cost. Value vouchers provide relatively more flexibility and choice than commodity vouchers but are still inherently restricted as they can only be redeemed with designated vendors or service providers. Some value vouchers may also have restrictions on the range of commodities that can be purchased, exclude specific commodities, or be time-bound (e.g., expiry date).
SOCIAL AND BEHAVIOR CHANGE (COMMUNICATION)	Previously known as behavior change communication (BCC), SBCC is the strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs and behaviors. The terms BCC and SBCC are interchangeable, and they both refer to the coordination of messages and activities across a variety of channels to reach multiple levels of society, including the individual, the community, services and policy. (Source)
MODERATE ACUTE MALNUTRITION	Moderate wasting is defined as having a weight-for-height or weight-for-length between -3 Standard Deviation and below -2 Standard Deviation (≥ -3 SD to < -2 SD), or MUAC between 115 mm and less than 125 mm (≥ 115 mm to < 125 mm, and no nutritional oedema, in children 6–59 months of age. (WHO)
SPECIALLY FORMULATED FOODS	Specially formulated foods are defined as foods that have been specifically designed, manufactured, distributed, and used for either special medical purposes or for special dietary uses, as defined by Codex Alimentarius. (WHO)

EXECUTIVE SUMMARY

Given the scale of global malnutrition and the increasing use of Cash and Voucher Assistance (CVA) in aid programming, it was important to evaluate the evidence base to guide future program design, ensure effective resource allocation, and support the development of context-specific strategies that can improve nutritional outcomes for vulnerable populations. This review was conducted to assess **how CVA can be leveraged to prevent wasting and manage MAM in children 0-5 months, children 6-59 months, and PBWGs by improving access to and utilization of local, nutritious foods**, through what we refer to as "the food route". This route contrasts with non-food pathways, such as improving access to health services or childcare, and focuses specifically on interventions that enable the purchase or consumption of nutrient-dense foods through market-based mechanisms.

To conduct the review, the authors employed a dual-method approach combining a structured literature review and key informant consultations. The literature review was guided by the PICO framework, focusing on populations at risk of or recovering from MAM, interventions involving CVA for food access, and outcomes related to nutritional status and dietary diversity. Studies focusing only on outcomes related to access to health services, childcare, etc. (referred to as the "non-food route") were excluded. From an initial pool of 204 records, 55 studies and 7 Literature Reviews were selected based on inclusion criteria such as relevance to the food route, geographic diversity, and publication language. These studies spanned humanitarian and development contexts. Additionally, six key informant interviews and two focus group discussions were conducted with practitioners from international and local NGOs and UN agencies. These consultations helped fill gaps identified in the literature and provided operational insights. However, limitations included a scarcity of studies on MAM management, limited data on PBWGs, and underrepresentation of certain regions (Central and South America, the Middle East, and the Pacific).

The review finds that CVA can positively impact the prevention of wasting and poor growth among children under five. While many studies report improvements in anthropometric indicators and dietary diversity, some others failed to find positive effects. The evidence suggests that effectiveness of CVA varies depending on the modality used—cash, vouchers, or a combination—and whether complementary components, on top of Social and Behavior Change (SBC) interventions are included. There is emerging evidence on the impact of CVA for food on PBWGs nutritional status, with only a few studies addressing their nutritional outcomes. Similarly, the role of CVA in managing MAM is under-researched, with only three studies (including only one study published in a peer-reviewed scientific journal) exploring its use during the management of MAM among children or in preventing relapse.

Emerging evidence suggests that conditional cash transfers can reduce low birth weight and child mortality, but no studies have assessed the impact of vouchers on these outcomes. Dietary diversity among children and PBWGs shows more consistent positive results, especially when CVA is combined with SBC and other supportive elements. However, some interventions have failed to find positive impacts, underscoring the importance of program design and context.

The review highlights several evidence gaps. There is a lack of research on PBWGs, especially adolescent mothers, and children under two, which are critical groups during the 1000-day window of opportunity. Most studies look at children under 5 years of age and do not disaggregate the data further by age, limiting insights into when CVA is most effective. The role of CVA in MAM recovery through the food route remains under investigated. Last, few studies compare the effectiveness of different modalities, and the contribution of SBC and other complementary components needs further exploration.

To address these gaps, the report recommends expanding research to include underrepresented groups and regions, conducting age-specific analyses, and evaluating the impact of CVA on access and utilization of nutritious foods. Comparative studies between cash, vouchers, and in-kind aid and other modalities of intervention (such as agricultural support) are needed, especially in crisis contexts when feasible. It also calls for deeper investigation into the role of SBC and complementary components, including public health interventions that improve access to comprehensive Maternal, Newborn and Child Health care (MNCH), such as antenatal services, skilled birth attendance, and support for managing pregnancy-related conditions, or interventions ensuring access to water.

Operational recommendations emphasize the need for context-specific targeting strategies, alignment of interventions with seasonal and crisis cycles, and appropriate transfer values based on the cost of nutritious diets. Complementary components should be integrated thoughtfully, based on an in-depth context analysis to understand impact pathways, and physical and technological barriers to access should be addressed. Monitoring and evaluation frameworks should include intermediate indicators and individual-level metrics to better capture nutritional outcomes. Coordination across sectors and clear communication between CVA designers and nutrition experts are essential for maximizing impact.

In conclusion, while CVA shows promise in improving nutrition outcomes and should be considered for improving access to nutritious food, its potential impact remains under investigated notably for the management of MAM. Existing evidence suggest that this is not a standalone solution. Its effectiveness depends on context, implementation quality, and the integration of complementary components. There is a need for clearer operational guidance and more robust evidence on the use of CVA in preventing wasting and managing MAM through the food route. The review encourages continued exploration, refinement and assessment of CVA strategies for improving nutrition outcomes of vulnerable populations.

INTRODUCTION

The global burden of malnutrition remains a critical challenge, particularly for vulnerable populations such as children under five years of age and pregnant and breastfeeding women and girls (PBWGs). An estimated 150.2 million children under five are currently stunted globally, 42.8 million are wasted, and 35.5 million are overweight (UNICEF et al., 2025[1]), while more than one billion adolescent girls and women are experiencing at least one form of malnutrition (UNICEF, 2024), including some 520 million women aged 15-49 who are suffering from anemia (FAO et al., 2024).

The 2023 WHO guideline[2] on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under five years emphasizes the importance of locally available, nutrient-dense diets for infants and children with moderate wasting. The guideline encourages preventative interventions that include access to nutrient-dense and local diets, highlighting the need for evidence on the impacts of local diets on the prevention of wasting. In addition to prevention, the guideline also underscores that the management of Moderate Acute Malnutrition (MAM) requires reliable access to nutrient-dense foods, reinforcing the need for context-specific strategies that support both preventive and therapeutic nutrition approaches.

Within the broader context of global humanitarian assistance, Cash and Vouchers Assistance (CVA) has emerged as a key intervention to prevent or to support the management[3] of acute malnutrition. Although CVA shows promise, the evidence on its impact on nutrition outcomes is still limited and fragmented. More research is needed to understand how CVA can improve access to nutritious and locally available foods, especially for children and PBWGs.

CVA has demonstrated a wide range of benefits, such as reducing poverty and food insecurity, improving access to healthcare and education, and supporting shelter needs. It also empowers women by enhancing their control over financial decisions and promoting gender equality. Compared to traditional aid, CVA is often more cost-effective and better received by beneficiaries, as it allows them to make choices based on their own needs and priorities. Additionally, CVA can stimulate local economies through a multiplier effect, where money spent locally generates further economic activity.

There are three main pathways through which CVA can influence nutrition: by enabling direct access to essential goods and services; by increasing household income through livelihood support, which reduces economic stress and supports better nutrition-related decisions; and by encouraging behavioral changes through conditional transfers or complementary support (known as “Cash Plus”). However, the effectiveness of these pathways varies by context and remains poorly understood due to gaps in data and program design.

1 https://data.unicef.org/resources/jme/
2 WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years (https://www.who.int/publications/i/item/9789240082830)
3 According to the 2023 WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under five years, nutritional supplementation (for moderate wasting) describes “the regular outpatient services, whereby infants and children with moderate wasting receive medical care and nutritional supplementation to achieve clinical and anthropometric recovery, as well as referring them to ongoing appropriate preventative and supportive services if needed and possible." For the purposes of this review, the term ‘MAM management’ will be used.

To address these gaps and recognizing the importance of evidence-based interventions, Action Against Hunger seeks to **review existing evidence related to using Cash and Vouchers Assistance (CVA), to affect nutritional outcomes, especially as an intervention aimed at enhancing access to local nutritious foods and Specially Formulated Foods (SFF):**[4]

- (i) in the prevention of wasting and risk of poor growth and development among pregnant and breastfeeding women and girls (PBWGs) and healthy children 0-59 months and/or

- (ii) in supplementation of children 6-59 months and PBWGs with moderate acute malnutrition (MAM).

This review was developed in collaboration with the Global Nutrition Cluster (GNC) to ensure alignment and avoid duplication. The findings aim to support stakeholders in designing more effective programs for the prevention and management of moderate acute malnutrition (MAM), and should be considered alongside other GNC reviews for a comprehensive approach.

4 Initially the review planned to collect evidence on using CVA to access Specially Formulated Foods that are available for purchase in the market, and not distributed free of charge through a Severe Acute Malnutrition (SAM) or MAM management program. However, none were found so SFFs are not included in the analysis.

METHODOLOGY AND LIMITATIONS

The evidence review methodology followed two main components, a literature review and key informants consultation through interviews and group discussions.

Literature review

A **Literature Review** was conducted to identify, synthesize, and evaluate existing literature on the use of CVA for improving access to and utilization of local nutritious foods and SFFs to prevent wasting and manage MAM among children under five years of age and PBWGs.

This review has been structured using the PICO framework summarized below:

- **Population:** Children 0-5 months, children 6-59 months, and PBWGs, including those at risk of, with, or recovering from MAM.
- **Intervention:** CVA for access to local, nutritious foods and specially formulated foods for MAM management and prevention of wasting/poor growth and development.
- **Comparison:** No specific comparison was required; studies were not excluded based on the presence or absence of a comparator.
- **Outcomes:** It was anticipated that direct evidence on CVA to enhance access to and utilization of local nutritious food to prevent or manage MAM might be limited, so we looked at indicators along the causal chain that were likely to be measured within studies. Key outcomes included: prevention of and recovery from MAM, anthropometric improvements, and individual dietary diversity scores.

Searches were conducted across multiple academic and technical databases, including Google Scholar, PubMed, Field Exchange, the Global Nutrition Cluster, and repositories of grey literature. The search strategy combined terms related to:

- **CVA modalities** (e.g., "cash transfers," "vouchers," "cash based assistance").
- **Food access and quality** (e.g., "local nutritious food," "supplementary food," "specially formulated food").
- **Nutrition outcomes** (e.g., "MAM," "wasting prevention," "dietary diversity," "anthropometric outcomes").
- **Target populations** (children under five; pregnant and breastfeeding women).

All search results were screened using the PICO criteria, and additional references shared by key informants (KIIs) or Steering Committee members were incorporated. The review followed a structured, sequential process that moved from the identification of relevant studies to their final synthesis.

The first stage involved an **initial screening** during which titles and abstracts were examined to remove studies that did not meet the scope defined by the PICO framework. This step applied to publications identified through database searches as well as those shared via key informant interviews and Steering Committee contributions. Studies that passed this initial filter were then subjected to **a full text review**, allowing the team to assess them in greater depth against the inclusion and exclusion criteria and to confirm their relevance to the objectives of the review.

The following inclusion and exclusion criteria were used:

- Studies focused **on the use of CVA for improving access to and utilization of local nutritious foods** (referred to as the "food route") **for preventing wasting and managing MAM in children 0-5 months, children 6-59 months, and PBWGs**. Studies focusing only on outcomes related to access to health services, childcare, etc. (referred to as the "non-food route") were excluded.

- Published research articles (31), literature reviews (7), review articles (4), dissertations (2), research reports (2) and grey literature (16) (e.g., project reports, evaluations) were included.

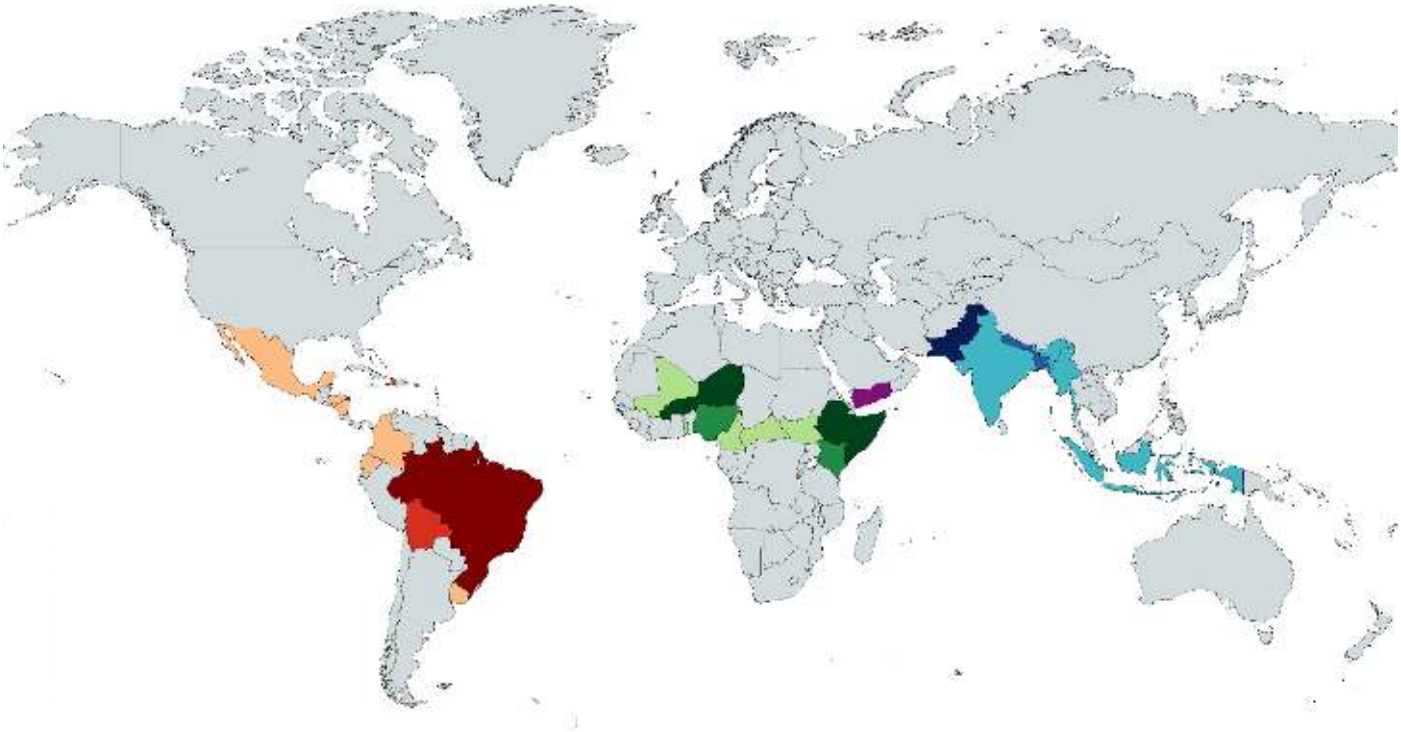
- Publications on low- and middle-income countries (LMICs), including urban, peri-urban, rural, and internally displaced people (IDP)/refugee camps were included.

- Publications in English, French, Spanish, and Portuguese, from the past 15 years (2009-2024). Publications in languages other than those specified were excluded, as well as literature before 2009.

From 204 total records identified during the preliminary search, a total of 62 studies covering either humanitarian (24) or development (27) contexts or both (11), were finally included during the initial screening and full-text review. Once the eligible studies were identified, data extraction was carried out using a standardized template. This template ensured systematic collection of information on study design, population characteristics, intervention components, outcomes assessed, and key findings. To evaluate the robustness of the evidence, the findings were subsequently appraised through a quality assessment process. This assessment drew on categorization criteria adapted from recent literature reviews (Eleanor Crook Foundation, 2024; Tom et al., 2023), enabling the classification of results according to the maturity and reliability of the available evidence: **established evidence** (findings backed by multiple studies including RCTs and before–after designs—across more than six countries consistently showing similar results in terms of impact or lack thereof), **emerging evidence** (findings backed by several studies or reports from two to five countries suggesting an effect or lack thereof but with limited generalizability) and **limited evidence** (findings backed by one or two studies conducted in one or two countries only, showing an effect or lack thereof, considered preliminary due to limited comparability).

Main limitations **from the literature review are as follows**. First, the analysis focuses on prevention of wasting and poor growth, as only three studies were found on CVA for food for managing MAM. A second important limitation is the limited number of studies (only nine studies from eight countries) that examined the impact of CVA intervention on preventing MAM among PBWGs or improving their diet diversity. Last, the analysis reveals a limited geographical distribution of studies, highlighting a gap of research in some regions of the world: most studies were coming from Africa (29), Asia (12), Latin America and the Caribbean (12) while few came from the Middle East (three on Yemen and one on oPT) and none from the Pacific.

REGION	COUNTRY (# OF STUDIES)
Africa (West)	Burkina Faso (5), Mali (1), Niger (5), Togo (1)
Africa (South)	Zambia (2)
Africa (East)	Ethiopia (6), Kenya (3); Somalia (5), South Sudan (1)
Africa (Central)	Burundi (1); Cameroun (1); Central African Republic (1), Nigeria (2)
Asia (South)	Bangladesh (2), India (1), Nepal (3), Pakistan (4)
Asia (South East)	Myanmar (1), Indonesia (1)
Central America and the Caribbean	Honduras (1), Mexico (1), Nicaragua (1), Haiti (2)
South America	Bolivia (2), Brazil (6), Colombia (1), Ecuador (1), Uruguay (1)
Middle East	Yemen (3), oPT (1)



Number of Studies by Country

- Africa - 5 to 6 studies
- Africa - 3 studies
- Africa - 1 study
- Asia - 4 studies
- Asia - 2 to 3 studies
- Asia - 1 study
- Americas - 6 studies
- Americas - 2 studies
- Americas - 1 study
- Middle East - 3 studies
- Middle East - 1 study (oPT)

Key informants consultations

Key Informant Interviews (six KIIs with 10 interviewees) and **Focus Group Discussions** (two FGDs with 14 participants) were conducted to address evidence gaps identified during the literature review. The selection of these 24 KIIs ensured a diverse range of insights from different I/LNGOs, UN agencies, from various countries of operations, and from headquarters and field teams. One limitation is that KIIs focused on nutrition programmers, while it would have been beneficial from speaking with members from the food security cluster and the nutrition cluster at country level, potentially bringing in documents to complement operational learning.

1. KEY FINDINGS

Key findings are presented by outcomes as expressed in the PICO table used during the literature review exercise, and include findings related to contextual adaptations and modalities comparison. This allows highlighting evidence gaps, research needs and operational recommendations.

1.1 "CVA FOR FOOD" IMPACT ON THE PREVENTION OF WASTING AND RISK OF POOR GROWTH AND DEVELOPMENT

The review provides an **established evidence**, yet in a field marked by considerable heterogeneity and methodological weaknesses, both regarding program implementation, research design, and outcomes analyzed that **CVA interventions can have significant positive impacts on preventing wasting and poor growth and development in children under five**. There is **limited evidence** on such interventions' impact on **preventing MAM among PBWGs**.

Prevention of wasting and risk of poor growth and development among children under 5

CVA interventions aimed at enhancing access to local, nutritious foods or specially formulated foods **can prevent wasting and poor growth and development among children under 5**, as established by 16 studies across 13 countries [1 to 16]. These individual studies were further supported by five additional literature reviews [17 to 21] among which the latest one [18] that reviewed 129 studies and concludes that "cash transfer programmes improved linear growth among young children, reducing wasting and stunting, but effects are heterogeneous and somewhat small overall". Providing a light nuance to this established evidence, nine studies [22 to 28; 30] from seven countries and one literature review [29] found negligible impacts, or failed to find positive impact of CVA interventions on the prevention of wasting and poor growth and development in targeted groups. These findings highlight the **importance of good programme design and implementation practices to expect impact on nutritional outcomes**. In terms of **restriction applied to the modality** (cash, voucher or mix), there **is a limited evidence** regarding the impact from **Voucher Assistance**; as two studies (references [6] looking at WHZ and [10] looking at MUAC] from two countries showed positive impacts, and one study [23] from one country found negligible impact of conditional vouchers on MUAC. Last, as showed by two studies [22 and 23] from two countries there is **a limited evidence of negligible impacts from a mixed approach** combining either cash and voucher [22] or combining cash, voucher and in-kind food assistance [23]. This further highlights the need for more research on vouchers or combined modalities.

In terms of outcomes, **various positive outcomes** were observed: lowered incidence of wasting (one study), reduced prevalence of MAM (six studies), reduced prevalence of wasting (12 studies), improvement in Weight-for-Height Z-score (four studies and two literature reviews), improvement in Weight-for-Age Z-score (two studies and one literature review), improvements in MUAC (four studies) and reduction in underweight (four studies).

Looking at **the programmatic approach** adopted (CVA as a stand-alone intervention or combined with complementary elements, known as "Cash Plus" approach), findings provide **emerging evidence that Cash Transfers can have a positive impact even when provided as a stand-alone intervention**. This is supported by six studies [1, 4, 5, 6, 11 and 12] in five countries, while four studies [2, 22, 25 and 26] in four countries showed negligible impact. There is as well limited evidence that Cash Transfers associated with SBCC only has a positive impact (two studies 8 and 11 in two countries) or even a negligible impact (one study 27 in five countries). This suggests that **Cash Transfers and SBCC should be combined with other elements to have the desired impact**, as established by 10 studies [2, 3, 7-9, 11, 13-16] from 10 countries and by the latest literature review [18]. These complementary components include, on top of SBCC, elements such as implementing cooking demonstrations, or providing supplementary food, fortified flour or micronutrients, livelihoods/assets transfer and capacity building, or assuring the quality of health services and attendance (growth monitoring, screening, vaccination, capacity building of local health system actors, etc.). One study [11] offers evidence against the importance of SBCC, finding that an intervention providing Cash Transfer with SBCC and an intervention providing Cash Transfer alone each reduced the prevalence of MAM, with negligible differences between the two. Conversely, only two studies [22 and 28] reviewed one same intervention in Somalia which combined Cash Transfers with components designed to improve access to safe water and found negligible impact: this stands as a considerable gap in the literature. For **Vouchers Assistance**, there are too few studies [6, 10 and 23] to set evidence. The same limitation applies to mixed approaches with two studies [22 and 23] from two countries.

Looking at the **conditions applied to the chosen modality** (unconditional or conditional CVA), findings provide an **established evidence that both Unconditional Cash Transfers** (UCT) as supported by nine studies [1, 2, 4-6, 11, 12, 15 and 16] from seven countries, **and Conditional Cash Transfers** (CCT) as supported by six studies [3, 7-9, 13 and 14] from seven countries, **have a positive impact**. Looking at the complexity to put in place conditions, these findings suggest that a simpler "unconditional" approach (even when conditions are set as soft ones) would be as beneficial as a "conditional" one. However, there is as well an emerging evidence, supported by five studies [2, 22 and 25-27] in five countries, that UCT have a negligible impact, once again highlighting the complexity of the evidence base.

In terms of **studied population**, the majority of studies [12 studies 1, 4, 6, 9, 12-16, 26, 27, 31 from 14 countries] examined **children under five years of age**, without examining different age groups within this five-year range, thus not indicating if the effects were felt more prominently by older or younger children, or neither. Other 11 studies [2, 3, 5, 7, 8, 10, 11, 22, 24, 25, and 30] from 12 countries examined eight different specific age groups, not being able to provide established evidence for any specific group due to the limited number of studies. Last, only one study [15] showed different impacts among age groups examined impacts on different age groups and found an unconditional cash transfer program in Nepal contributed to a significant reduction in the prevalence of wasting among children 24-59 months old, but no impact for children younger than 24 months.

Last, in terms of **context**, there is emerging evidence that **CVA interventions** (four Cash Transfers, two Vouchers Assistance) **can have a positive impact** on the prevention of wasting and poor growth and development, **even in countries experiencing acute food crisis**, with high levels of food insecurity and malnutrition, as supported by six studies from four countries (Yemen, Somalia, Pakistan and Niger) and one literature review [32].

Prevention of wasting among Pregnant and Breastfeeding Women and Girls (PBWGs)

Only two studies examined the impact of CVA on the prevention of wasting among PBWGs, indicating a clear literature gap. The two studies compared different modalities: one in Somalia [31], comparing a food vouchers intervention to a mixed approach intervention (in-kind food, vouchers and cash) and showing an improvement in MUAC in both groups; the second in Nepal [33], comparing the impact on MUAC of PBWGs of an Unconditional Cash Transfer (UCT) versus an-kind food distribution, both being complemented with SBCC and capacity building of local health workers. Findings showed better results with the UCT intervention.

1.2 "CVA FOR FOOD" IMPACT ON THE MANAGEMENT OF MODERATE ACUTE MALNUTRITION (MAM)

Only three studies from three countries looked at CVA used to enhance access to food to support MAM management. MAM management is understood here as supporting patients during the management, but as well supporting the prevention of relapse after discharge.

Among these studies, only one was published as in a peer-reviewed scientific journal [34]. It examined the impacts of **Conditional Commodity Food Voucher** on recovery from MAM (defined as MUAC between 115mm and 124 mm) among children aged 6-59 months old in Northern Cameroon. This was a prospective study with 474 MAM children aged 6–59 months led by Helen Keller International. Food voucher distribution, yet no provision of specially formulated foods, and MUAC screening were conducted at 6 bi-weekly visits or until the child was recovered. MAM children were enrolled in a Conditional Commodity Food Voucher in which caretakers received a voucher valued at 8,000 FCFA (~ USD 15) at each visit, redeemable for a standardized basket of locally available foods from a designated vendor. The food basket, designed using NutVal to meet energy and micronutrient needs and to account for expected intra-household sharing, included eggs (750 g), fruits (750 g), vegetables (750 g), milk (4,500 ml), sugar (450 g), oil (450 g), and red millet flour (1,500 g). Beyond food provision, the intervention incorporated behavior change components: caretakers participated in group discussions on essential nutrition and hygiene practices, attended cooking demonstrations using voucher foods, and received fortnightly home visits from community health workers to reinforce messages and monitor food use. Caretakers were also required to bring their child back to the health center every two weeks for a medical check-up and to collect the next voucher, ensuring continuous follow-up throughout the recovery period. The results obtained were within the acceptable range of Global Sphere standards for moderate acute malnutrition.

The other study, performed by Concern Worldwide on its pilot project in Ethiopia, and published in the technical journal Field Exchange [35], examined the impact of **Fresh Food Vouchers (FFV) associated with SBCC, cooking demonstrations and supplementary feeding** on MAM management. Based on the national guidelines, children were admitted to TSFP with mid-upper arm circumference (MUAC) between 110 mm and < 120 mm and PLW with MUAC < 210 mm. The ration provided as part of the TSFP consisted of 6.25 kg of CSB/Famix premixed with 1 liter of vegetable oil per beneficiary per month. Because TSFP rations were frequently shared within households due to high levels of food insecurity, reducing their nutritional impact on the target child, the FFV intervention was introduced to complement the TSFP by providing additional fresh, nutrient-rich foods directly to beneficiaries. The FFV intervention was implemented in addition to the standard TSFP, meaning that all eligible children and PLW received both the regular TSFP ration and the FFV. To complement the TSFP ration, beneficiaries received a weekly FFV that could be redeemed for fresh foods. A weekly distribution schedule was established to align

with the existing fortnightly TSFP visit. Each beneficiary household received weekly voucher equivalent to 2 eggs, 4 kg of fruits, and 3.5 kg of vegetables, with ration sizes based on recommended daily intake for children aged 6–59 months and adjusted for an expected two to three young children per household as well as intra-household sharing due to high food insecurity. PLW received the same FFV ration as children under five. All children discharged from OTP were also admitted into the TSFP and thus benefited from FFV. The program recorded a 86% cured rate, with <1% defaulter rate, <1% death rate, and 13% non-response rate. The mean IDDS changed from 1.96 at admission to 4.17 at discharge and the proportion of children who received more than four food groups increased from 4.2% to 71.4%. The FFV project was well received by communities and the project's participants reported health and nutrition benefits for their children above those from the TSFP alone.

A last study was a report produced Action Against Hunger UK's Monitoring, Evaluation, Accountability and Learning Services for World Vision, on a project led by World Vision in South Sudan in 2019 [36]. In this project, highly vulnerable urban households in Juba received **Conditional Cash Transfer for food and for health, associated with medical treatment and livelihoods capacity building**. Around 30% of all beneficiaries were identified through nutrition services as having a child with MAM or SAM. Eligible households received a monthly conditional cash transfer of USD 45 for six consecutive months, with payments strictly conditional upon attending monthly behavior change and skills-building sessions covering nutrition, hygiene/WASH, home gardening, protection, and basic business skills. The transfer aimed to boost purchasing power for food and health expenses while also supporting longer-term resilience through livelihoods training. Beneficiaries were routinely counselled to use the cash for nutritious foods and essential health-related costs, while also investing part of the transfer in small income-generating activities. Generally, it appeared that the additional purchasing power of cash for food and medical fees, combined with clinical treatment programs for malnutrition and behavior change sessions related to hygiene and nutrition, has led to improved health among mothers and children, and has helped to reduce malnutrition relapse rates among children under five.

1.3 "CVA FOR FOOD" IMPACT ON LOW BIRTH WEIGHT AND CHILD MORTALITY

Low Birth Weight

Two studies from two countries found a **positive impact of Cash Transfers on birth weight**, showing that unconditional cash transfers [37] in Uruguay or conditional cash transfers combined with MNCH interventions [38] in Brazil, reduced the likelihood of Low Birth Weight (LBW)[1]. Three literature reviews supported these findings [20, 39 and 40]; as LBW contributes to a higher risk of wasting and poor growth and development in children up to 23 months old, these findings contribute to those discussed above, further establishing the ability of CVA to prevent acute malnutrition.

However, neither of the identified studies, and none of the literature reviews, showed positive impacts on LBW from interventions providing vouchers, again, establishing this as a literature gap.

1 Low birth weight has been defined by WHO as weight at birth of < 2500 grams (5.5 pounds).

Child Mortality

There is an emerging evidence of the positive impacts of Cash Transfer interventions on child mortality as found in four studies [41-44] from three countries (Bolivia, Nigeria and Brazil, and supported by three literature reviews [20, 39 and 45]. No study examined the impact of vouchers assistance on this specific outcome. Therefore, this rather limited number of studies researching into the impact of CVA for food on child mortality can be seen as a gap in the literature, particularly as compared to the number of researches which established the evidence of CVA positive impacts on the prevention of MAM in children under five.

In terms of programmatic **approaches and conditions**, all four studies looked at Conditional Cash Transfers (CCT) as part of a Cash Plus approach: in Brazil and Bolivia, conditions included participating in preventative services including antenatal visits, assisted births, postnatal visits, up to 12 child health visits in the first two years of life, vaccination etc. In Nigeria, the study was made on a comprehensive CVA+ program which combined CCT (conditional on enrollment and attendance at a health center), with micronutrient supplementation and the provision of insecticide-treated nets, as well as SBC on breastfeeding, complementary feeding, and management of malnutrition.

In addition, one study [46] used a forecasting model to estimate the impacts of replacing in-kind food aid distribution policies with "cash-based interventions" that included both cash (conditional and unconditional) and vouchers in Northern Kenya, finding that doing so would provide a 16.2% relative reduction in child mortality. This study supports findings [23 and 31] indicating that CVA interventions can be equally impactful, and possibly more cost-effective, than food aid interventions.

In terms of **studied population**, studies included a variety of target groups and findings suggest that CCT programs combined with other elements may reduce child mortality for different age groups. Three studies [42, 43 and 46] showed reductions in child mortality in children under five, while one study [44] and two literature reviews [20 and 45] showed CVA lowering infant mortality (under one year), one study [41] showed a reduction in stillbirths, and one literature review [39] showed reductions in neonatal mortality (under four weeks).

1.4 "CVA FOR FOOD" IMPACT ON INDIVIDUAL DIET DIVERSITY

Individual Diet Diversity among children under 5

There is an **established evidence** supported by 20 studies [3, 8, 11, 28, 35, 42, 47-60] from 16 countries that **CVA interventions can have a positive statistically significant impact on children under 5 dietary diversity**, which is crucial for child health. The studies were supported by additional three literature reviews [18, 19 and 61], positioning the ability of CVA to improve the dietary diversity of children as established evidence. Conversely, several studies [11, 23, 48, 60 and 62] from five countries failed to find positive impacts of CVA programs on the child dietary diversity, providing a modest retort to the established evidence offered by other studies.

In terms of **outcomes**, positive impacts were observed either in terms of improvement of the child **IDDS** (12 studies and three literature reviews), or improvements in children meeting **MDD** (three studies) or **MAD** (seven studies).

Examining the findings by **modality and the restrictions applied (cash or voucher)**, there is **established evidence that Cash Transfers have a positive impact on child diet diversity**, as supported by 13 studies from ten countries [3, 8, 11, 28, 42, 47, 50-52, 55, 56, 58 and 59], while two studies [11 and 48] from two countries found negligible impacts. There is as well **emerging evidence of the positive impact of vouchers assistance on diet diversity**, supported by seven studies [35, 48, 49, 53, 54, 57 and 60] from seven countries, while few studies [23, 60 and 62] from three countries failed to find positive impacts. Last, each of the three literature reviews showed positive impacts from CVA in general providing a more balanced view of the impacts of the different modalities on children's dietary diversity.

In terms of **programmatic approaches**, and examining the added-value to associate complementary elements or not to achieve the desired impact, there is **emerging evidence that Cash Transfer alone could have an impact**, as supported by four studies [47, 50-52] in three countries. There is as well emerging evidence that **Cash Transfers combined with SBCC on nutrition and health only could have positive impact** as supported by four studies [3, 11, 55 and 59] in four countries. Taken together with other studies that examined various combination of complementary elements [28] including to SBCC (four studies 8, 42, 56 and 58 from four countries), these findings contribute to **establish evidence that programs which combined Cash Transfers, SBCC related to nutrition and additional components showed positive impacts on the dietary diversity of children under five**. Additional components to SBCC vary from one country to the other, and include cooking demonstrations, support to local market/supply chain, health support (malaria, diarrhea, or pneumonia treatment), NFI items or mosquito nets, micronutrients or supplementary food, household social assistance, or piped water.

When looking at **Vouchers Assistance**, there is **limited evidence that vouchers alone can have the desired impact on child diet diversity** (two studies 49 and 53 from six countries). Two studies from two countries even showed negligible impact [23 and 60]. There is an **emerging evidence of Voucher Assistance positive impact, when associated with SBC** (four studies 35, 48, 54 and 60 from two countries), or with SBC combined with other elements [57] (in one country).

Several studies [11, 48, 54, 55 and 60] directly **compared different combination of modalities and approaches**. Two studies [11 and 55] found that combining Cash Transfers with an SBC component had significantly higher positive impacts on child dietary diversity than the provision of Cash Transfers alone. Looking at interventions combining Vouchers Assistance and SBC, findings provide similar results : one study [60] found that **combining food vouchers with an SBC** component increased dietary diversity children under 5 (IDDS, MDD and MAD), while vouchers alone had no effect on any of these measurements ; another one study [54] showed that combining SBCC with food vouchers increased IDDS of children by 21.0%-23.1%, noting that increased paternal involvement does not necessarily translate into improvements in child feeding outcomes. However one study [48] directly compared fresh food vouchers to cash transfers, both conditional on attendance to what was called "nutrition education classes", finding that **nutrition education was not as significant of a factor at promoting nutritious food choices as vouchers** which provided no other option than to be exchanged for nutritious foods. Similarly, one study in Haiti reported that children targeted by the fresh food voucher program experienced reduced consumption of nutritious foods at the same time as overall household dietary diversity scores for beneficiary households increased, despite the intervention was combining food vouchers and nutrition-focused SBCC. This underscores the importance of tracking program impacts on different groups, and particularly those targeted by programs, in order to gauge whether there are different impacts between groups from the same intervention. Moreover, **understanding the intra-household decision-making dynamics that underlie this is an important area for future research**.

In terms of **conditionality**, findings establish the evidence that UCT (12 studies [11, 28, 47, 50-52, 55, 58, 59] in nine countries) or Unconditional Voucher Assistance (three studies [35, 56 and 60] in two countries) have a positive impact on child diet diversity while there is limited evidence of their negligible impact. There is emerging evidence that CCT (three studies [3, 8 and 42] in three countries), or Conditional Voucher Assistance (one study [48] in one country) have a positive impact as well. Given the complexity to set conditions, **findings suggest to opt for unconditional assistance, associated with complementary components to ensure the objective is achieved**.

In terms of **studied population**, the findings suggest that CVA can promote dietary diversity in both younger and older children under five.

In terms of **contexts**, three studies [3, 51 and 53] showed improvements in children's dietary diversity even during times when the availability and accessibility of food was under threat in local markets (Burkina Faso, Bolivia and Niger).

Individual Diet Diversity among Pregnant and Breastfeeding Women and Girls (PBWGs)

This review highlights a lack of literature examining the impacts of CVA programs, and especially Vouchers Assistance, on the nutrition of PBWGs, compared to impact on children under 5. However, despite this limit, the **positive impact of CVA in improving the dietary diversity of PBWGs is established** by six studies [8, 10, 11, 33, 36 and 57] from seven countries.

In terms of **outcomes**, three studies showed increases in the proportion of PBWGs reaching MDD-W while three showed improvements in the IDDS of PBWGs.

In terms of **modalities** (cash or vouchers), four studies from four countries examined the impact of Cash Transfers [8, 11, 33, 36] and three studies from three countries examined Vouchers Assistance [10, 57 and 62].

In terms of **programmatic approaches** (conditionality, complementary activities), findings suggest that **CVA alone will not have the desired impact on PBWGs dietary diversity**: one study found that an UCT had negligible impacts on the MDD-W of PBWGs in Myanmar [11]. Cash Transfers associated with SBCC related to nutrition showed more positive impacts as supported by three studies [8, 11, 36] ; one study [10] showed a positive impact from the association of Vouchers and SBC only. Last, positive impacts were found from programs combining Cash [33] or Vouchers [57], with SBCC and other components. Other complementary components include provision of micronutrient or mosquito nets, capacity building of local community health workers or local retailers, or support to address women depression and anxiety. Findings therefore provide **emerging evidence of the added value of a comprehensive or "cash plus" approach**. However, one study from Haiti [62] underscores the importance of tracking program impacts on different groups, and particularly those targeted by programs, in order to gauge whether there are different impacts between groups from the same intervention. Moreover, understanding the intra-household decision-making dynamics that underlie this is an important area for future research.

Conversely, as only two studies [11 and 33] directly compared the effectiveness of interventions which combined CVA and SBCC only with interventions providing CVA alone, the evidence generated that combining CVA with an SBCC component only can have significantly greater impacts on the dietary diversity of PBWGs than CVA alone, can only be considered as "limited".

2. CONCLUSIONS

The document presents a nuanced and comprehensive analysis of the impact of CVA for food interventions on nutrition outcomes.

It concludes that CVA can positively influence the **prevention of wasting and poor growth** in children under five, even though some few studies report negligible effects, underscoring that programme characteristics influence programme effectiveness. Only two studies examined the impact of CVA on the prevention of wasting among PBWGs, indicating a clear literature gap.

Cash transfers generally demonstrate stronger and more consistent positive outcomes than vouchers or mixed modalities, which lack sufficient evidence of impact, highlighting a gap in the literature. However, the effectiveness of CVA is significantly enhanced when combined with complementary components such as Social and Behavior Change Communication (SBCC), supplementary food, health services, and other supportive measures. These "Cash Plus" approaches tend to yield better results than CVA alone.

Both unconditional and conditional cash transfers have shown positive impacts, but given the complexity of implementing conditions, unconditional assistance may be equally beneficial and more practical. The evidence also suggests that CVA interventions can be effective even in crisis contexts with high levels of food insecurity and malnutrition.

In terms of **managing Moderate Acute Malnutrition** (MAM), although CVA should be considered for improving access to nutritious home food, to support recovery and prevent relapse, there is still a lack of evidence on its effectiveness, since there is a dearth of studies on this topic. However, the little evidence available indicates positive impact, especially when integrated with health and nutrition services.

Regarding **low birth weight and child mortality**, cash transfers—particularly when conditional and part of a broader health-focused program—have shown promising results.

Dietary diversity among children under five is one of the most well-supported outcomes, with numerous studies confirming the positive influence of CVA. Cash transfers again show stronger results than vouchers, and the inclusion of SBCC and other components further enhances effectiveness. However, some studies report negligible or fail to find positive impacts, pointing to the importance of program design and implementation. For

pregnant and breastfeeding women and girls (PBWGs), the evidence is more limited but suggests that CVA alone may not be sufficient to improve dietary diversity. Programs that combine CVA with SBCC and additional support services appear to be more effective. The literature also reveals a need for more studies focusing specifically on PBWGs and their nutritional outcomes.

Overall, the findings emphasize that CVA interventions can be impactful, but **their success depends heavily on the modality, conditionality, complementary components, and contextual factors**. While there is existing guidance for implementation, some of the implementation issues KIIs flagged may suggest areas where additional guidance, coordination or learning may be helpful.

There are **clear gaps in the evidence base**, particularly concerning vouchers, age-specific impacts, and intra-household dynamics, which future research should aim to address. There is more work to be done to get people aware of the potential of CVA for nutrition in some contexts, even though overall there is good evidence for the use of CVA for nutrition. We need to be clear however on what we mean by CVA for nutrition outcomes, since CVA can impact through numerous pathways, including the "food route".

3. RECOMMENDATIONS

3.1 EVIDENCE GAP AND RESEARCH RECOMMENDATIONS

A more representative research to understand specific population groups and regions needs

Only nine studies examined the **impacts of CVA on PBWG via the food route**, eight looking at its impact on improving PBWGS's dietary diversity, and two looking at its impact on the prevention of wasting. This stands as a notable gap in the literature, in contrast to the number of studies examining the impact of CVA on children under 5 and highlights the need for further research on this target group.

The studies which measured the impacts of CVA interventions on preventing wasting and poor growth and development among children under five often **lacked disaggregated data for specific age groups**. Future research is needed which takes a more targeted approach to different age sub-groups among children under five[1]: this will help determine when CVA interventions are most impactful on the prevention of wasting and poor growth and development among children, as one study showed different impacts. This need is further supported by the fact that findings suggest that CVA can promote dietary diversity in both younger and older children under five.

Looking at the impact of CVA for food on PBWGs (including adolescent mothers) and children under two age groups, would reinforce evidence on the 1,000 days window of opportunity.

Last, research should include **underrepresented regions like Central and South America, the Middle East and the Pacific** to strengthen the evidence base.

Filling the research gap on Management of MAM through CVA via the food route

Only three studies [34, 35 and 36] were found by this review examining the specific impacts of CVA through the food route on **recovery from MAM among children under 5.** This stands as a notable gap in the literature, in contrast to the established evidence of the impacts of CVA on the prevention of MAM. It also indicates a significant research gap especially in light of WHO's 2023 guidance emphasizing the importance of access to nutrient-dense diets for children with MAM.

1 It is important to note that to be able to analyze further by smaller age group, the sampling / number of children will need to be large enough to be able to draw conclusions from the analysis.

WHO Good practice statement B11

Infants and children aged 6–59 months of age with moderate wasting (defined as a weight for-height between 2 and 3 z-scores below the WHO child growth standards median and/or a mid upper arm circumference 115 mm or more and less than 125 mm, without oedema) should have ***access to a nutrient-dense diet to fully meet their extra needs for recovery of weight and height and for improved survival, health, and development***.

The 2023 WHO guideline identifies several research gaps related to the use of locally available foods in the management of MAM in children. These include the need to better understand the nutrient requirements of MAM children and to evaluate the efficacy of home foods across different contexts.

Future guidance on the management of MAM with CVA must be grounded in stronger and more methodologically robust research. Strengthening the global evidence base is essential for informing future WHO recommendations and ensuring that the management of MAM through the food route is both effective and feasible in diverse contexts. Achieving this higher standard of evidence will require greater harmonisation of how recovery is measured in programmes relying on local foods, given the current inconsistencies in MUAC thresholds, follow-up periods, and dietary assessment methods. It will also require the consistent use of standard, globally recommended indicators to assess dietary adequacy when CVA is used to enhance access to home foods, as inconsistent application or non-collection of these indicators continues to limit comparability across studies and restricts learning.

Building on this, future research should explore how the management of MAM through the food route can be effectively integrated within national health systems. A deeper understanding is also needed of how market functionality, price volatility, and seasonality shape the capacity of CVA to sustain access to nutrient-dense foods, particularly in contexts where food environments are unstable. In parallel, rigorous cost-effectiveness analyses comparing CVA approaches with Specially Formulated Foods should be prioritised, given the absence of solid evidence to guide investment decisions.

As this research agenda advances, it will be critical to ensure that studies simultaneously address issues of food safety, hygiene, and consistency of nutrient intake in household diets supported through CVA, particularly where reliance on home-prepared foods is being promoted. Equally important is generating operational evidence on how caregivers actually use CVA transfers, including purchasing patterns, intra-household allocation of food, and practical barriers that may constrain optimal feeding practices. These efforts must be supported by strong formative research to confirm which local foods and recipes are appropriate, acceptable, and feasible for caregivers to use before the start of program. These areas of inquiry will be essential for developing future guidance that supports safe, effective, and context-appropriate management of MAM through CVA and locally available foods.

In addition to these formal research priorities, KII conducted for this review highlighted a lack of operational guidance on how, when, and under what conditions local foods can be used effectively to manage MAM. While WHO guidance acknowledges the potential of local foods, there is limited clarity on practical implementation, such as how to adjust recipe portions based on child weight or determine appropriate kcal/kg targets, or proportion of the total daily energy requirements which should be supplied through supplementary foods, depending on context.

Access to "local" and "nutritious" food: how to assess, what to assess?

Only **one study [8]** directly examined the specific impact of CVA on access to or use of **local nutritious foods, looking at expenditure patterns at household level**. Studies which show positive impacts generated by cash for food programs do not indicate whether, or how greatly, impacts can be attributed to the utilization of nutritious foods, compared to cash being spent to address other needs. Future research should include both quantitative and qualitative indicators to evaluate not only access but also utilization of nutritious foods (expenditure patterns, intra-household decision-making and consumption patterns), and the specific type of food (distinction between food, fresh food or specific products/fortified flours etc.) and the most impactful food made accessible through cash or vouchers (highlighting the type of food that is most impactful for different age groups for instance).

The WHO remarks that

- Nutrient-dense foods are those high in nutrients relative to their energy content; they have a relatively high content of vitamins, minerals, essential amino acids and healthy fats. Examples of nutrient-dense foods include animal source foods, beans, nuts and many fruits and vegetables.

- Nutrient-dense foods enable children to consume and maximize the absorption of nutrients in order to fulfil their requirements for energy and all essential nutrients. Animal-source foods are more likely to meet the amino acid and other nutrient needs of recovering children. Plant-source foods, in particular legumes or a combination of cereals and legumes, also have high-quality proteins, although they also contain some anti-nutrients such as phytates, tannins or inhibitors of digestive enzymes, which may limit the absorption of some micronutrients, particularly minerals.

- Adequate locally available diets include foods available in the market and/or household typically consumed by the child that are adequate in terms of nutrients.

Does modality matters? Comparing cash, commodity vouchers and value vouchers

Looking at modalities, while this review found 35 outcomes provided by cash interventions, it identified only 16 interventions showing outcomes from vouchers (not always specifying if these were value or commodity vouchers), and only three compared cash to vouchers [6, 22 and 48]. This gap is specifically valid for the impact of vouchers on preventing wasting and poor growth and development, and on LBW.

Vouchers are seen as more effective for achieving specific nutrition outcomes since they can specify that recipients receive nutritious food, while cash interventions are more flexible, allowing recipients to spend as they see fit (USAID, 2023), providing a critical distinction between modalities under the broad umbrella of CVA interventions. **Future research should therefore directly compare cash and vouchers (value and commodity) within specific interventions to determine whether one or the other is more effective at providing desired outcomes in specific contexts; this is all the truer in crisis situations as in such context multipurpose cash is seen as the by default modality, whereas fresh food vouchers are expected to be more effective in achieving nutritional specific outcomes**.

The other comparative studies [23, 31, 33 and 46] compare a wide range of combination: food vouchers to a mix of cash, food vouchers to in-kind assistance [23 and 31], or cash or CVA to in kind assistance [33 and 46]. Findings suggest that **modality matters**, but the too limited number of comparative studies prevents firm conclusions and more evidence is needed. **Comparative studies between cash/voucher modalities and in-kind aid, especially in crisis contexts (where appropriate and safe to do so) are also needed to understand their relative effectiveness**.

Assessing the specific contribution of SBC and other "complementary components"

Last, **investigating the specific role of complementary components** such as SBC, support to access to health services, and agricultural support is essential to assess the specific impact of CVA within this large spectrum of interventions. Assess combinations of CVA modalities with SBC and / or other complementary components will help to determine optimal configurations. The findings indicate a wide variety of potential components can be combined alongside cash or vouchers to contribute to positive outcomes.

Findings from studies examining impact of CVA on child mortality suggest that comprehensive CVA packages may be required to achieve positive impacts, but further research is required to understand **how less comprehensive CVA+ interventions may impact child mortality**, alongside how they might impact mortality of more targeted age groups.

Future research should **examine interventions which combine cash or vouchers, or cash and vouchers, with a variety of additional components** in order to ascertain which combination of components is most effective in different contexts. Further comparative studies are therefore needed. This could include research looking at both modalities combined within specific interventions with the same components, as only five studies [2, 11, 54, 57 and 60] have compared different combination of modalities, yielding mixed evidence. Research looking at SBC more specifically (what type of intervention, what target group, etc.) could help strengthen emerging evidence: for instance as only one study findings suggest that increased paternal involvement does not necessarily translate into improvements in child feeding outcomes, understanding the intra-household decision-making dynamics that underlie this is an important area for future research.

Last, it would be highly valuable to expand the scope of future research to examine the impact of **combining CVA interventions with public health interventions** that improve access to comprehensive MNCH care, such as antenatal services, skilled birth attendance, and support for managing pregnancy-related conditions. During the design of the program, an assessment could be conducted to identify the main factors contributing to preterm birth and low birth weight in specific contexts. Understanding the underlying cause, whether medical, nutritional, environmental, or socioeconomic, is essential for designing effective CVA-linked interventions. Such assessments can inform the integration of MNCH services, ensuring that assistance is tailored to address the most pressing risks and barriers to healthy pregnancy outcomes. These infections during pregnancy are significant contributors to low birth weight, which increases the risk of malnutrition in children. The same applies for interventions combining CVA for food with SBC and water-support interventions. Integrating this dimension could enhance the effectiveness of CVA by addressing underlying causes of malnutrition.

3.2 OPERATIONAL RECOMMENDATIONS

Based on the above mentioned findings, and especially looking at the discrepancies in establishing evidence of CVA or CVA + SBC and other complementary interventions' impact on preventing wasting or managing MAM, it is suggested that **context, implementation quality, and complementary components play critical roles. While guidance on CVA implementation—covering targeting, duration, and modality—exists, its application is often inconsistent due to the unpredictable and resource-constrained nature of humanitarian settings. Flexibility and guidance contextual adaptation to humanitarian realities are essential**.

Context Analysis and understanding the impact pathways

The intervention design should be based on a fair understanding of the most likely impact pathways in the communities targeted by the intervention. Socio-economic or socio-anthropological studies are needed for designing the intervention that is the most impactful, clearly establishing impact pathways.

Targeting Strategies

Targeting must be context-specific, reflecting local vulnerabilities and cultural norms. Nutrition-sensitive indicators should be integrated into targeting criteria, including anthropometric measures and dietary diversity scores. Multi-layered targeting may be necessary, starting with broad vulnerable groups and households, and refining to specific individuals such as children under five and PBWGs.

Timing and Duration of Interventions

Interventions should align with seasonal patterns (e.g., lean seasons) and crisis cycles (in anticipation, in prevention or in response to a shock) or other periods of heightened vulnerability. Early warning systems and anticipatory action frameworks should inform program design. If SBC components are included, it requires sustained engagement—typically more than three months—to influence behavior meaningfully. KIIs emphasized that short-term SBC efforts often fail to produce lasting change.

Transfer Value and Market Considerations

Transfer values must be based on the actual cost of a nutritious diet among other basic needs, and be flexible to adjust for inflation and market volatility. Market functionality is a prerequisite for CVA success. Market assessments should evaluate availability and affordability of healthy, safe and nutritious food, as well as supply chain reliability over time. Tools and methodologies must be adapted to capture local food diversity, local food environment, and people's preferences.

Integration of Complementary Components

It is recommended to integrate complementary components. SBC is a critical component and should be context-specific, sustained, and well-timed, all critical for effectiveness. It should begin before CVA distribution and continue throughout the intervention. Moreover, clarity is needed on its sequencing, and content. It should be integrated with other complementary components such as micronutrient supplementation, agricultural inputs and training or other livelihoods support, health services (e.g., maternal care, treatment of infections), psychosocial support, and WASH interventions.

Physical and Technological Barriers

Moreover, actions should be put in place to lift physical and technological barriers; access to financial services included transportation costs or delivery tools (mobile phone for instance) should be addressed (and even included in the transfer value or the program itself). Strengthening financial literacy among project participants is also critical to ensure informed decision-making and optimal use of assistance.

Monitoring, Evaluation, and Sustainability

Monitoring frameworks should be revisited to include intermediate indicators and clearly defined impact pathways that link CVA inputs to expected outcomes. Long-term indicators like child mortality may not be suitable for short-term interventions (e.g., 6 months). Instead, it is recommended to use anthropometric indicators to monitor nutritional impact, alongside intermediate indicators such as psychosocial wellbeing of caregivers and households, individual food consumption behaviors, and individual-level metrics like Minimum Dietary Diversity (MDD) and MDD-Women (MDD-W), which provide more accurate insights into nutritional outcomes than household-level indicators (like Food Consumption Score FCS).

Mixed findings were found according to the studied age group, underscoring the importance of tracking program impacts on different groups, and particularly those targeted by programs, in order to gauge whether there are different impacts between groups from the same intervention.

Several KIIs noted that positive effects often diminish after distributions end. Sustainability of impact could be ensured through linking CVA recipients to longer-term services. It must be assessed through longitudinal follow-up and post-intervention tracking, to understand lasting effects and inform future programming. In the case of management of MAM, the follow-up would allow to understand the impact of CVA or "Cash Plus" on relapse.

Coordination and Multi-sectoral Collaboration

Nutrition cluster leadership is vital to promote existing guidance[2], support implementation, and ensure coherence with other clusters and across sectors. Common language and collaboration between CVA experts and sectoral experts are needed to align objectives, share understanding and maximize impact and funding.

2 GNC (2023). Learning brief: cash and voucher assistance for nutrition in emergencies a summary of programmatic challenges and promising practices (nutritioncluster.net/sites/nutritioncluster.com/files/2023-11/CVA%20for%20nutrition_challenges-promising%20practices_GNC%20WG_FINAL_Nov2023.pdf); and GNC (2020). Evidence and guidance note on the use of cash and voucher assistance for nutrition outcomes in emergencies (nutritioncluster.net/resources/evidence-and-guidance-note-use-cash-and-voucher-assistance-nutrition-outcomes-emergencies)

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APPENDICES

Appendix 1 / Extraction table Template

This template was used to systematically collect and analyze relevant data from each study included in the review.

1. **Study Identification:** authors, title, year, source (URL/DOI)
2. **Study Characteristics:** Project MEAL Report, Dissertation, Article, Published Research Article, Literature Review, Research Report
3. **Context settings:** region/country, type of intervention (development, humanitarian), additional characteristics (informal settlements, camps, rural/urban, etc.)…
4. **Population**
    - Children by Age Group:
        - Children 0-5 months
        - Children 6-59 months
    - Pregnant and Breastfeeding Women and Girls (PBWG)
5. **Intervention**
    - Type of CVA:
        - Cash
        - Vouchers
        - Conditional/Unconditional
    - Associated Interventions (if any)
6. **Outcomes**
    - Primary Outcomes:
        - For Children 6-59 months:
            - Prevention of wasting
            - Recovery from MAM
        - For Pregnant Women and Girls:
            - Prevention of poor growth
            - Recovery from MAM
        - For Breastfeeding Women and Girls and children <6 months:
            - Prevention of poor growth
            - Recovery from MAM
    - Secondary Outcomes:
        - Anthropometric measures (e.g., WHZ, MUAC)
        - Dietary diversity (MDD-C, MAD, IDDS, MDD-W)
        - Other relevant nutritional or health outcomes
7. **Key Findings**
    - Effectiveness of CVA, main findings, conclusions
    - Differences by CVA modality (if applicable)
    - Lesson learned and recommendations
8. **Limitations Noted by Authors**
9. **Reviewer's Comments**

Appendix 2 / Outcome Prevention of MAM

#	STUDY	INTERVENTION	COMPLEMENT	POPULATION	SAMPLE SIZE	FINDINGS	IMPACT	QUALITY OF EVIDENCE
1	AIR, 2013	UCT		Children under 5	2,515 households	The intervention induced an improvement in the weight of young children, with effects on WHZ and WAZ of about 0.12 SD.The study investigated whether program impacts are different for different age groups among young children and reported a large effect on WHZ among children aged 3-5 years.	POSITIVE	ESTABLISHED EVIDENCE
2	BOUGUEN AND DILLON, 2024	UCT COMPARED TO 2 DIFFERENT UCT+	Cash Transfer Cash+Animal Assets Cash+Animal Assets+Gardening Kit +Nut Food+BCC	6-23 months	3,500 households	T3 only showed significant improvements: Severe wasting: ↓ 46% (from 2.6% to 1.4%) ; The proportion of children with acute malnutrition decreased by 1.2% after one year of the intervention. Severe stunting: ↓ 26–41% Severe underweight: ↓ 31% Weight-for-age and height-for-age scores improved.	POSITIVE	ESTABLISHED EVIDENCE
3	BLISS, 2014	CCT	Mother's attendance of health and education sessions, which include messages on IYCF and hygiene as well as cooking demonstrations	6-24 months	424 children	Children in intervention households gained 1.22 kg more weight on average than those in control households over the 2-month duration of study. WHZ gains associated with the intervention were 1.49 Z on average, and the prevalence of acute malnutrition declined from 40% to <5% among intervention children while remaining approximately 20% among controls.	POSITIVE	ESTABLISHED EVIDENCE
4	ECKER AND AL., 2024	UCT		Children under 5	2,312 households	While a 1 SD increase in armed conflict intensity reduces children's WHZ by 9.6%, the studied cash transfer program mitigated this impact by 42.4%.	POSITIVE	ESTABLISHED EVIDENCE
5	FENN AND AL., 2015	UCT		6-36 months	412 households	Anthropometric measurements (WHZ and MUAC) showed significant improvements (P<0·001) from baseline. The percentage of children with WHZ <−1 to ≥−2 was significantly lower in the final survey (30·0 % v. 45·8 % at baseline; P<0·001)	POSITIVE	ESTABLISHED EVIDENCE
6	FENN AND AL., 2017	UCT COMPARED TO FRESH FOOD VOUCHERS		Children under 5	3,584 households	The odds of a child being wasted were significantly lower in both the unconditional cash and fresh food voucher arms after 6 months compared to the control group. Mean WHZ significantly improved in both the fresh food vouchers and cash arms at 6 months (FFV: z-score = 0.16; 95% CI 0.05, 0.26; p = 0.004; DC: z-score = 0.11; 95% CI 0.00, 0.21; p = 0.05) compared to the control group.	POSITIVE	ESTABLISHED EVIDENCE
7	FERRÉ AND SHARIF, 2014	CCT	Monthly attendance at growth monitoring of children aged 0–36 months, and nutrition session for mother/caregiver	10-22 months	2,718 households	The intervention reduced the share of children with WHZ <2 SD by 40%.	POSITIVE	ESTABLISHED EVIDENCE
8	KURDI AND AL., 2019	CCT	Monthly nutrition education sessions and malnutrition screening	Children under 2	2,000 households	The intervention reduced the share of children reported to have been diagnosed with MAM in the past 2 years by 10% compared to a control group.	POSITIVE	ESTABLISHED EVIDENCE
9	KUSUMA AND AL., 2017	CCT	Not specified (health/education)	Children under 5	14,000 households	The intervention reduced the probability of wasting and severe wasting by 33% and 41%, respectively, compared to the control group.	POSITIVE	ESTABLISHED EVIDENCE
10	LEWIS, 2016	NUTRITIOUS FOOD VOUCHERS+	SBC on nutrition and child feeding, cooking demonstrations	6-24 months	Not available	By the end of the intervention, 65% of children had improved their MUAC score.	POSITIVE	ESTABLISHED EVIDENCE
11	MAFFIOLI AND AL., 2019	UCT COMPARED TO UCT+	SBC covering topics related to nutrition and health	6-29 months	4,972 mothers	The program resulted in a 2.8% reduction in the proportion of MAM children (p < 0.1) from 11% to 8.2% in the proportion of children suffering from MAM in the Cash+SBCC arm. Similarly, we observe a 2.6 percentage point reduction, from 11% to 8.4% (p < 0.1) among children in the Cash-Only arm. This suggests that cash transfers could help reduce wasting.	POSITIVE	ESTABLISHED EVIDENCE
12	MUSTAFA AND AL., 2019	UCT		Children under 5	22,969 households	Using WAZ, the study found that low and very low levels of underweight among children improved from 57.44% to 64.45% during the intervention, while using WHZ, the study found levels of moderate and severe wasting declining over time.	POSITIVE	ESTABLISHED EVIDENCE
13	PAES-SOUSA AND AL., 2011	CCT	Health and nutrition agenda including prenatal care, vaccinations, and health surveillance	Children under 5	22,375 children	Children from families exposed to the intervention were 26% more likely to have normal WAZ than those from families not receiving the intervention.	POSITIVE	ESTABLISHED EVIDENCE

14	PATWARDAN AND AL., 2023	CCT	Micronutrient supplementation, vaccinations for children, counseling sessions for mothers, child is weighed, childbirth is registered	Children under 5	36,257 children-mother dyads	The program reduced child wasting by 7 percentage points, a 39% reduction compared to the average prevalence of wasting in the pre-program period. The reduction in child wasting is driven by children from households in the top four of five national wealth quintiles, for whom the program reduced wasting by 13 percentage points or a reduction of about 80%. Children from households in the bottom wealth quintile were 13 percentage points more likely to suffer from wasting than their wealthier counterparts.	POSITIVE	ESTABLISHED EVIDENCE
15	RENZAHO AND AL., 2017	UCT+	SBC on child nutrition, IYCF, and hygiene, as well as capacity building of local bodies	Children under 5	3,000 households	The intervention resulted in a 7.4% reduction in the prevalence of underweight and a 2.8% reduction in the prevalence of wasting.	POSITIVE	ESTABLISHED EVIDENCE
16	RENZAHO AND AL., 2019	UCT+	SBC on child nutrition, IYCF, and hygiene, as well as capacity building of local bodies	Children under 5	3,647 households	There was a linear growth among children, with a corresponding increase of 0.50 weight-for-age Z-scores and 0.34 weight-for-height Z-scores between the study period, equating to a decline in child undernutrition of 16.5% and 5.1% for underweight and wasting respectively.	POSITIVE	ESTABLISHED EVIDENCE
22	ACTION AGAINST HUNGER, 2017	UCT+ (PAK) VALUE FRESH FOOD VOUCHER + (PAK) CCT+ (SOMALIA) UCT+(NIGER)	Pak : SAM treatment, micronutrient supplementation (children and PLW), and BCC on the causes of undernutrition, IYCF, WASH Niger : SBC + screening Somalia : SBC + NFI + piped water	6-48 months	3,462 children from 2,469 households	No reduction in the prevalence of wasting was recorded for either the cash or voucher interventions. Only the 'double cash' arm provided positive impacts.	NEGLIGIBLE	EMERGING EVIDENCE
23	DOOCY AND AL., 2020	NUTRITIOUS FOOD VOUCHERS COMPARED TO MIX (IN-KIND, UCT AND VOUCHER)		6-59 months	656 households	The prevalence of MAM declined from 11.4% to 9.3% among those receiving food vouchers.	NEGLIGIBLE	EMERGING EVIDENCE
25	HOUNGBE AND AL., 2017	UCT		0-36 months	1,250 children from 1,162 households	No reduction in the incidence of wasting was recorded among beneficiaries in either the intervention or control groups.	NEGLIGIBLE	EMERGING EVIDENCE
26	SIBSON AND AL., 2018	UCT		6-59 months	2,199 children	No changes were recorded in the prevalence of moderate acute malnutrition among beneficiaries, wasting levels remained elevated in both four- and six-month interventions.	NEGLIGIBLE	EMERGING EVIDENCE
27	USAID, 2023	UCT+	SBC on health and nutrition	6-59 months	774 households	There was no improvement in the prevalence of acute malnutrition in the treatment arm versus control.	NEGLIGIBLE	EMERGING EVIDENCE
28	GRIJALVA-ETERNOD CS ET AL.	CCT+	SBC + NFI + piped water	6-59 months	intervention (n = 759) and control (n = 1,379) arms (child cohort)	The CBI did not appear to reduce the risk of acute malnutrition: unadjusted hazard ratio 0.83 (95% CI 0.48; 1.42) and hazard ratio adjusted for age and sex 0.94 (95% CI 0.51; 1.74).	NEGLIGIBLE	EMERGING EVIDENCE
24	HODDINOT AND BASSETT, 2009	CCT	Routine growth monitoring at health facilities	0-36 months	Not given	Impact assessment found one study that showed negative impacts on weight gain, one study that found negligible impacts on weight gain.	FAILED TO FIND POSITIVE IMPACT	LIMITED EVIDENCE
30	LABRECQUE AND AL., 2018	CCT	Monthly SBC nutrition education sessions and malnutrition screening	24-month-old children	1,703 children	Transfer beneficiaries had a reduction in WAZ.	FAILED TO FIND POSITIVE IMPACT	LIMITED EVIDENCE
33	DOOCY AND AL., 2020b	NUTRITIOUS FOOD VOUCHERS		PBWG	514 PBWGs	Mean MUAC increased significantly among women receiving food vouchers (0.9cm, CI: 0.6-1.3, p = 0.001).	POSITIVE	LIMITED EVIDENCE
35	HARRIS-FRY AND AL., 2018	UCT+	SBC on good health during pregnancy and infant health, as well as training provided to local health workers on child health	PBWG	789 households	The mean MUAC of PBWG in the SBC plus cash group was 0.75 higher than the control arm, and 0.26 higher than the SBC plus food group.	POSITIVE	LIMITED EVIDENCE

Appendix 3 / Outcome Management of MAM

#	STUDY	INTERVENTION	COMPLEMENTARY INTERVENTION	POPULATION	SAMPLE SIZE	FINDINGS	IMPACT	QUALITY OF EVIDENCE
34	TETA AND AL., 2023	NUTRITIOUS FOOD VOUCHERS		6-59 months	474 children	The recovery rate from MAM of enrolled children was 78.3%. Children aged 24–53 months were 30% more likely to recover than those aged 6–11 months.	POSITIVE	LIMITED EVIDENCE
35	KUMAR AND AL., 2013	FRESH FOOD VOUCHERS	TSFP ration	6-59 months	250 children	Project's participants reported health and nutrition benefits for their children above those from the TSFP alone.	NEGLIGIBLE	LIMITED EVIDENCE
36	WORLD VISION	CCT+	Cash for Health, Medical Treatment and Livelihoods capacity building	0-6 months	Not mentioned	Improved health among mothers and children, and has helped to reduce malnutrition relapse rates among children under five	POSITIVE	LIMITED EVIDENCE

Appendix 4 / Outcome Low Birth Wight and Child Mortality

LOW BIRTH WEIGHT (LBW)

#	STUDY	INTERVENTION	COMPLEMENTARY INTERVENTION	POPULATION	SAMPLE SIZE	FINDINGS	IMPACT	QUALITY OF EVIDENCE
37	LUCAS AND AL., 2022	CCT	Vaccines for children, medical checkups for PBWG	N/A	5,246,874 individuals	Children born in a household where the mother received the intervention were less likely to have LBW (OR 0.93, CI; 0.92-0.94) or very LBW (0.87, CI; 0.84-0.89).	POSITIVE	LIMITED EVIDENCE
38	AMARANTE AND AL., 2011	UCT		N/A	Not provided	Participation in the intervention led to a 15% reduction in the incidence of LBW.	POSITIVE	LIMITED EVIDENCE

MORTALITY

#	STUDY	INTERVENTION	COMPLEMENTARY INTERVENTIONS	POPULATION	SAMPLE SIZE	FINDINGS	IMPACT	QUALITY OF EVIDENCE
41	CELHAY AND AL., 2017	CCT	Preventative services including prenatal checkups, assisted births, a health checkup after birth, up to 12 child health visits in the first two years of life	Stillbirth	2,616 municipality-year observations	The intervention reduced the rate of stillbirths by 38.8%.	POSITIVE	EMERGING EVIDENCE
42	DUERR AND AL., 2020	CCT	Enrollment in a health center, plus SBC on breastfeeding and complementary feeding, as well as micronutrient supplementation and insecticide nets.	Children under 2	Not available	The intervention reduced under-five mortality rate.	POSITIVE	EMERGING EVIDENCE
43	RASELLA AND AL., 2013	CCT	Health and nutrition agenda including prenatal care, vaccinations, and health surveillance	Children under 5	2,853 municipalities	The under-5 mortality rate decreased as intervention coverage increased. The rate ratios for the effect of the intervention on overall under-5 mortality rate were 0·94 (95% CI 0·92–0·96) for intermediate coverage, 0·88 (0·85–0·91) for high coverage, and 0·83 (0·79–0·88) for consolidated coverage.	POSITIVE	EMERGING EVIDENCE
44	SHEI, 2013	CCT	Health and nutrition agenda including prenatal care, vaccinations, and health surveillance	Children under 1	Not given	The intervention was associated with a 9.3% reduction in overall infant mortality rates.	POSITIVE	EMERGING EVIDENCE
46	NIKULKOV AND AL., 2016	CASH-BASED INTERVENTIONS		Children under 5	2,236 children	Switching to cash-based interventions from US-flag vessel food aid reduced child mortality from 4.4% to 3.7% (a 16.2% relative reduction).	POSITIVE	EMERGING EVIDENCE

Appendix 5 / Outcome Child Diet Diversity (MDD, MAD, IDDS)

#	STUDY	INTERVENTION	COMPLEMENTARY INTERVENTIONS	POPULATION	SAMPLE SIZE	FINDINGS	IMPACT	QUALITY OF EVIDENCE
3	BLISS, 2014	CCT	SBCC (mother's attendance of health and education sessions, which include messages on IYCF and hygiene as well as cooking demonstrations)	6-24 months	424 children	IDDS improved by one food group in the intervention group.	POSITIVE	ETABLISHED EVIDENCE
8	KURDI AND AL., 2019	CCT	SBCC (monthly nutrition education sessions) and malnutrition screening	Children under 2	2,000 households	The program increased the IDDS of participating children by 0.8 food groups, partially making up for the decline of 1.3 food groups between baseline and follow-up seen in nonparticipating households without access to food distribution programs.	POSITIVE	ETABLISHED EVIDENCE
11	MAFFIOLI AND AL., 2019	UCT+	SBCC (topics related to nutrition and health)	6-29 months	4,972 mothers	IDDS increased 0.661, while the proportion of children meeting MDD and MAD increased 18.6% and 21.1% respectively.	POSITIVE	ETABLISHED EVIDENCE
28	GRIJALVA-ETERNOD AND AL., 2018	UCT+	Non-food items kit and free piped water	6-59 months	332 children	IDDS increased by 0.53 in the intervention group.	POSITIVE	ETABLISHED EVIDENCE
35	KUMAR AND AL., 2013	FRESH FOOD VOUCHERS	SBC (nutrition, dietary diversity, IYCF, food preparation)	6-59 months	250 children	The mean IDDS changed from 1.96 at admission to 4.17 at discharge and the proportion of children who received more than four food groups increased from 4.2% to 71.4%..	POSITIVE	ETABLISHED EVIDENCE
42	DUERR AND AL., 2020	CCT	SBCC (breastfeeding and complementary feeding), enrollment in a health center, micronutrient supplementation and insecticide nets	Children under 2	Not available	The intervention increased children meeting MDD and MAD.	POSITIVE	ETABLISHED EVIDENCE
47	AHMED AND AL., 2022	UCT		5-23 months	301 families	LThe percentage of children meeting minimum dietary diversity score (MDDS) rose from 16% to 89% after four rounds of cash distribution over four consecutive months.	POSITIVE	ETABLISHED EVIDENCE
48	HEWITT, 2019	CONDITIONAL FRESH FOOD VOUCHERS	SBCC (nutrition education classes)	6-59 months	876 children	IDDS increased by 0.44 points for the intervention group.	POSITIVE	ETABLISHED EVIDENCE
49	HIRVONEN AND AL., 2019	FRESH FOOD VOUCHERS		6-23 months	535 households	The number of children meeting recommended IDDS rose from 13% to 22% during the intervention, while the number of children meeting MAD rose from 8%-22%.	POSITIVE	ETABLISHED EVIDENCE
50	HOUNGBE AND AL., 2019	UCT		Children under 5	1143 households and 1247 children	The mean IDDS in intervention children was 17% higher than the control group..	POSITIVE	ETABLISHED EVIDENCE
51	TONGUET-PAPUCCI AND AL. (2017)	UCT		14-27 months	322 children	The MDD of two-thirds of the children who benefited from cash transfers was adequate compared with only one-third in the control group.	POSITIVE	ETABLISHED EVIDENCE
52	PRIMSON, 2017	UCT		Children under 2	2,100 households	16% more children achieved MDD at the endline of the intervention in comparison to the baseline..	POSITIVE	ETABLISHED EVIDENCE
53	ACF, 2012	FRESH FOOD VOUCHERS		Children under 5	Not given	IDDS improved from 4.30 at baseline to 6.40 at endline for children benefitting from the intervention..	POSITIVE	ETABLISHED EVIDENCE
54	HAN AND AL., 2023	NUTRITIOUS FOOD VOUCHERS+	SBC (nutrition, dietary diversity, IYCF, food preparation)	4-20 months	779 women–child dyads	Fresh Food Vouchers (value) / vs Voucher +BCC/ vs BCC only Combining SBC with food vouchers increased IDDS of children by 21.0%-23.1%.	POSITIVE	ETABLISHED EVIDENCE
55	ANGOOD AND AL., 2022	UCT+	Fresh Food Vouchers (value) / vs Voucher +BCC/vs BCC only Combining SBC with food vouchers increased IDDS of children by 21.0%-23.1%	Children under 2	3,800 households	Compares UCT vs UCT+nut. counselling. The intervention resulted in a 44% increase in children achieving a MAD.	POSITIVE	ETABLISHED EVIDENCE
56	UNICEF, 2022	UCT+	SBCC (nutrition, hygiene, and early child development), training to social workers and volunteers to assist the program	Children under 5	Not available	Children participating in the intervention saw a 100% increase in MDD over endline comparison mean.	POSITIVE	ETABLISHED EVIDENCE

57	WFP, 2022	FRESH FOOD VOUCHERS+	CCSC (nutrition) + engagement de la chaîne d'approvisionnement de détail	6 à 23 mois	Not available	The percentage of intervention children that met the MAD increased from 22% to 42.9%.	POSITIVE	ETABLISHED EVIDENCE
58	BRIAUX AND AL., 2020	UCT+	SBCC (health-seeking behavior, breastfeeding, hygiene), birth registration, screening and treatment of malaria, diarrhea, and pneumonia	18-29 months	4,689 households	IDDS increased by 0.29 for intervention children.	POSITIVE	ETABLISHED EVIDENCE
59	OXFORD POLICY, 2019	UCT+	SBCC (nutrition and health)	6-23 months	5,433 households	The number of children meeting MDD was 16% higher in the intervention group than the control group.	POSITIVE	ETABLISHED EVIDENCE
60	PARK AND AL., 2018	FRESH FOOD VOUCHERS +	SBC (children's dietary diversity, IYCF, cooking sessions).	4-20 months	640 mother and child pairs	IDDS increased 0.62 food groups in the intervention group, while the proportion of children meeting MAD rose 15%.	POSITIVE	ETABLISHED EVIDENCE
11	MAFFIOLI AND AL., 2019	UCT		6-29 months	4,972 mothers	The intervention had no statistically significant effect on IDDS of beneficiaries or the proportion of children meeting MAD.	NEGLIGIBLE	LIMITED EVIDENCE
23	DOOCY AND AL., 2020	NUTRITIOUS FOOD VOUCHERS		6-59 months	656 households	There were no statistically significant changes in IDDS or the proportion of children with MAD for the intervention group.	NEGLIGIBLE	LIMITED EVIDENCE
48	HEWITT, 2019	CCT	SBCC (nutrition education classes)	6-59 months	876 children	Conditional cash transfers did not have a significant impact on IDDS of beneficiaries.	NEGLIGIBLE	LIMITED EVIDENCE
60	PARK AND AL., 2018	FRESH FOOD VOUCHERS		4-20 months	640 mother and child pairs	Voucher treatment alone did not have an impact on IDDS for children.	NEGLIGIBLE	LIMITED EVIDENCE
62	BATTISTA AND ZEPHIRIM, 2017	NUTRITIOUS FOOD VOUCHERS+	SBCC (health and nutrition)	6-23 months	650 children	While the intervention improved household dietary diversity, children 6-23 months consumed less nutritious foods.	FAILED TO FIND POSITIVE IMPACT	LIMITED EVIDENCE

Appendix 6 / Outcome Women Diet Diversity

#	STUDY	INTERVENTION	COMPLEMENTARY INTERVENTIONS	POPULATION	SAMPLE SIZE	FINDINGS	IMPACT	QUALITY OF EVIDENCE
8	KURDI AND AL., 2019	CCT	SBCC (nutrition education sessions), malnutrition screening	PBWG	2,000 households	The intervention improved MDDW, with increases of 0.35 food groups on normal days and 0.30 food groups on Fridays.	POSITIVE	ETABLISHED EVIDENCE
10	LEWIS, 2016	NUTRITIOUS FOOD VOUCHERS +	SBC (nutrition and child feeding, cooking demonstrations)	PBWG	Not available	IDDS increased from 5 to 8 for women in the intervention. All women had a score of at least 4.	POSITIVE	ETABLISHED EVIDENCE
11	MAFFIOLI AND AL., 2019	UCT+	SBCC (nutrition and health)	PBWG	4,972 mothers	IDDS increased from 3.940 to 4.384 for PBWG in the intervention, while they became 14.8% more likely to meet MDD-W.	POSITIVE	ETABLISHED EVIDENCE
33	HARRIS-FRY AND AL., 2018	UCT+	SBC (good health during pregnancy and infant health), training to local health workers on child health.	PBWG	789 households	IDDS was 0.4 food groups higher in intervention arm than in the control arm.	POSITIVE	ETABLISHED EVIDENCE
36	WORLD VISION, 2019	CCT	SBCC, healthcare checkups before and after birth	PBWG	33 interviews	PBWG in the intervention increased the diversity of their diet, including a wider range of vegetables.	POSITIVE	ETABLISHED EVIDENCE
57	PAM, 2022	FRESH FOOD VOUCHERS +	SBC (nutrition), retail supply chain engagement	PBWG	Not available	MDD-W of women enrolled in the program increased from 3% to 31.7%.	POSITIVE	ETABLISHED EVIDENCE
11	MAFFIOLI AND AL., 2019	UCT		FPBWG	4,972 mothers	The intervention had no statistically significant effect on IDDS or MDD-W of beneficiaries.	NEGLIGIBLE	LIMITED EVIDENCE
62	BATTISTA AND ZEPHIRIM, 2017	NUTRITIOUS FOOD VOUCHERS +	SBC (health and nutrition)	PBWG	650 children	Bien que l'intervention ait amélioré la diversité alimentaire des ménages, les FFEA consommaient moins d'aliments nutritifs.	FAILED TO FIND POSITIVE IMPACT	LIMITED EVIDENCE

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FOR WATER.
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FOR NUTRITION.
FOR KNOWLEDGE.
FOR CHILDREN.
FOR COMMUNITIES.
FOR EVERYONE.
FOR GOOD.
FOR ACTION.
AGAINST HUNGER.

ACTION AGAINST HUNGER