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EVIDENCE-TO-POLICY BRIEF

What Works to Improve Outcomes for Children?

A rapid evidence assessment of cash plus programmes in Low- and Middle-Income Countries, informed by Social and Behaviour Change (SBC) strategies

Contents

Key findings

Finding 1

Social and behaviour change communication (SBCC) is the most common social and behaviour change (SBC) approach used in cash-plus programmes.

Finding 2

Cash-plus SBC programmes are effective in reducing poverty for households with children living in low- and middle-income countries, similar to cash-only programmes.

Finding 3

The available evidence indicates that impacts on health and nutrition, and access to health services, education, child protection and water, sanitation and hygiene (WASH) from SBC informed cash-plus programmes are inconsistent.

Finding 4

There is some evidence that cash-plus SBC programmes perform better than cash-only programmes, particularly in outcome domains like nutrition and feeding practices that SBC interventions are trying to affect.

Finding 5

More research is needed to determine contextual factors that improve the effectiveness of cash-plus SBC programmes.

OUTCOME DOMAIN

Percentage of measures better than comparison

34%

Nutrition
(anthropometric* indicators)

Consistency of results	–
Quality of evidence	High

47%

Feeding practices

Consistency of results	–
Quality of evidence	High

24%

Child development

Consistency of results	–
Quality of evidence	High

28%

Physical health

Consistency of results	–
Quality of evidence	High

Mental health

Consistency of results	– (too few studies)
Quality of evidence	Limited (too few studies)

23%

Access to health care services

Consistency of results	–
Quality of evidence	Moderate

27%

Education

Consistency of results	–
Quality of evidence	High

19%

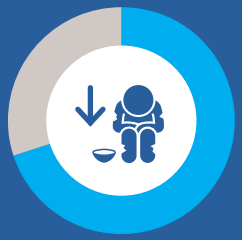
Violence, exploitation, child labour, early marriage

Consistency of results	–
Quality of evidence	High

33%

Access to water, sanitation and hygiene (WASH)

Consistency of results	–
Quality of evidence	High



70%

Poverty reduction

Consistency of results	+
Quality of evidence	High

Note: For any outcome domain, one of three 'consistency of results' ratings is possible: '++' when at least 75% of measures for that outcome are better for intervention than control, '+' when this proportion lies between 50% and below 75%, and '–' when it is less than 50% or if there are fewer than five studies reporting the outcome. * Anthropometric indicators refer to measurements on height and weight of children.

About this brief

The aims of this rapid evidence assessment are:

- to assess the effectiveness of cash transfers combined with social and behaviour change (SBC) components to improve outcomes for children;
- to identify which types of SBC are effective in improving outcomes;
- to identify the contextual factors that are necessary to successfully deliver cash-plus interventions with SBC components.

What is a cash-plus programme?

Cash transfers are a type of social protection measure that help to reduce the effects of poverty. They are typically delivered in the form of cash or vouchers that beneficiaries can use for various expenses in the same way as earned income.

While cash-transfer programmes have shown positive effects on important first-order outcomes, such as food security, household consumption and education, there are limits to the effectiveness of cash transfers alone in addressing all development needs. Many interventions have had inconsistent or no impact on other important well-being outcomes, such as child nutrition, early marriage, health-seeking behaviour, and sexual and reproductive health (Tirivayi et al., 2021). In order to improve the effectiveness of social protection in addressing these multidimensional needs, cash transfers are modified to cash-plus interventions by combining them with additional elements, such as in-kind resources, behaviour change interventions and links to other social services.

SBC components of cash-plus interventions aim to address the drivers of behaviours that affect children's well-being *(see Figure 1)*. This may be achieved by supporting individuals or communities to change their behaviours or by using policies and services to address the social and environmental barriers that prevent communities from adopting or sustaining behaviour changes.

Figure 1. Socioecological model of behaviour change

Source: UNICEF, n.d.

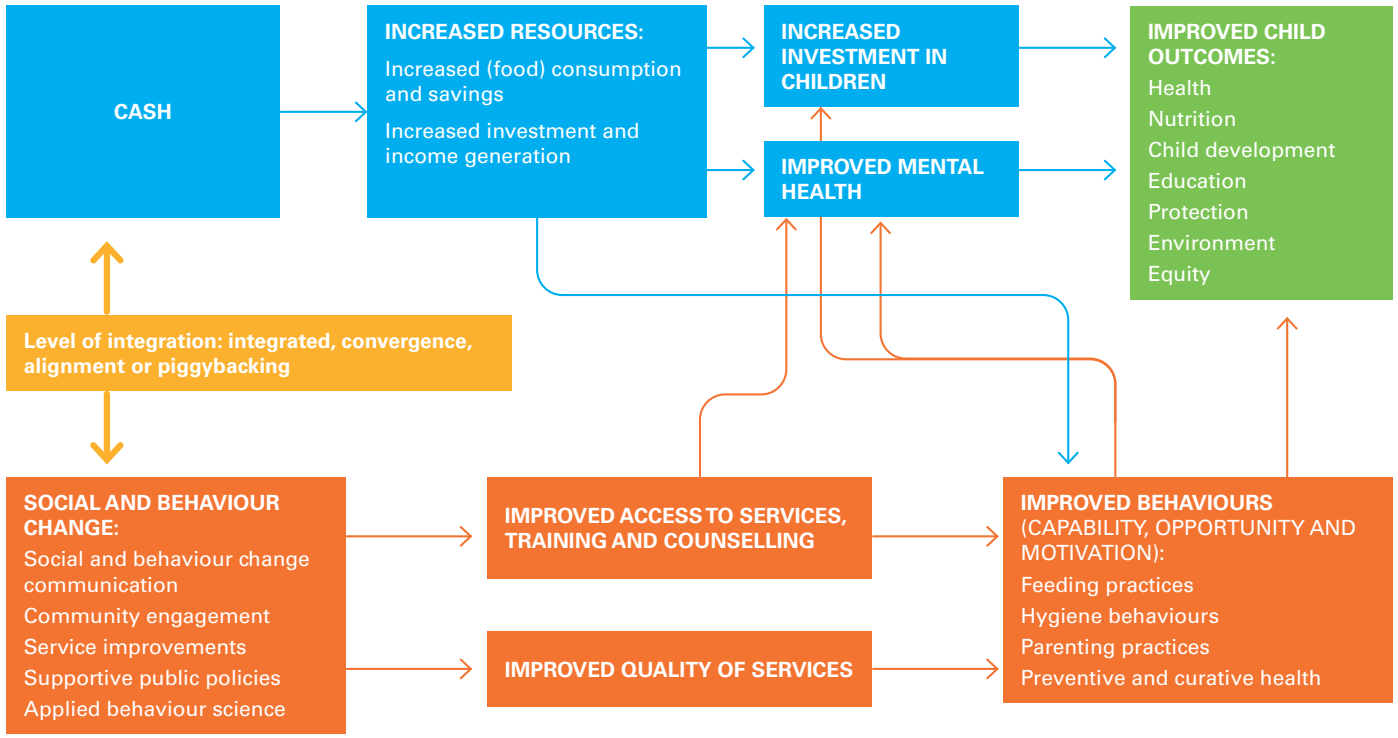
A conceptual model of cash-plus SBC programmes

We present a conceptual model of how cash-plus social and behaviour change (SBC) programmes can lead to improved child well-being outcomes *(see Figure 2)*. The upper section of the figure shows that a cash transfer can increase resources available for (food) consumption or savings and encourage investments in income generating activities, like setting up a small business or investing in productive assets. This leads to an improved economic situation for households, which can translate into increased investment in children and improved mental health among caregivers that, together, lead to improved child outcomes.

The lower section of Figure 2 shows specific SBC interventions, which can be broadly categorized as: (I) strategic communication or SBC communication (SBCC), (II) community engagement, (III) service improvements, (IV) supportive public policies and (V) applied behaviour science.[1] These interventions can lead to improved access to services, training and counselling, as well as improved quality of services. In turn, such improvements may lead to improved behaviours, for example in terms of feeding practices, hygiene behaviours, parenting practices, and preventive and curative health behaviours. These behaviours are expected to lead to improved child outcomes, and they may also influence investment in children and the mental health of caregivers.

1. There are two types of SBC that are not covered here because they are difficult to combine with cash transfers: social movements and systems strengthening.

Figure 2. Conceptual approach: Cash-plus programmes with SBC interventions



An important element of cash-plus programming is the level of integration between the cash transfer and the SBC intervention. We follow Arriagada et al.'s (2020) framework to **identify four models of integration**:

Integrated services model, in which the cash-transfer programme agency either directly manages the SBC intervention through its own staff or by contracts out its delivery to an external provider. Importantly, the responsibility of both components rests with the same implementing agency.

Convergence model, in which the cash-transfer programme and SBC intervention are managed by different agencies, which coordinate explicitly to bring the services to the same population.

Alignment of services model, in which the cash-transfer programme and the SBC intervention are managed and operated by different agencies with no coordination between them. There is some form of alignment, however, in terms of the geographical area or type of beneficiaries both programmes cover.

Piggybacking model, in which a programme adds an intervention to an established platform or programme, such as a primary health care facility or existing community group. For example, a cash transfer is added to an existing SBC intervention or an SBC intervention is added to an existing cash-transfer programme. In this model, each programme is managed by a different agency.

Methods overview

We conducted a rapid evidence assessment (Bakrania, 2020) for which we devised inclusion criteria *(see Table 1)*. While the inclusion criteria for outcomes were deliberately broad to include as many studies as possible, the exact definition of indicators depended on how a particular study measured them.

Table 1. Inclusion criteria for the rapid evidence assessment

Participants	Interventions	Comparisons	Outcomes	Study designs
Households with children or adolescents (up to 19 years old)	Cash-plus interventions including one or more of the following social and behaviour change (SBC) approaches (only unconditional transfers or those for which conditionality was not implemented were included; 'graduation' programmes for poverty reduction were excluded): ■ Strategic communication or SBC communication (SBCC) ■ Community engagement ■ Service improvements ■ Supportive public policies ■ Social movements ■ Systems strengthening ■ Applied behaviour science approaches	Only studies that had at least one treatment (cash-plus SBC group) and at least one of the following comparison groups were included: ■ No intervention ('control') ■ Cash-only interventions ■ Other (non-cash) interventions	The following 10 broad outcome areas were considered, based on UNICEF Strategic Plan Goal Areas: ■ Nutrition (anthropometrics) ■ Feeding practices ■ Child development ■ Physical health ■ Mental health ■ Accessing health services ■ Education ■ Violence against children, exploitation, child labour and early marriage ■ Accessing water, sanitation and hygiene (WASH) services ■ Poverty	■ Randomized controlled trials ■ Non-randomized trials ■ Quasi-experimental ■ Interrupted time series ■ Controlled before and after studies ■ Cost-benefit and cost-effectiveness studies

Our targeted search included studies from January 2010 to August 2022. We searched multiple academic databases in combination with searches of grey literature (e.g., PhD dissertations and study reports from websites of research institutes and international organizations). After screening search records against our inclusion criteria, we extracted relevant data from each included study to collect information on population, intervention, SBC, setting characteristics and reported outcome measures.

We used a 'vote-counting' approach to synthesize the evidence, an approach summarized in the next two paragraphs. Our evidence rating has two aspects: the consistency of findings for outcomes and the quality of evidence.

To determine an impact rating for interventions, we looked at the impact of each intervention on our primary outcomes and tallied these outcome measures according to whether they were better or worse than for the control (no intervention) comparison, based on statistical significance with p-values of 0.05 or lower.[2] We used the overall tally for the primary outcomes across all study comparisons to determine the 'consistency of findings' rating *(see Table 2)*.

For the 'quality of evidence' rating, we critically appraised each study using the Joanna Briggs Institute's (JBI) critical appraisal tools (JBI, n.d.). The JBI tools have different criteria for randomized controlled trials (RCTs) and quasi-experimental studies. The RCT tool evaluates a study on 13 criteria, including randomization process, intervention implementation, measurement of key outcomes and appropriate statistical techniques. We considered a score of 10 or higher as 'good', while scores between 5 and 9 were 'fair' and studies scoring less than 5 were 'limited'. The tool for quasi-experimental studies evaluates a study on nine criteria, including study design, the ability to draw causal conclusions, measurement of outcomes and appropriate statistical techniques. We classified quasi-experimental studies as 'good' if the score was 7 or higher, 'fair' if the score was between 4 and 6, and 'limited' otherwise. We used this classification to develop the quality of evidence rating *(see Table 2)*.

Table 2. Evidence rating criteria

Consistency of findings	
++	≥ 75% of outcome measures are significantly better for intervention than control (minimum 5 studies)
+	≥ 50% to <75% of outcome measures are significantly better for intervention than control (minimum 5 studies)
–	< 50% of outcome measures are significantly better for intervention than control or if fewer than 5 studies
Quality of evidence	
High	≥ 3 RCTs or ≥ 5 non-RCTs, at least 50% of which are 'good' quality; not more than 25% of the evidence can be 'limited' quality
Moderate	2 RCTs or ≥ 3 and < 5 non-RCTs, at least 50% of which are 'good' quality; not more than 25% of evidence can be 'limited' quality
Limited	Neither of the above conditions are met

2. Conventionally, vote counting is undertaken based on the direction of effect rather than on the statistical significance of individual measures. However, for this review, subject-matter experts on cash-plus and cash-transfer programmes preferred to use statistical significance as the basis for vote counting.

What we found

Our targeted search (January 2010–August 2022) found 13,744 records. After removing duplicates, we used the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI Centre) Reviewer machine-learning 'Priority Screening' tool to increase screening efficiency (EPPI Centre, n.d.). After an initial trial run using the tool, we needed to screen only 30 per cent of the records before the probability of finding new relevant records dropped to almost zero. Next, we screened 219 full-text articles against our inclusion criteria.

We included 30 studies from 41 publications with 82 comparisons across different intervention arms and time points. Seventy comparisons were reported immediately at the end of the cash-plus programme, while the other comparisons were measured some time after the intervention had ended. Endpoint durations varied widely, ranging from one month to five years with a median of two years. Most comparisons (68 in 29 studies) assessed cash-plus social and behaviour change (SBC) interventions versus control (25), cash-only (20) or non-cash interventions (23). Fourteen comparisons (six studies) assessed one type of cash-plus SBC intervention against another. The findings from these 14 comparisons were not used in the vote counting as they do not compare cash-plus to non-cash-plus interventions.

Of the 30 studies, 22 were randomized controlled trials, and the rest had a quasi-experimental design. Assessing the quality of the studies for risk of bias, we judged 19 as 'good', 9 as 'fair' and 2 as 'limited.' Findings from the 'limited' studies were excluded from the vote-counting process.

We report the number of studies and measures by outcome domain *(see Table 3)*.

Type of SBC component

Social and behaviour change communication (SBCC) was included in nearly every cash-plus programme in our review. Often it was the only 'plus' component.

SBCC was typically delivered by trained volunteers, community health workers or professionals in the participants' homes or in the community. The most covered topics included child nutrition, psychosocial stimulation, childcare and hygiene. Mothers were usually the recipients of SBCC but, in some cases, fathers, mothers-in-law and other family members were also invited to take part.

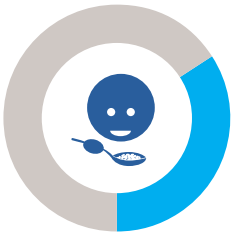
Community engagement, which included mobilization of local leadership and advocacy at community level, was seen in a small number of studies (four) but always in combination with SBCC. Similarly, service improvements, such as providing a helpdesk for children with disabilities or setting up youth-friendly reproductive services for adolescents, were coupled with SBCC in a few studies only. The Livelihood Empowerment Against Poverty (LEAP) programme in Ghana, which offered enrolment in a national insurance programme as the plus component and a study from Uganda offering subsidized childcare to promote female entrepreneurship were classified as 'supportive public policies'. They were the only intervention programmes in our review that did not have an SBCC component.

Given the prevalence of SBCC across interventions included in this review, our conclusions are relevant to cash-plus programmes that include SBCC as the plus element with or without other SBC components.

Table 3. Number of studies and measures by outcome domain

OUTCOME DOMAIN

Percentage of measures statistically significantly better for cash plus vs comparison



Nutrition
(anthropometric indicators)

No. of studies (comparisons)	19 (40)
No. of measures reported	165

Feeding practices

No. of studies (comparisons)	15 (24)
No. of measures reported	60

Child development

No. of studies (comparisons)	8 (16)
No. of measures reported	165

Physical health

No. of studies (comparisons)	14 (29)
No. of measures reported	75

Mental health

No. of studies (comparisons)	2 (3)
No. of measures reported	18

Access to health care services

No. of studies (comparisons)	7 (8)
No. of measures reported	31

Education

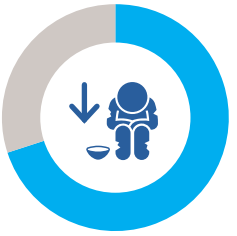
No. of studies (comparisons)	8 (20)
No. of measures reported	66

Violence, exploitation, child labour, early marriage

No. of studies (comparisons)	9 (20)
No. of measures reported	36

Access to water, sanitation and hygiene (WASH)

No. of studies (comparisons)	6 (13)
No. of measures reported	43



Poverty reduction

No. of studies (comparisons)	6 (19)
No. of measures reported	64

Settings and participants

Geographical locations

Cash-plus social and behaviour change (SBC) programmes were implemented in Bangladesh (three programmes), Colombia, the Democratic Republic of the Congo, Ethiopia, Ghana (two), Kenya, Mexico (two), Mozambique, Myanmar, Nepal (three), the Niger (three), Nigeria, Pakistan (two), Paraguay, the Philippines, the United Republic of Tanzania (two), Togo, Uganda, Yemen and Zimbabwe *(see Figure 3 and Table 4)*.

Settings

The most common sites for SBC activities were the community (10 studies), the home (7 studies) and both the home and the community (6 studies). This is unsurprising as almost every study had an SBC communication (SBCC) component. SBCC sessions were delivered by trained volunteers from the same community or by specialists in participants' homes or in group settings in the community. Other settings were health care facilities and schools.

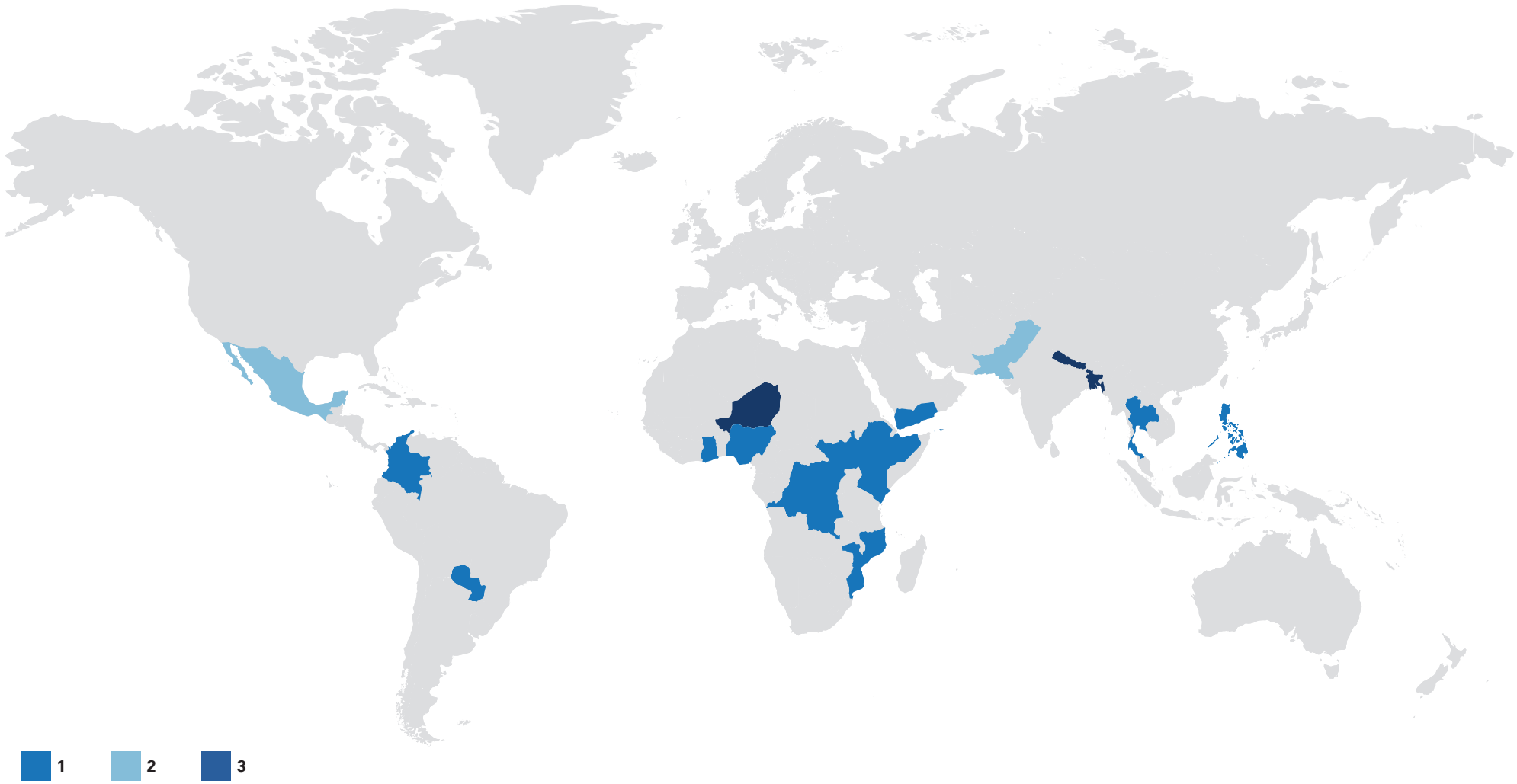
Age of children

Nearly all the programmes targeted both the cash transfer and the SBCC content at mothers and caregivers of young children (< 5 years old). So, the SBCC sessions were mostly designed for mothers and focussed on nutrition, feeding, hygiene, healthy practices and general childcare. Two programmes targeted adolescents in Kenya and the United Republic of Tanzania with a focus on violence prevention, life-skills training and sexual and reproductive health services. Many studies included older children in their analysis to study the impact of cash-plus programmes on other children in the household.

Level of integration

Of the 30 programmes, the most common type of integration model was 'integrated services' (18 programmes), followed by 'convergence' (6 programmes) and alignment of services and piggybacking (3 programmes each) *(see Appendix, Table A1)*. In terms of implementation methods, most programmes (18) were implemented through government systems, while 7 were controlled by a research team and 4 were implemented by non-governmental organizations (NGOs). It was not possible to disaggregate the analysis by level of integration due to the low number of studies on programmes that were not integrated. The only comparison we could make was between the integrated services and convergence models for nutrition (anthropometric outcomes). In this case, 36 per cent of measures had significantly better outcomes in the integrated services model, compared to 26 per cent in the programmes that adopted the convergence model.

Figure 3. Number of cash-plus SBC programmes



The designations employed in the maps contained in this report do not imply on the part of UNICEF the expression of any opinion whatsoever concerning the legal status of any country or territory, or of its authorities or the delimitations of its frontiers.

Table 4. List of cash-plus programmes and countries

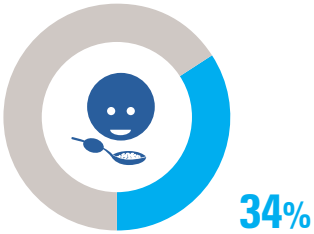
Programme name	Country
Maternity allowance plus psychosocial stimulation	Bangladesh
Shombhob	Bangladesh
The Transfer Modality Research Initiative	Bangladesh
Familias en Acción	Colombia
Cash Transfer with Integrated Management of Acute Malnutrition	Democratic Republic of the Congo
Integrated Nutrition – Social Cash Transfer (IN-SCT)	Ethiopia
Livelihood Empowerment Against Poverty (LEAP)	Ghana
LEAP 1000	Ghana
Adolescent Girls Initiative – Kenya (AGI-K)	Kenya
Education Initial + Prospera	Mexico
Programa de Apoyo Alimentario (PAL)	Mexico
Child Grant 0–2	Mozambique
Learning, Evidence Generation, and Advocacy for Catalyzing Policy (LEGACY)	Myanmar
Child Cash Grant	Nepal
Low Birth Weight South Asia Trial (LBWSAT) – a randomized controlled trial	Nepal
Nepal Poverty Alleviation Fund	Nepal
Comparison of supplementary foods with or without household support (cash or food transfer)	Niger
National Cash Transfer Programme	Niger
National Cash Transfer Programme + Volet Comportemental	Niger
Child Development Grant Programme	Nigeria
Benazir Income Support Program plus Integrated Reproductive Maternal Newborn, Child Health & Nutrition Program	Pakistan
Cash transfer pilot within Women and Children/Infant Improved Nutrition in Sindh (WINS) project	Pakistan
Tekoporã	Paraguay
Pantawid Pamilyang Pilipino Program (4Ps)	Philippines
Community health worker (CHW) interventions and conditional cash transfers (CCTs)	United Republic of Tanzania
Ujana Salama (Adolescent Cash Plus Pilot)	United Republic of Tanzania
Pilot Cash Transfer Program	Togo
Uganda Childcare Subsidy and Cash Transfer Study	Uganda
Cash for Nutrition	Yemen
Harmonized Social Cash Transfer	Zimbabwe

Findings on programme effectiveness

Our evidence rating system had two aspects. First, the intervention's impact was based on the proportion of outcome measures that were significantly ($p < 0.05$) better for the cash-plus group than the comparison group. Second, we looked at the quality of the available evidence for each outcome, based on the quality rating for each study. This assessment examined how well the individual studies were conducted and how reliable their findings were likely to be. We applied our evidence rating criteria based on the consistency of findings and the quality of evidence for each of the outcome domains. We now discuss our findings for each outcome domain and also present a summary *(see Table 5)*.

Nutrition (anthropometric indicators)

In the nutrition (anthropometrics) domain, we considered indicators such as height for age, weight for age, stunting and other forms of malnutrition. We found 19 studies with a total of 40 comparisons. Together, these studies reported 165 outcome measures of which 56 (34 per cent) were significantly better for the cash-plus group than the comparison group. When considering the type of comparison, we found that the highest rate of improvement occurred against other non-cash interventions (53 per cent); we observed fewer improvements when making comparisons with cash-only interventions (31 per cent) and controls (20 per cent). We rated the quality of the evidence for this domain as high. Positive effects compared to other non-cash interventions have been observed, for example, by Grellety et al. (2017), who studied a programme in the Democratic Republic of the Congo. In that case, a cash transfer was provided to children with uncomplicated severe acute malnutrition (SAM) who were receiving treatment according to the national protocol and infant and young child feeding counselling for caregivers. Insignificant findings compared to the control group can be explained by, for example, interventions that were too short in duration to have a sustained impact on anthropometry (e.g., Saville et al. (2018) in Nepal or UNICEF et al. (2020) in Ethiopia), or where there were limitations to the improvement of underlying determinants, such as health and a clean, safe (in terms of water, sanitation and hygiene) home environment in Mozambique (UNICEF, 2022).

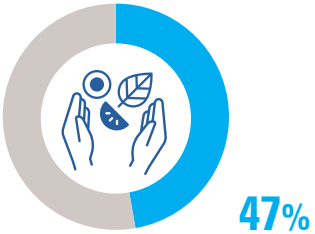


Nutrition
(anthropometric indicators)

Consistency of results	–
Quality of evidence	High

Feeding practices

The feeding practices domain included indicators related to children's diet, like diet diversity, breastfeeding and meal frequency. We included a total of 15 studies with 24 comparisons. These studies reported 60 measures of which 28 (47 per cent) were significantly better for the cash-plus group than the comparison group. Only four studies compared cash plus to cash only, which was below our threshold (five studies) for determining consistency. We found a 44 per cent improvement rate when we compared cash-plus to non-cash interventions and a 39 per cent improvement rate for comparisons with a control group. We considered the quality of the evidence for feeding practices to be high. For example, the Transfer Modality Research Initiative in Bangladesh found the cash-plus nutritional SBCC programme resulted in significant improvements in terms of calories, proteins and minimum dietary diversity compared to the control group and the cash-only group (Ahmed et al., 2019; Tauseef, 2022). Meanwhile, no impact was observed, compared to the control group, in Nepal (Participatory Learning and Action women's groups with and without cash transfers during pregnancy – the LBWSAT study) and Ethiopia (the Integrated Nutrition – Social Cash Transfer pilot), for example. In the first case, the intervention was only active during pregnancy, and the impact may not have been sustained throughout the complementary feeding period (Saville et al., 2018). In Ethiopia, the authors argue that implementation constraints caused the intensity of the interventions to be insufficient to have a meaningful impact and spillovers dampened the impact within communities (UNICEF, et al., 2020).



Feeding practices

Consistency of results	–
Quality of evidence	High

Child development

We included a total of eight studies that reported some measure of child development (e.g., cognitive, language, verbal and social-emotional development indicators). These studies contained a total of 16 comparisons with 94 measures. Overall, 23 (24 per cent) of these measures were significantly better for the cash-plus group than the comparison group. This rate was highest when cash plus was compared to the control group (43 per cent) and lower when compared to the cash-only group (15 per cent). The most notable examples in this domain are from Latin America. In Colombia, an early childhood development programme with a focus on psychosocial stimulation was added to the Familias en Acción conditional cash-transfer programme. Compared to the cash-only group, this yielded a positive impact on cognitive and language scores in the short term (18 months) (Attanasio et al., 2014), but these results were not sustained in the long term, two years after the intervention (Andrew et al., 2018). The authors argue that challenges in maintaining commitment to the evidence-based intervention model in the scale-up of the programme may have contributed to the lack of impact. In Mexico, a group-based parenting programme was combined with the national conditional cash-transfer programme Prospera. The evaluation showed positive effects on a general cognitive index and verbal and memory scores, but only when the parenting intervention was actively promoted to the cash-transfer beneficiaries (Fernald et al., 2017). There were non-significant impacts in the Niger, for example, when the national cash-transfer programme was combined with SBCC on nutrition, psychosocial stimulation, health and sanitation (Premand & Barry, 2020). The authors explain that generally low levels of literacy and stimulation activities remained significant obstacles to improving child development outcomes. Similarly, in Nigeria, the Child Development Grant Programme, which combined cash transfers with SBCC on childcare and nutrition, did not have any significant impacts (Carneiro et al., 2021). The authors do not provide explanations for this lack of impact, although it should be noted that the SBCC intervention did not specifically target these domains.

24%

Child development

Consistency of results	–
Quality of evidence	High

Physical health

Our review found 14 studies that reported a physical health outcome (e.g., reduction in diarrhoea, pneumonia and other illnesses), with a total of 29 comparisons and 75 measures. Overall, 21 (28 per cent) of the measures were significantly better for the cash-plus group than the comparison group, with the highest rate when cash plus was compared to a control group (35 per cent), and with lower rates when cash plus was compared to cash-only (22 per cent) and non-cash (27 per cent) interventions. A notable example of positive effects comes from the Transfer Modality Research Initiative in Bangladesh. The cash-plus intensive nutrition-related SBCC activities (including weekly sessions) had a significant impact on the prevalence of fever and cough/colds (but not diarrhoea) compared to other groups (control, cash only and food transfer) (Ahmed et al., 2019). Other studies found no or limited effects. For example, the Learning, Evidence Generation, and Advocacy for Catalyzing Policy (LEGACY) programme in Myanmar, combining cash transfers with an SBCC component focussed on nutrition, yielded no effects on episodes of child illness but succeeded in improving children's diets (Field & Maffioli, 2021). The authors do not explore the reasons for this lack of impact.

28%

Physical health

Consistency of results	–
Quality of evidence	High

Mental health

Mental health outcomes were reported in two studies only, which does not meet the five-study minimum for our evidence rating. These two studies contained three comparisons and a total of 18 measures, with only one of these being significantly better for the cash-plus group. All comparisons were made with a cash-only group.

Mental health

Consistency of results	– (too few studies)
Quality of evidence	Limited (too few studies)

Access to health care services

Seven studies reported on household access to health care treatments and preventive services, such as treatment for respiratory illnesses and diarrhoea and obtaining routine childhood immunizations. Out of 31 measures, only 7 (23 per cent) demonstrated significantly better access for recipients of cash-plus interventions compared to non-recipients. Most comparisons were made against a control group (20 out of 31 measures), with a few comparisons to a cash-only group (5 measures). The quality of evidence was rated as 'moderate' *(see Table 5 for details)*. Positive effects occurred, for example, in the Ghana Livelihood Empowerment Against Poverty (LEAP) programme, which had a positive impact on enrolment in the National Health Insurance Scheme (NHIS), which was an extra entitlement for cash-transfer beneficiaries (Handa et al., 2014; Palermo et al., 2019). Meanwhile, in Myanmar, the cash-plus SBCC programme (monthly sessions) did not affect seeking treatment for child illnesses or health care expenditure, a finding which is not further explored by the authors (Field & Maffioli, 2021).

Access to health care services

Consistency of results	–
Quality of evidence	Moderate

Education

The education outcome domain included multiple measures, such as school enrolment, educational attainment, school attendance, grade progression and test scores. Eight studies (20 comparisons) reported on one or more educational outcomes. The studies included three RCTs rated 'good' and six non-RCTs of which five were rated 'good' during the critical appraisal process. Of the 66 educational outcomes, 27 per cent were significantly better for cash-plus than comparison groups. The proportion was 24 per cent (significantly better) compared to a control group, but the number of studies comparing cash-plus to cash-only or non-cash interventions was too small for meaningful assessment. An example of positive impact comes from the Adolescent Girls Initiative in Kenya. The cash-transfer component was conditional on attendance, and the programme had a positive effect on several educational outcomes, more so when combined with other interventions including health and life-skills training and wealth creation (Austrian et al., 2021). In Ethiopia, the Integrated Nutrition – Social Cash Transfer (IN-SCT) programme, combining cash plus with monthly nutrition-focussed SBCC sessions, did not have a strong impact on school attendance and enrolment, although these were not specific objectives of the programme (the same applies to other programmes that had no impact on schooling) (UNICEF, 2022).

Education

Consistency of results	–
Quality of evidence	High

Protection from violence, abuse, exploitation and neglect

Nine studies assessed whether SBC cash-plus programmes improved child protection outcomes. Out of 36 outcome measures, only 7 (19 per cent) showed a significant difference between cash-plus and comparison groups. The highest rate of improvement was found when cash-plus groups were compared to control groups (38 per cent), with fewer positive impacts when compared to cash-only groups (11 per cent). We judged most of the studies as 'good', resulting in an overall 'high' rating. A notable example of positive impact is from the Child Grant 0–2 in Mozambique, where the cash-plus intervention reduced psychological aggression, violent discipline and the belief that violent discipline was needed to raise children, compared to the control group. Integrating the case-management model with the cash-transfer programme had a strong additional effect (UNICEF, 2022). Most other programmes failed to have an impact on childhood violence, for example, the Childcare Subsidy and Cash Transfer Study in Uganda (an example of SBC supporting public policies), which found no impacts on violent discipline of children, although this was not an objective of the programme (Bjorvatn et al., 2022)

19%

Violence, exploitation, child labour, early marriage

Consistency of results	–
Quality of evidence	High

Water, sanitation and hygiene (WASH)

Access to safe water, sanitation and hygiene (WASH) was reported in six studies. We rated the quality of evidence as 'high' as most studies fell under this category. Fourteen out of 42 (33 per cent) of outcome measures were significantly better for cash-plus than comparison groups, with a similar rate observed when comparing cash-plus with control groups (30 per cent). Significant effects were observed in Bangladesh as a result of the Transfer Modality Research Initiative, which combined a cash transfer with SBCC on nutrition and which affected hygiene behaviours, including latrine use, bathing with soap and water and hand-washing, behaviours that were part of the SBCC curriculum (Ahmed et al., 2019). In contrast, the LEAP 1000 programme in Ghana had no impact on beneficiary households' WASH conditions, which the programme did not incentivize (De Groot et al., 2022).

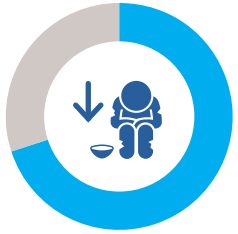
33%

Access to water, sanitation and hygiene (WASH)

Consistency of results	–
Quality of evidence	High

Poverty reduction

Six studies reported on poverty reduction from cash-plus programmes and found that 70 per cent of reported poverty reduction measures were significantly better for cash-plus households compared to others. We rated the quality of available evidence as 'high'. These findings are in line with the evidence on cash-transfer programmes without plus components reducing poverty (e.g., see Bastagli et al., 2019). For example, the Child Development Grant Programme in Nigeria, which combines a cash transfer with SBCC on childcare and nutrition practices during pre-, peri- and post-natal periods, caused a 2 per cent reduction in extreme poverty in participating households (Carneiro et al., 2021). An example of a programme that did not affect poverty measures was the Adolescent Girls Initiative in Kenya, which had no impact on the wealth of beneficiary households. This could be due to the cash transfer being targeted at adolescent girls in the household with a condition on school attendance, limiting the likelihood of affecting poverty outcomes (Austrian et al., 2021).



70%

Poverty reduction

Consistency of results	+
Quality of evidence	High

Table 5. Summary of evidence-synthesis findings

Outcome domain	Finding	Evidence criteria met	Evidence rating	
Nutrition (anthropometric indicators)	34% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	14 randomized controlled trials (RCTs) of which 9 rated 'good' and 5 'fair'; 5 non-RCTs, all rated 'good'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High
Feeding practices	47% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	11 RCTs of which 5 rated 'good', 5 'fair' and 1 'limited'; 4 non-RCTs, all rated 'good'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High
Child development	24% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	8 RCTs of which 4 rated 'good' and 4 'fair'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High
Physical health	28% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	11 RCTs of which 7 rated 'good' and 4 'fair'; 3 non-RCTs, all rated 'good'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High
Mental health	Only 2 studies (minimum 5 studies needed)	Too few studies	Consistency of results	–
		Too few studies	Quality of evidence	
Outcome domain	**Finding**	**Evidence criteria met**	**Evidence rating**	

Access to health care services	23% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	3 RCTs of which 1 rated 'good' and 2 'fair'; 4 non-RCTs of which 3 rated 'good' and 1 'fair'	2 RCTs or ≥ 3 and < 5 non-RCTs of which at least 50% high quality; not more than 25% of evidence can be limited quality	Quality of evidence	Moderate
Education	27% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	3 RCTs, all rated 'good'; 5 non-RCTs of which 4 rated 'good' and 1 'fair'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High
Violence against children, exploitation, child labour and early marriage	19% measures better for cash plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	5 RCTs of which 3 rated 'good' and 2 'fair; 4 non-RCTs, all rated 'good'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be low quality	Quality of evidence	High
Access to water, sanitation and hygiene (WASH)	33% measures better for cash-plus vs comparison	< 50% of outcome measures significantly better for intervention than comparison (minimum 5 studies)	Consistency of results	–
	3 RCTs of which 1 rated 'good' and 2 'fair'; 3 non-RCTs, all rated 'good'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High
Poverty reduction	70% measures better for cash plus vs comparison	≥ 50% to <75% of outcome measures significantly better for intervention than comparison	Consistency of results	+
	4 RCTs and 2 non-RCTs, all rated 'good'	≥ 3 RCTs or ≥ 5 non-RCTs of which at least 50% good quality; not more than 25% of evidence can be limited quality	Quality of evidence	High

Note: For any outcome domain, one of three 'consistency of results' ratings is possible: '++' when at least 75% of measures for that outcome are better for intervention than control, '+' when this proportion lies between 50% and below 75%, and '–' when it is less than 50% or if there are fewer than five studies reporting the outcome.

Cash-plus compared to cash-only programmes and control

It is interesting to compare the impacts of cash-plus SBC programmes to cash-only programmes to determine if the SBC element has an incremental effect on top of the cash-only impact. To do this, we looked specifically at studies with three arms: cash plus, cash only and control. Our review included 5 such studies, which together reported on 92 measures in 9 domains (mental health measures were not reported in these studies) *(see Table 6)*.

Findings from these studies show that 31 measures were significantly better when comparing cash plus to cash only, while 38 measures were significantly better when comparing cash plus to control. It was unsurprising that there were more significant results in the comparison with the control arm, but the most interesting finding was that many cash-plus impacts were also better than cash-only impacts. This is particularly noteworthy in the nutrition and feeding practices domains, which were specifically targeted by these studies. In contrast, we see fewer significant improvements when comparing cash plus to cash only in the poverty reduction and child development domains (however, cash-plus impacts were significantly better than controls in all 16 measures in the poverty reduction domain). This was also to be expected as the impact on poverty will mostly be through the receipt of cash, not the plus component. The comparison of treatment arms in this selected number of studies provided some evidence that cash-plus programmes performed better than cash-only programmes, especially in the domains that the plus intervention was trying to affect.

Table 6. Comparison of cash-plus measures with cash-only measures and control in selected studies

Domain		Cash plus vs cash only	Cash plus vs control
Nutrition (anthropometric indicators)	# measures	17	17
	# significantly better	4	3
Feeding practices	# measures	12	12
	# significantly better	8	6
Child development	# measures	13	13
	# significantly better	3	7
Physical health	# measures	6	6
	# significantly better	2	2
Access to health care services	# measures	3	3
	# significantly better	0	0
Education	# measures	9	9
	# significantly better	1	0
Violence against children, exploitation, child labour and early marriage	# measures	3	3
	# significantly better	0	0
Access to water, sanitation and hygiene (WASH)	# measures	13	13
	# significantly better	3	4
Poverty reduction	# measures	16	16
	# significantly better	10	16
Total	# measures	92	92
	# significantly better	31	38

Note: The selected studies were Ahmed et al. (2019, 2020), Bjorvatn et al. (2022), Field and Maffioli (2021), Hossain et al. (2022), Tauseef (2022), and UNICEF et al. (2020).

Taking a deep dive into anthropometric impacts

A limitation of the vote-counting approach was that some studies reported on multiple outcomes in the same domain, while others reported only one outcome. A lack of impact among studies that reported multiple outcomes may therefore have pushed the overall rating for a domain downwards, or upwards in the case of positive impacts. Hence, we report the count for specific indicators that were reported frequently across studies (stunting, height-for-age z-score (HAZ), wasting and weight-for-height z-score (WHZ)[3] *(see Table 7)*.

HAZ was reported most often, in 23 comparisons in 14 studies. In 12 comparisons (52 per cent), the impact was positive. This rate was highest among comparisons to other non-cash interventions (75 per cent), primarily driven by findings from one study in Pakistan (Fenn et al., 2017). Compared to a control group, only 33 per cent of impacts were significant, based on nine comparisons from nine different studies.

We found that the highest rate of positive impact overall (60 per cent) was on stunting, which was reported in 20 comparisons across 13 studies. Compared to a control group, 55 per cent of impacts were significant, based on a total of 11 comparisons from 10 studies.

The evidence for impact on wasting and WHZ was much weaker, with a rate of 41 per cent and 14 per cent overall, respectively. The only reliable breakdown we could produce for these indicators was for comparisons with a control group, which yielded a positive impact rate of 22 per cent and 0 per cent, respectively.

Economic analyses

Economic evaluations were only included in some studies. The methods of evaluation and assumptions used to estimate economic returns were heterogeneous. We provide details of the various types of economic benefit reported in these studies *(see Table 8)*. Cost estimates per beneficiary per year ranged from US$17 to US$500. A programme from the Niger that combined a national cash-transfer programme with coaching and entrepreneurship training had benefit-to-cost ratios ranging from 0.88 to 20.87, compared to cash only (Bossuroy et al., 2021). A programme from Nigeria reported a benefit-to-cost ratio of almost 4 per child (Carneiro et al., 2021).

A cash-plus SBCC programme in Pakistan was not cost-effective at reducing the prevalence of stunting until a food transfer was also added to the mix (Khan et al., 2019).

3. Height-for-age z-score is the deviation, expressed in standard deviation (SD) units, of the child's length or height at a given age, compared to the length/height of a healthy reference group. Children with a deviation of more than 2 SDs below the reference median are considered stunted. Similarly for weight-for-height, a child is considered wasted if the weight-for-height z-score is lower than 2 SDs below the reference median.

Table 7. Impacts on specific anthropometric indicators

	Stunting	HAZ	Wasting	WHZ
Number of comparisons reporting outcome	**20**	**23**	**22**	**22**
Cash only	3	6	2	8
Control	11	9	9	7
Other non-cash	6	8	11	7
Number of positive impacts	**12**	**12**	**9**	**3**
Cash only	2	3	1	1
Control	6	3	2	0
Other non-cash	4	6	6	2
Percentage of positive impacts	**60%**	**52%**	**41%**	**14%**
Cash only	67%	50%	50%	13%
Control	55%	33%	22%	0%
Other non-cash	67%	75%	55%	29%
Number of studies	**13**	**14**	**11**	**12**
Cash only	3	6	2	5
Control	10	9	8	7
Other non-cash	3	5	3	4

Note: HAZ = height-for-age z-score; WHZ = weight-for-height z-score.

Table 8. Studies that included a measure of costs or cost-effectiveness

Study	Programme	Country	Type	Cost per beneficiary per year	Economic returns
Ahmed et al. (2019)	The Transfer Modality Research Initiative	Bangladesh	Cash + social and behaviour change communication (SBCC)	$50 (SBCC activities)	Not reported
Attanasio et al. (2014)	Familias en Acción	Colombia	Cash + psychosocial stimulation	$500	Impact at age 4 is associated with 7.5% increase in earnings at age 30
Bjorvatn et al. (2022)	Childcare Subsidy and Cash Transfer Study	Uganda	Cash + childcare subsidy	$111 (childcare subsidy)	Not reported
Bossuroy et al. (2021)	National Cash Transfer Programme	Niger	Cash + psychosocial support	$145 (psychosocial stimulation)	Benefit-to-cost ratio ranging from 1.15 to 20.87; internal rate of return ranging from 13% to 70%
Bossuroy et al. (2021)	National Cash Transfer Programme	Niger	Cash + psychosocial support + capital grant	$322 (full package)	Benefit-to-cost ratio ranging from 0.88 to 13.52; internal rate of return ranging from –3% to 53%
Carneiro et al. (2021)	Child Development Grant Programme	Nigeria	Cash + SBCC	$54 (information package)	Benefit-to-cost ratio ranging from 0.66 to 3.95; internal rate of return ranging from –1.12% to 4.92%
Ferre and Sharif (2014)	Shombhob	Bangladesh	Cash + SBCC	$17 (administrative costs for cash transfer)	Not reported
Premand and Barry (2020)	National Cash Transfer Programme + Volet Comportemental	Niger	Cash + SBCC	$50 (SBCC component)	Not reported

Study	Programme	Country	Type	Cost per beneficiary per year	Economic returns
Khan et al. (2019)	Benazir Income Support Program plus Integrated Reproductive Maternal Newborn, Child Health & Nutrition Program	Pakistan	Cash + SBCC	Not reported	■ Cost per stunting case prevented: $5,925.18 to $6,547 (not CE) ■ Cost per wasting case prevented: $8,184 to $9,003 (not CE) ■ Cost per underweight case prevented: $4,092 to $4,501 (marginally CE) ■ Cost per stunting and wasting case prevented: $3,445.99 to $3,790.59 (CE)
Khan et al. (2019)	Benazir Income Support Program plus Integrated Reproductive Maternal Newborn, Child Health & Nutrition Program	Pakistan	Cash + SBCC + food transfer	Not reported	■ Cost per stunting case prevented: $2,325 to $2,530 (CE) ■ Cost per wasting case prevented: $8,184 to $9,003 (not CE) ■ Cost per underweight case prevented: $5,239 to $5,824 (not CE) ■ Cost per stunting and wasting case prevented: $1,702 to $1,872 (CE)

Note: The internal rate of return (IRR) reflects the discount rate for which the net present value (the difference between the total discounted costs and benefits) is zero. If the IRR is larger than the discount rate, the programme is considered cost-effective. For Khan et al. (2019), the World Health Organization (WHO) threshold of three times the gross domestic product (GDP) per capita is defined as cost-effective (CE). GDP per capita was US$1,437 in Pakistan in 2019. Interventions that cost less than the GDP per capita are considered very cost-effective, while interventions costing between one and three times the GDP per capita are considered cost-effective.

Transferability, equity and implementation considerations

Transferability of findings

We found that cash-plus social and behaviour change (SBC) programmes are implemented in multiple low- and middle-income countries across the world. We found studies from South Asia, West and Central Africa, East and Southern Africa, and Latin America. Almost all programmes included an SBC communication (SBCC) component, usually targeted at the mother, to improve the nutrition and care of young children.

The SBCC sessions focussed on improving the capabilities of mothers and other caregivers by improving their knowledge, attitudes, practices and skills on nutrition, feeding, playing with their child and improving hygiene and health. Most SBCC sessions were delivered in the participants' home, in community settings or a combination of both.

In some instances, cash-plus interventions also added other SBC components, such as community engagement (e.g., mobilizing community leaders and establishing community advocacy groups), systems strengthening (e.g., training health care providers to deliver more adolescent-friendly sexual and reproductive health services) and service improvements (e.g., providing a helpdesk for children with disabilities), with comparable results to interventions that included SBCC only.

While we excluded cash transfers with strictly enforced conditions (e.g., attending nutritional counselling sessions to receive cash) from our review, the findings are likely to be transferable to conditional interventions targeting mothers and young children with SBCC.

Findings from this review are applicable to cash-transfer programmes in low- and middle-income countries looking to add SBC elements to improve outcomes for children.

Equity

Cash-plus programmes are inherently designed to improve equity as they target the most vulnerable populations. Improvements in outcomes for participants in these programmes are likely to improve equity as the programmes are focussed on reducing disparities. From our review findings, cash-plus SBCC programmes could improve equity in nutrition indicators and educational outcomes while also reducing poverty. Such programmes are also likely to improve equity by reducing illnesses among young children living in poverty, improving child-development outcomes and increasing the adoption of water, sanitation and hygiene (WASH) practices.

A programme from Zimbabwe provided a helpdesk, on the days beneficiaries were paid, to link children in need of special support, such as those with disabilities, with available welfare services (Chakrabarti et al., 2020). The programme reduced some measures of physical violence, although it is unclear what role the helpdesks played and to what extent children with disabilities were affected by the programme. A programme in Kenya, which included a violence-prevention intervention for girls combined with cash transfers for education and life-skills and financial literacy training, found some improvements in educational outcomes (with the cash being conditional on attendance), but not in violence prevention or poverty outcomes (Austrian et al., 2021).

Implementation considerations

We collected implementation considerations from the included studies, the broader literature and input from an advisory group comprised of experts in cash-plus programmes from research, policy and practice. Aspects to consider include the following:

- Ensure adequate duration and intensity for the SBC components.
- Consider the initial levels of socioeconomic conditions and contextual factors that moderate the impact of cash plus, for example, pre-existing dietary habits and norms, literacy and parenting behaviours.
- Assess and consider the availability of supply-side services, for example, social work for childcare SBC, health care facilities when there is health/nutrition counselling.
- Target the SBCC component at mothers or other primary caregivers of young children but be mindful to not further exacerbate their unpaid care burden and time poverty. Involve fathers and other caregivers in the process as they are also involved in decision-making around children's well-being.
- Identify gaps in parental knowledge, attitudes and practices to determine the content and delivery of SBCC activities. Customize SBCC sessions based on the local context and resources available.
- Think about ways to promote participation in SBCC sessions other than through conditions connected to receiving cash, considering intended beneficiaries' preferences for methods of delivery, duration and location.
- Identify appropriate personnel who have a trusted place in the community (such as community health workers) and who can effectively engage with parents and caregivers to deliver SBCC content.
- Plan training for and oversight of SBCC-delivery personnel to provide them with ongoing support and ensure sufficient capacity for delivery of quality services.
- Consider adding other types of SBC components (e.g., community engagement) and other types of cash-plus components (such as food transfers) based on the situation (although the incremental benefit of adding these compared to cash-plus SBCC components is not clear from the review).
- Engage local policymakers and community leaders to share results and gain support.
- Consider the applicability of programme content and delivery based on local political, social and economic contexts.

Limitations

We used a vote-counting method, which, while legitimate as a method in the context of a heterogeneous evidence base, comes with certain inherent limitations. This method indicates the consistency of findings for a body of evidence and does not offer an interpretation of the magnitude of effect. In addition, vote counting does not consider the number of outcome measures reported per study. Some studies reported fewer outcomes while others reported multiple outcomes per domain, potentially driving the overall results for a particular domain. Furthermore, the guidance on vote counting is to count based on the direction of individual effect measures rather than on statistical significance. However, subject-matter experts on cash-plus programmes were of the view that using statistical significance would be better perceived by the field.

By including multiple outcome domains, we were not able to focus on distinct types of outcome measure within a domain like, for example, immunization or seeking care for fever behaviours in the accessing health care services domain, which would require a deep dive into selected anthropometric indicators of specific studies.

Finally, the findings from our evidence rating system should only be used as a starting point for implementers and policymakers looking to make decisions based on the evidence. Careful deliberation of specific needs and contexts is necessary to interpret the findings, and we encourage readers to access the full studies included in this review to gain deeper insights into the successes and failures of specific interventions.

Appendix

Table A1: Programme characteristics of included studies

Study ID	Programme name	Country	Type of CT	Type of social and behaviour change (SBC)	Model of integration	Implementation	References
1	The Transfer Modality Research Initiative	Bangladesh	UCT	SBC communication (SBCC)	Integrated services	Non-governmental organization (NGO)	Ahmed et al. (2019, 2020), Tauseef (2022)
2	Familias en Acción	Colombia	CCT	SBCC (psychosocial stimulation)	Piggybacking	Research trial	Andrew et al. (2018), Attanasio et al. (2014)
3	Adolescent Girls Initiative – Kenya (AGI-K)	Kenya	CCT	SBCC + community engagement	Integrated services	Research trial	Austrian et al. (2021, 2022), Kangwana et al. (2022)
4	Programa de Apoyo Alimentario (PAL)	Mexico	UCT	SBCC (nutrition, health, hygiene)	Integrated services	Government	Avitabile et al. (2019), Ramirez-Luzuriaga (2016)
5	Uganda Childcare Subsidy and Cash Transfer Study	Uganda	UCT	Supportive public policies (free childcare)	Integrated services	Research trial	Bjorvatn et al. (2022)
6	National Cash Transfer Programme	Niger	UCT	SBCC + community engagement	Integrated services	Government	Bossuroy et al. (2021)
7	Pilot Cash Transfer Program	Togo	UCT	SBCC (health, nutrition and child protection)	Convergence	Government	Briaux et al. (2020)
8	Child Development Grant Programme	Nigeria	UCT	SBCC (child nutrition, childcare, mothers' nutrition using low intensity (mass media) and high intensity (parent groups, home visits intervention)	Integrated services	Research trial	Carneiro et al. (2021)
9	Harmonized Social Cash Transfer	Zimbabwe	UCT	SBCC + service improvements (discussion of welfare and protection issues at pay points, emphasis on children with disabilities, helpdesks for various services)	Integrated services	Government	Chakrabarti et al. (2020)

Study ID	Programme name	Country	Type of CT	Type of social and behaviour change (SBC)	Model of integration	Implementation	References
10	Cash transfer pilot within Women and Children/Infant Improved Nutrition in Sindh (WINS) project	Pakistan	UCT	SBCC (nutrition)	Integrated services	NGO	Fenn et al. (2017)
11	Education Initial + Prospera	Mexico	CCT	SBCC (group parenting programme)	Convergence	Government	Fernald et al. (2017), Knauer et al. (2016)
12	Shombhob	Bangladesh	CCT	SBCC (nutrition-related sessions)	Integrated services (unclear)	Government	Ferre and Sharif (2014)
13	Learning, Evidence Generation, and Advocacy for Catalyzing Policy (LEGACY)	Myanmar	UCT	SBCC (monthly information sessions on four main topics: infant and young child feeding (IYCF) practices, health-seeking behaviour, hygiene practices and household expenditure)	Integrated services	NGO	Field and Maffioli (2021)
14	Livelihood Empowerment Against Poverty (LEAP) 1000	Ghana	UCT	Supportive public policies (free health insurance)	Alignment of services	Government	De Groot et al. (2022), Otieno et al. (2022), Palermo et al. (2019)
15	LEAP	Ghana	UCT	Supportive public policies (free health insurance)	Alignment of services	Government	Handa et al. (2014), Park (2013)
16	Cash Transfer with Integrated Management of Acute Malnutrition	Democratic Republic of the Congo	UCT	SBCC (nutrition)	Alignment of services	Research trial	Grellety et al. (2017)
17	Benazir Income Support Program plus Integrated Reproductive Maternal Newborn, Child Health & Nutrition Program	Pakistan	UCT	SBCC (health, nutrition and hygiene messages during monthly household visits and quarterly community sessions)	Convergence	Government	Khan et al. (2019)
18	Maternity allowance plus psychosocial stimulation	Bangladesh	UCT	SBCC (psychosocial stimulation)	Piggybacking	Government	Hossain et al. (2022)
19	Cash for Nutrition	Yemen	UCT	SBCC (monthly nutritional training sessions)	Integrated services	Government	Kurdi (2021)
20	Pantawid Pamilyang Pilipino Programme (4Ps)	Philippines	CCT	SBCC (parenting programme)	Piggybacking	Government	Lachman et al. (2021)

Study ID	Programme name	Country	Type of CT	Type of social and behaviour change (SBC)	Model of integration	Implementation	References
21	Comparison of supplementary foods with or without household support (cash or food transfer)	Niger	UCT	SBCC (nutritional education sessions)	Integrated services	NGO	Langendorf et al. (2014)
22	Nepal Poverty Alleviation Fund	Nepal	CCT	SBCC (nutrition sessions)	Integrated services	Government	Levere et al. (2016)
23	Ujana Salama (Adolescent Cash Plus Pilot)	United Republic of Tanzania	CCT	SBCC + service improvements + systems strengthening (life-skills training + mentoring + grant + linkages to reproductive and sexual health services and training for health care workers)	Integrated services	Government	Palermo et al. (2021), Prencipe et al. (2022)
24	National Cash Transfer Programme + Volet Comportemental	Niger	UCT	SBCC (nutrition and parenting practices related to psycho-social stimulation and child protection)	Integrated services	Government	Premand and Barry (2020)
25	Child Cash Grant	Nepal	UCT	SBCC + community engagement + systems strengthening	Convergence	Government	Renzaho et al. (2017, 2018)
26	Low Birth Weight South Asia Trial (LBWSAT) – a randomized controlled trial	Nepal	UCT	SBCC (participatory learning groups)	Integrated services	Research trial	Saville et al. (2018)
27	Community health worker (CHW) interventions and conditional cash transfers (CCTs)	United Republic of Tanzania	CCT	SBCC (delivered by CHW)	Integrated services	Research trial	Sudfeld et al. (2021)
28	Tekoporã	Paraguay	CCT	SBCC (monthly visits by social workers)	Integrated services	Government	Ribas et al. (2011)
29	Child Grant 0–2	Mozambique	UCT	SBCC (nutrition) + home-based case management services	Convergence	Government	UNICEF (2022)
30	Integrated Nutrition – Social Cash Transfer (IN-SCT)	Ethiopia	UCT	SBCC nutrition + improved access to services + community engagement	Convergence	Government	UNICEF et al. (2020)

Note: CT= cash transfer; UCT = unconditional cash transfer; CCT = conditional cash transfer.

List of included studies

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