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The Resourcing Families for Better Nutrition Common Approach: Comparing effectiveness and cost-effectiveness of Cash Plus interventions in preventing Acute Malnutrition in Somalia

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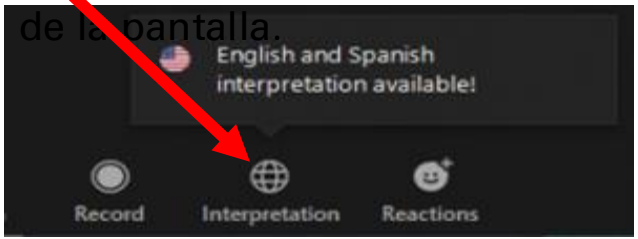

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The Resourcing Families for Better Nutrition Common Approach: Comparing effectiveness and cost-effectiveness of Cash Plus interventions in preventing Acute Malnutrition in Somalia

10 April 2025 **02:00 CTE**

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Cash and Voucher (CVA) Nutrition WG

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Webinar Objectives:

- Present the findings of the he research study "Research to Action in Humanitarian Setting (R2HC)", which tested the effectiveness and cost-effectiveness of Cash Plus interventions on the wasting status of children under five and pregnant and lactating women (including sub-studies on analysis of drivers of acute malnutrition and wasting relapse)
- Discuss how the results of this study can be useful

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Webinar Agenda

Section	Duration	Timing (Geneva time)
Welcome & Introduction	10 mins	14:00-14:10
1) **The Research to Action in Humanitarian Setting (R2HC):** Presentation of the Research Project findings	30 mins	14:10-14:40
2) **Resourcing Families for Better (RF4BN) common approach in humanitarian setting**: lessons learnt from the implementation of the Cash and Nutrition interventions	10 minutes	14:40-14:50
3) **Interactive session** with live questions from participants	20 min	14:50-15:10
4) **Messages from decision makers**: What does this project mean for future programming and policies on Cash for Nutrition?	20 mins	15:10-15:25
Closing & final remarks	5 min	15:25-15:30

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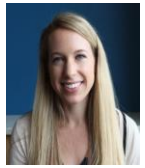
Today's Facilitators and Presenters



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Poll Question:

Do you believe that cash can be effective to prevent malnutrition?

- Yes
- No
- Not sure

SESSION 1: Research to Action in Humanitarian Crises (R2HC): Cash Plus to Prevent Acute Malnutrition

Results Presentation

April 10th, 2025

Somalia Background & Malnutrition Context

The State of Malnutrition in Somalia

- Recent IPC estimate: **1.7 million CU5** estimated to experience acute malnutrition from JANUARY - JUNE 2025
  - Number of SAM Children: 466,000
  - Number of MAM children 1,257,000
  - 61% of this burden concentrated in among rural populations, 23% IDPs and 16% urban.
  - **Overall CU5 GAM (using WHZ): 11.4%**

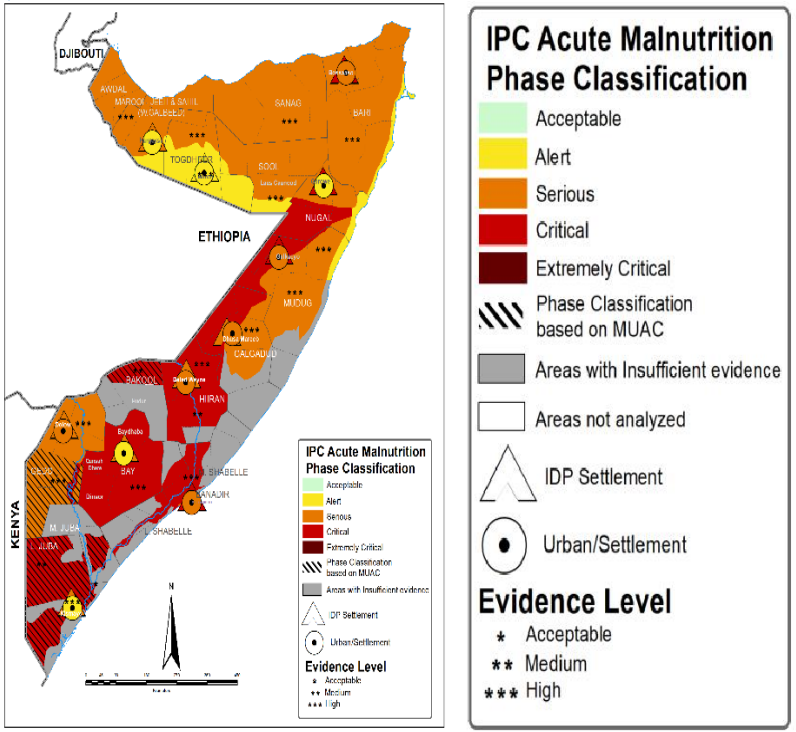
- 3.4 million people (17%) of the population are in Crisis or worse (IPC Phase 3 and higher) between January and March 2025

- In the projection period from April to June 2025, food security is expected to deteriorate further, with **4.4 million people (23%)** of the total population facing Crisis or worse (IPC Phase 3 and higher)

- Driven by poor rainfall, localized flooding, conflict/insecurity, high food prices, disease and poor health access, levels of acute food insecurity and malnutrition remain high in many parts of Somalia and are major contributors to increased mortality among CU5 in Somalia

- Disease outbreaks during the wet season, coupled with reduced humanitarian assistance, are expected to further exacerbate malnutrition.

Projected Nutrition Outcomes (Apr-Jun 2025)



https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1157950/?iso3=SOM

Somalia and Humanitarian Assistance

- 2024: **1.3 million people (35-40% of population in need) in Somalia received food security assistance from June – August 2024**
  - Food insecurity, water insecurity, in need of shelter, lacking WASH resources
  - Due to funding shortages, humanitarian assistance has declined since March 2024

- Aid has included **Cash Transfers**
  - Example: >250,000 households in Somalia expected to receive emergency cash aid from the World Bank in December 2023 after major flooding

- **Why Cash?**
  - Promotes dignity and autonomy
  - Allows the recipients to use for what is most needed
  - Supports local markets

https://civil-protection-humanitarian-aid.ec.europa.eu/where/africa/somalia_en#:~:text=In%202024%2C%20at%20least%206.9,saving%20humanitarian%20and%20protection%20assistance; https://www.worldbank.org/en/news/press-release/2023/12/15/over-250-000-afe-somali-households-to-benefit-from-cash-transfers-to-cope-with-flooding-and-food-insecurity

REACH Public Health Report. Mortality rates in Somalia: an integrated public health analysis. https://repository.impact-initiatives.org/document/impact/0d28044a/IMPACT_HQ_MSNA-PH-Report_Somalia_Jan2025_final-3.pdf

Research Objectives, Brief Methods and Key Results

Evidence Gaps around Cash Use for Humanitarian Assistance

- **Evidence gaps** around the most effective, cost-effective, and acceptable approaches to aid, including **cash transfers for nutrition**, in **humanitarian settings**.
  - Existing evidence primarily focused on cash transfers for food security
  - Limited evidence available around the use of CVA for nutrition outcomes in humanitarian settings, despite high use of cash assistance
    - For Save the Children, most of this evidence comes from their Resources for better Nutrition (RfBN) common approach (CVA+SBCC -> core components) that is used in development settings; need to test it in humanitarian setting

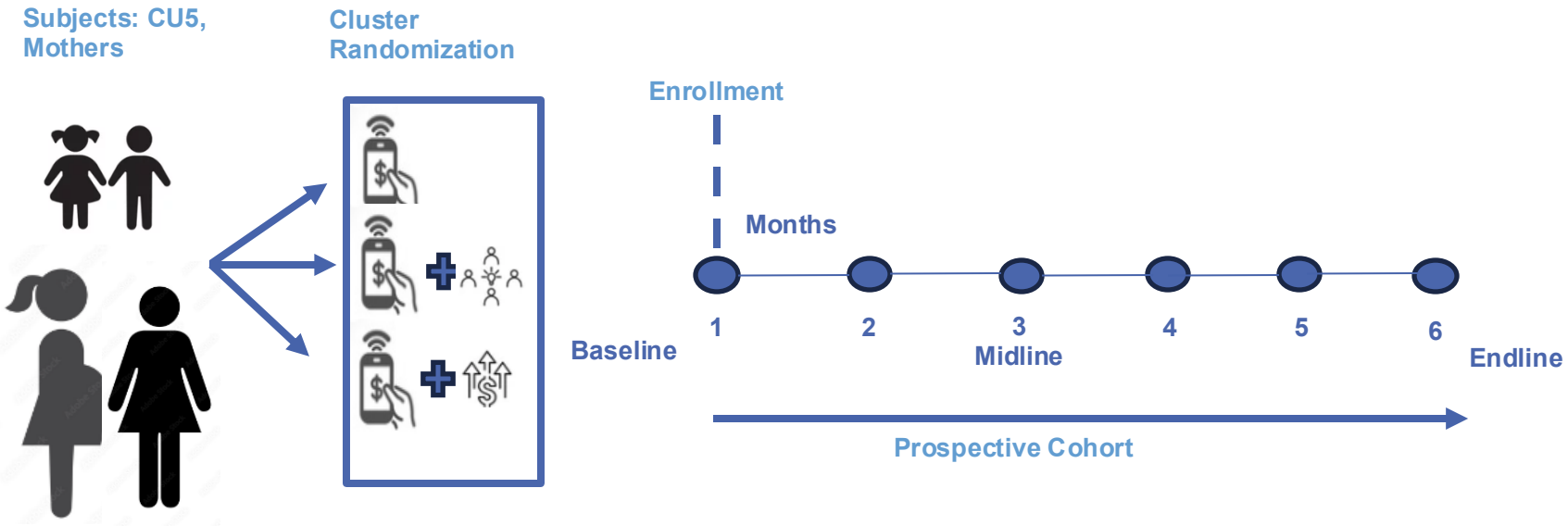
- There is a need for:
  - Research around CVA duration and amount
  - Cost-effectiveness design
  - Evidence generation in humanitarian settings

https://www.elrha.org/wp-content/uploads/2015/01/Evidence-Review-22.10.15.pdf; https://www.elrha.org/wp-content/uploads/2022/06/Elrha-HHER2-ExecutiveSummary.pdf; https://jhumanitarianaction.springeropen.com/articles/10.1186/s41018-018-0035-6; https://www.nutritioncluster.net/resources/evidence-and-guidance-note-use-cash-and-voucher-assistance-nutrition-outcomes-emergencies

Study Aims

- To address these evidence gaps, this study addressed the following aims:
  1. ***Compare wasting of CU5 and their mothers*** *receiving cash, cash + SBCC, or cash + top-up after 3 and 6 months*
     - Addresses CVA duration and intervention components
  2. ***Assess the costs and cost-effectiveness*** *of the different intervention arms*
     - Addresses cost-effectiveness design
  3. ***Understand the determinants/drivers*** *of and households' experiences in receiving program interventions*
     - Addresses evidence generation in humanitarian settings
  4. ***Understand concordance of MUAC and WHZ*** *based methods for measuring child wasting*
     - Addresses the gaps in wasting measurement reliability in programmatic settings
  5. ***Understand the rates and determinants of child wasting relapse*** *within 6 months of discharge treatment (sub-study)*
     - Addresses evidence gaps in the rates and risk factors for relapse in Somalia

Main Study Methodology



What were the interventions?

- Each participant received 1 mobile cash transfer per months for 6 months; transfer amount established based on the Minimum Expenditure Basket (MEB)

- Arm 1: cash only
  - Bay: $90 USD
  - Hiraan: $70 USD

- Arm 2: cash + SBCC
  - Bay: $90 USD + SBCC
  - Hiraan: $70 USD + SBCC

- Arm 3: cash + top-up
  - Bay: $90 USD + $35 top-up = $125 total
  - Hiraan: $70 USD + $35 top-up = $105 total

SBCC topics: Breastfeeding with in the first hour; exclusive breastfeeding for 6 months; complementary feeding; hygiene; physical and mental stimulation of the child; nutrition of PLWs

SBCC session details: Led by a trained lead mother who facilitated discussion with 10-15 mothers; weekly over 12 weeks for 45-60 minutes per session; also gives mothers a safe place to exchange ideas, share experiences

Study Results

Main Study Results

Primary Outcomes

Child

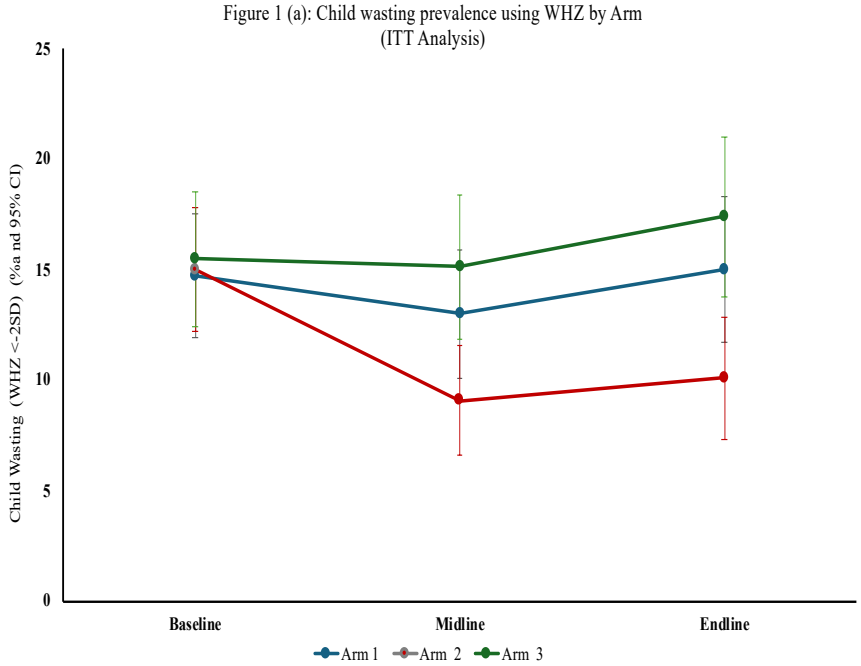
Child Outcomes – Key Findings

- Key child characteristics did not vary over time or by arm – indicating that sample remained representative and comparable across arms
  - With the exception of displacement – affected 15% of sample; differed by arm

- **Arm 2 (cash + SBCC) appears to have achieved the greatest and sustained benefit in reducing/preventing child wasting (in prevalence, incidence analysis); also across Bay and Hiraan regions**

Key Message: Study sample is representative; arms are balanced and comparable; Arm 2 yields the most benefit to reducing wasting prevalence (prevalence analysis) and also to preventing wasting (incident analysis)

Child Outcomes – Key Findings



	Baseline	Midline	Endline
Arm 1	14.74	12.99	15.03
95% CI	2.8	2.9	3.3
95% CI (L, U)	(12.1, 17.7)	(10.3, 16.1)	(12.0, 18.6)
Arm 2	15.03	9.07	10.08
95% CI	2.8	2.5	2.75
95% CI (L, U)	(12.4, 18.0)	(6.8, 11.8)	(7.6, 13.1)
Arm 3	15.49	15.12	17.39
95% CI	3.05	3.25	3.6
95% CI (L, U)	(12.6, 18.7)	(12.1, 18.6)	(14.0, 21.2)

Prevalence of child wasting comparing Arms

Testing differences between Study Arms			
	95% CI	95% CI	P-value (Chi2)
Baseline			
Arm1 Vs Arm 2	12.2, 17.6	12.5 , 18.0	0.881
Arm 1 vs Arm 3	10.4, 16.2	12.2, 18.6	0.323
Arm 2 vs Arm 3	6.9 ,11.8	12.2, 18.6	0.003*
Endline			
Arm1 Vs Arm 2	12.1, 18.5	7.7, 13.1	0.020*
Arm 1 vs Arm 3	12.1, 18.5	14.2, 21.1	0.326
Arm 2 vs Arm 3	7.7, 13.1	14.2, 21.1	0.001*

Arm 2 is the only one that is statistically different from the other two arms -> Arm 2 achieved the greatest benefit

No baseline differences -> randomization worked!

Incidence of child wasting – Between Arms

Wasting incidence comparing Study Arms	Arm 1	95% CI		Arm 2	95% CI		Arm 3	95% CI		Chi2
Baseline (Clean cohort										
Sample N(%)	572 (35.6%)			555 (34.6%)			479 (29.8%)			
WHZ										
Not wasted	567 (100.0%)			554 (100.0%)			478 (100.0%)			Ref
W										
M										
										Ref
W										
Midline										
Sample N(%)	544 (33.9%)			563 (35.0%)			500 (31.1%)			
WHZ										
Not wasted	469 (87.0%)	.838946	.8960241	501 (90.9%)	.8821821	.9305977	421 (84.9%)	.8144052	.8777611	0.010
Wasted	70 (13.0%)	.1039759	.161054	50 (9.1%)	.0694023	.1178179	75 (15.1%)	.1222389	.1855948	
MUAC										
Not wasted	535 (99.3%)	.9803555	.9972181	546 (98.9%)	.9759366	.9951085	488 (98.2%)	.9654469	.9905476	0.275
Wasted	4 (0.7%)	.0027819	.0196445	6 (1.1%)	.0048915	.0240634	9 (1.8%)	.0094524	.0345531	
Endline										
Sample N(%)	489 (33.2%)			517 (35.1%)			467 (31.7%)			
WHZ										
Not wasted	407 (85.0%)	.8147126	.8790396	446 (89.9%)	.8693557	.9228217	380 (82.6%)	.788584	.8581341	0.004
Wasted	72 (15.0%)	.1209604	.1852874	50 (10.1%)	.0771783	.1306443	80 (17.4%)	.1418659	.211416	
MUAC										
Not wasted	475 (98.8%)	.9723498	.9943733	491 (98.8%)	.9732898	.9945661	449 (97.6%)	.9572788	.9867295	0.260
Wasted	6 (1.2%)	.0056267	.0276502	6 (1.2%)	.0054339	.0267102	11 (2.4%)	.0132705	.0427212	

Arm 2 has the greatest and sustained benefit to wasting prevention (is statistically significantly different from the other two arms at each time point)

Primary Outcomes

Maternal

Maternal Outcomes – Key Findings

- Maternal wasting prevalence dropped from baseline to midline but bounced back by endline; no statistically meaningful difference across Arms though Arm 1 appears worst off at endline
  - Observed trend may be secular trend rather than linked to the intervention

- Maternal wasting incidence follows similar pattern as prevalence (no statistically meaningful differences across arms) through Arm 1 appears worst off and Arm 2 appears most protected

Key Message: The intervention does not appear to benefit maternal wasting as much as child wasting; though only cash has worst outcomes and cash + SBCC appears most protected

Cost-efficiency & Cost-effectiveness Results

Key Message:
Arm 2 (cash + SBCC) was cost-efficient and the most cost-effective arm using a programmatic and societal lens.

Driver of Wasting Results Across Arms

Drivers Across Arms-Immediate Factors

- At the immediate level, child diet diversity—including the intake of animal-source proteins—improved across all study arms, with Arm 3 showing the highest levels by endline. Reports of child illness declined in Arms 1 and 2 but increased in Arm 3.

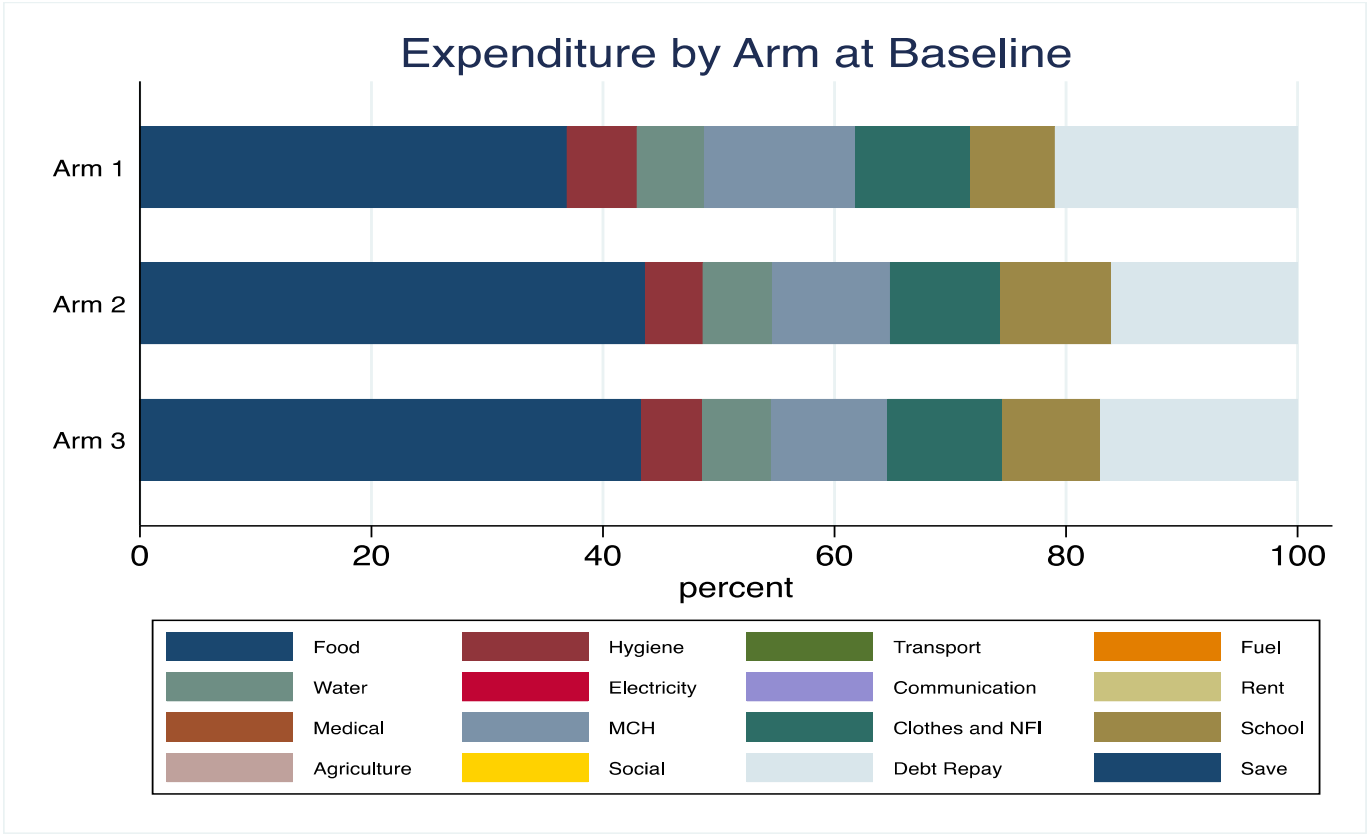
Child Wasting Drivers	Study Arm	Baseline Percentage (95% CI)	Midline Percentage (95% CI)	Endline Percentage (95% CI)
Meet Minimum Dietary Diversity for child (MDD-C), %		n=415	n=904	n=1,022
	Arm 1	5.1 (2.6, 9.9)	35.0 (29.1, 40.2)	28.1 (23.3, 33.3)
	Arm 2	12.0 (7.5, 18.8)	33.4 (28.4, 38.9)	32.3 (27.6, 37.1)
	Arm 3	10.4 (6.1, 17.2)	36.6 (31.4, 42.2)	42.5 (37.3, 47.8)
Child received animal-sourced protein (meat, eggs, milk), %		n=478	n=1,112	n=1,153
	Arm 1	53.1 (45.7, 60.4)	76.2 (71.5, 80.4)	73.5 (68.7, 77.8)
	Arm 2	58.8 (50.9, 66.2)	74.9 (70.2, 79.0)	73.3 (68.7, 77.4)
	Arm 3	56.6 (48.3, 64.6)	69.4 (64.6, 73.8)	81.6 (77.4, 85.1)
Had childhood illness* 2 weeks prior (malaria, diarrhea and/or cough), %		n=477	n=1,112	n=1,153
	Arm 1	41.1 (34.0, 48.6)	31.5 (26.8, 36.6)	25.4 (21.2, 30.2)
	Arm 2	31.4 (24.7, 39.1)	31.8 (27.2, 36.7)	27.8 (23.6, 32.4)
	Arm 3	25.9 (19.3, 33.7)	30.8 (26.4, 35.6)	36.6 (31.9, 41.5)

Drivers Across Arms-Underlying Factors

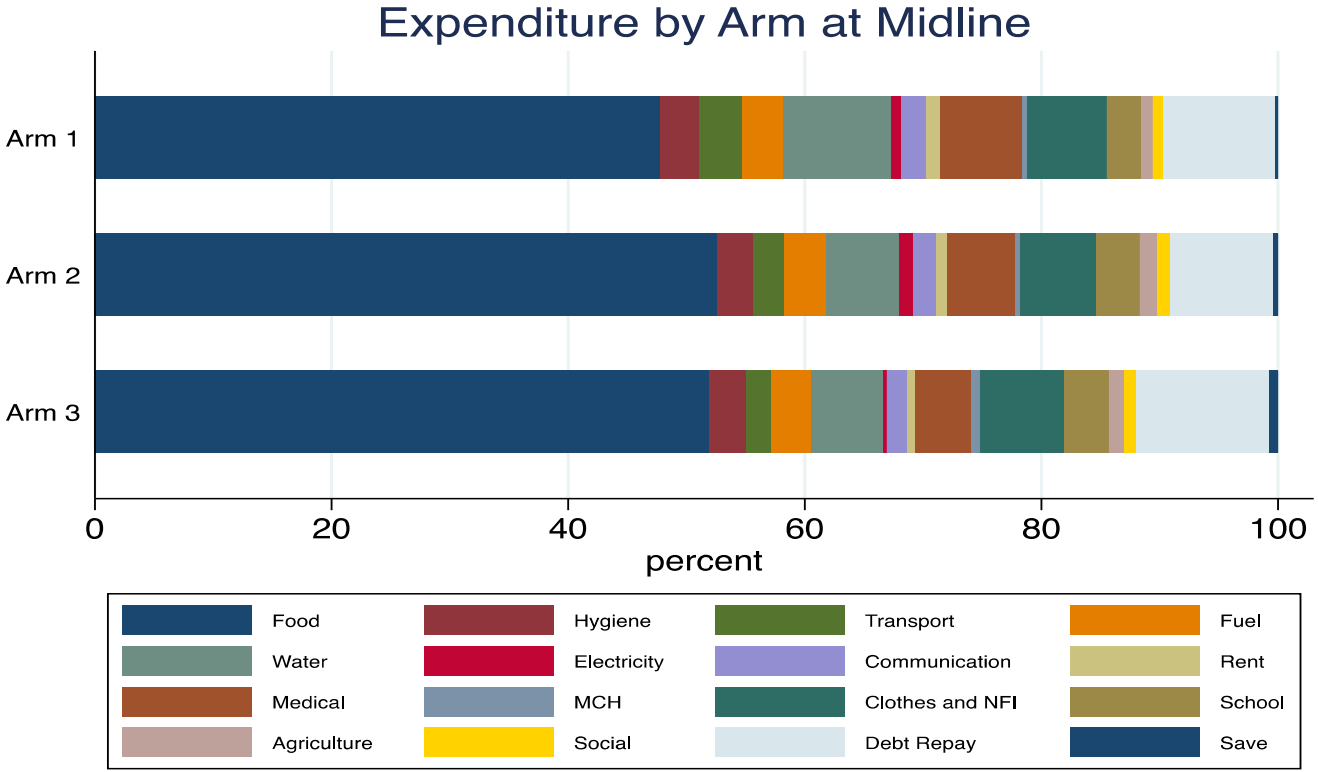
- Food insecurity indicators—moderate/severe hunger and borderline/poor food consumption scores—improved in all arms except Arm 3, where food consumption scores worsened.
- Vaccination coverage increased across all arms, with Arm 2 achieving the highest rates by endline.
- Access to protected water sources improved, though open defecation persisted and even increased in Arm 3.
- Handwashing facilities became more available, but gains were limited in Arm 3.

Child Wasting Drivers	Study Arm	Baseline Percentage (95% CI)	Midline Percentage (95% CI)	Endline Percentage (95% CI)
Borderline-Poor Food Consumption Score, %		n=1,489	n=1,112	n=1,153
	Arm 1	75.5 (71.6, 79.1)	52.4 (47.1, 57.6)	64.1 (59.0, 68.9)
	Arm 2	78.5 (73.6, 83.4)	48.9 (43.9, 54.0)	63.3 (58.4, 67.8)
	Arm 3	58.3 (51.1, 65.1)	51.7 (46.7, 56.6)	54.2 (49.2, 59.1)
Coping Strategies Index Score (mean, CI)		n=1,489	n=1,112	n=1,153
	Arm 1	14.5 (13.7, 15.3)	13.5 (12.5, 14.5)	14.5 (13.5, 15.5)
	Arm 2	15.3 (14.5, 16.0)	14.3 (13.2, 15.3)	14.6 (13.5, 15.7)
	Arm 3	14.9 (14.0, 15.7)	12.4 (11.5, 13.3)	14.1 (13.1, 15.0)
Received any childhood vaccination, %		n=1,477	n=1,112	n=1,153
	Arm 1	50.9 (43.4, 58.2)	62.7 (57.5, 67.7)	79.8 (75.4, 83.7)
	Arm 2	48.4 (40.7, 56.2)	59.4 (54.3, 64.2)	86.8 (83.0, 89.7)
	Arm 3	46.2 (38.1, 54.4)	67.6 (62.8, 72.1)	75.4 (70.9, 79.5)
Households practicing open defecation, %		n=1,485	n=1,086	n=1,140
	Arm 1	23.5 (20.0, 27.4)	28.7 (24.1, 33.8)	22.7 (18.7, 27.3)
	Arm 2	13.7 (10.9, 17.0)	15.0 (11.7, 19.0)	19.0 (15.4, 23.2)
	Arm 3	21.3 (17.8, 25.2)	27.3 (23.1, 32.0)	33.5 (29.0, 38.4)
No access to handwashing facilities %		n=1,489	n=1,112	n=1,153
	Arm 1	95.5 (93.3, 97.0)	97.7 (95.5, 98.9)	78.8 (74.2, 82.7)
	Arm 2	99.0 (97.6, 99.6)	94.4 (91.5, 96.3)	83.3 (79.3, 86.6)
	Arm 3	98.7 (97.2, 99.4)	99.2 (97.6, 99.8)	89.8 (86.3, 92.4)

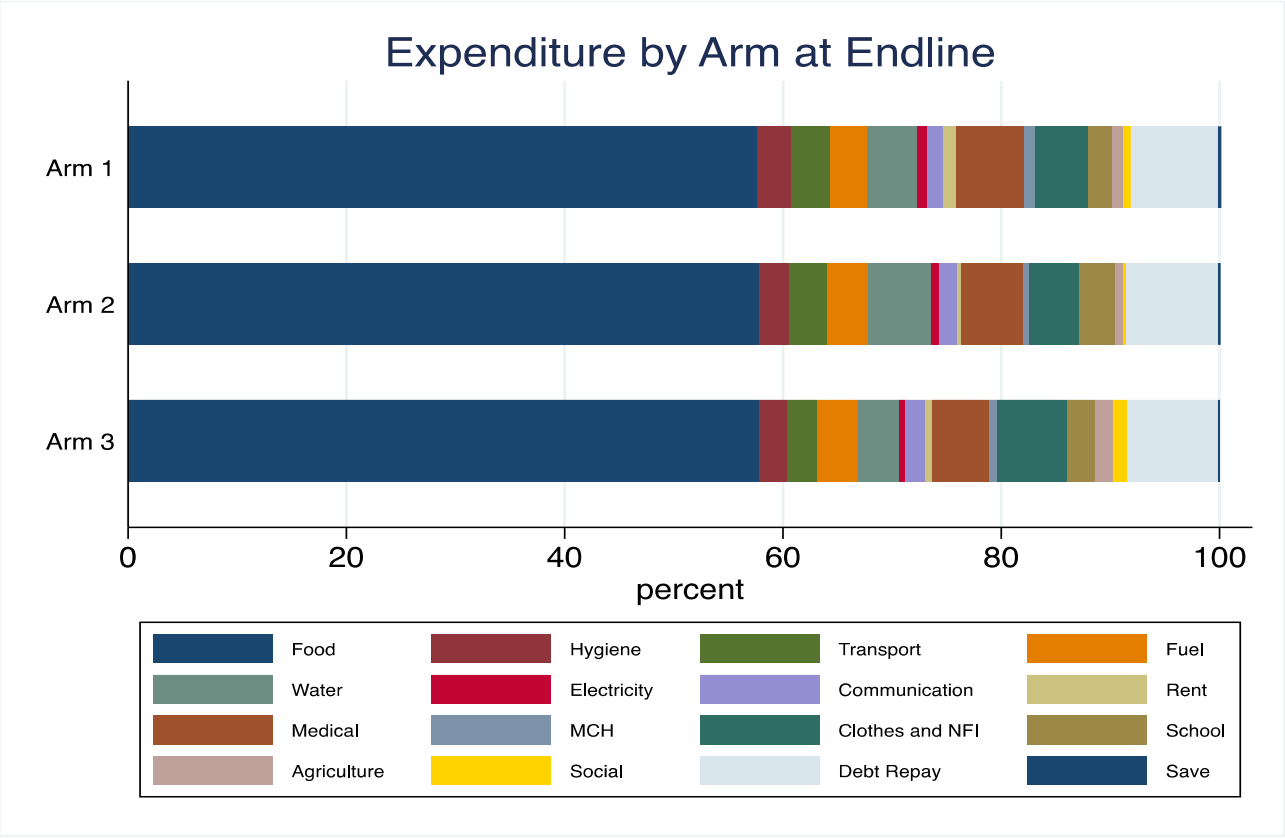
Household expenditure Items by Arm at Baseline



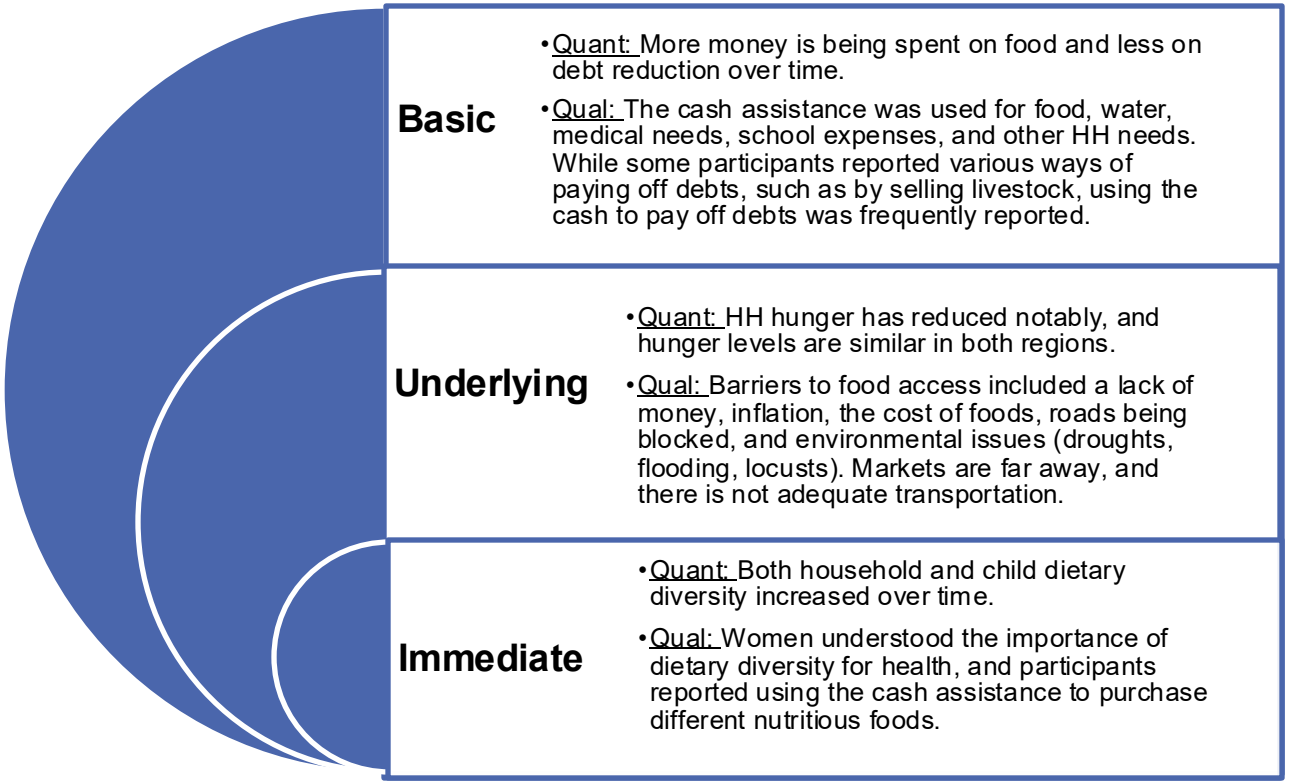
Household expenditure Items by Arm at Midline



Household expenditure Items by Arm at Endline



Qualitative Results Contextualize Quantitative Findings



"That cash assistance has been covering some of our basic needs like water expenses, electricity, educational fees, food, and milk for the children…"
- Mother, Hiraan, Arm 2

"There is a lot that I can't afford, such as meat and milk, because of a lack of money" – Mother, Bay, Arm 3
"We are in inflation. The road between Baidoa and Mogadishu is cut off. There is not enough food for us." – Husband, Bay

"It is used to buy nutritious food for the children, such as bananas, eggs, and soft food that will be of great help to them." – Mother, Hiraan, Arm1
"Eating a variety of foods is healthy." – Mother, Bay, Arm 2

Understanding Cash Plus Program Views

- **Program Quality & Satisfaction**: In general, participants spoke positively of the program and reported that it positively impacted not only beneficiaries, but also the community. Yet, they requested an increase in the cash amount & duration and more trainings & awareness.

"I am happy for the program one hundred percent…before the program, we didn't have anything and when [we] got the program, we were prosperous, and we had never seen a program like this." – Mother, Bay, Arm 3

- **Role of SBCC**: Participants reported learning about multiple topics, including nutrition, young child feeding, health-seeking, & hygiene.

"After getting the messages, we changed from previous behaviors, and we opted to choose the nutrition."– Mother, Hiran, Arm 1

Wasting Measurement Concordance Results

Wasting Measurement Concordance Analysis: Objectives

- Analysis Objectives:
  - 1) Generate wasting prevalences using MUAC, MUACZ, and WHZ
  - 2) Compare the concordance and agreement between MUAC, MUACZ, and WHZ, and stratify by child age (9-23 months vs 24-59 months)
  - 3) Examine sensitivities and specificities of higher MUAC and MUACZ thresholds compared to WHZ
    - How does raising the MUAC cutoff above 12.5cm impact its diagnostic ability?

Key Terms for Analysis

Concordance: agreement between 2 methods for diagnosing a disease/illness

MUACZ: an age-adjusted and sex-adjusted MUAC z-score

Concordance Result: Wasting Prevalences

- Wasting prevalence varied significantly by measurement technique

Measurement Technique	Wasting Prevalences				
	Full Sample	**Female**	**Male**	**6-23 months**	**24-59 months**
MUAC	1.5%	1.3%	1.7%	4.1%	0.9%
MUACZ	8.5%	7.9%	9.2%	5.56%	9.23%
WHZ	14.8%	12.7%	16.9%	12.22%	15.38%
WHO Guidelines (MUAC, WHZ, and edema)	15.5%	13.3%	17.7%	14.07%	15.82%

- In agreement with previous studies
  - **MUAC** identified wasting in **younger children** (6-23 months)
  - **WHZ** identified wasting in **male and older children** (24-59 months)

Concordance Results & Key Messages

- MUAC alone **failed to diagnose 94% of WHZ-wasted children**
- MUAC and WHZ only had **slight agreement**; MUACZ and WHZ had **fair/moderate agreement**
- **Age** is an important factor to consider for wasting measurement

Key Message:
Ideally, WHZ should be adopted for community screening as a gold standard for wasting measurement.

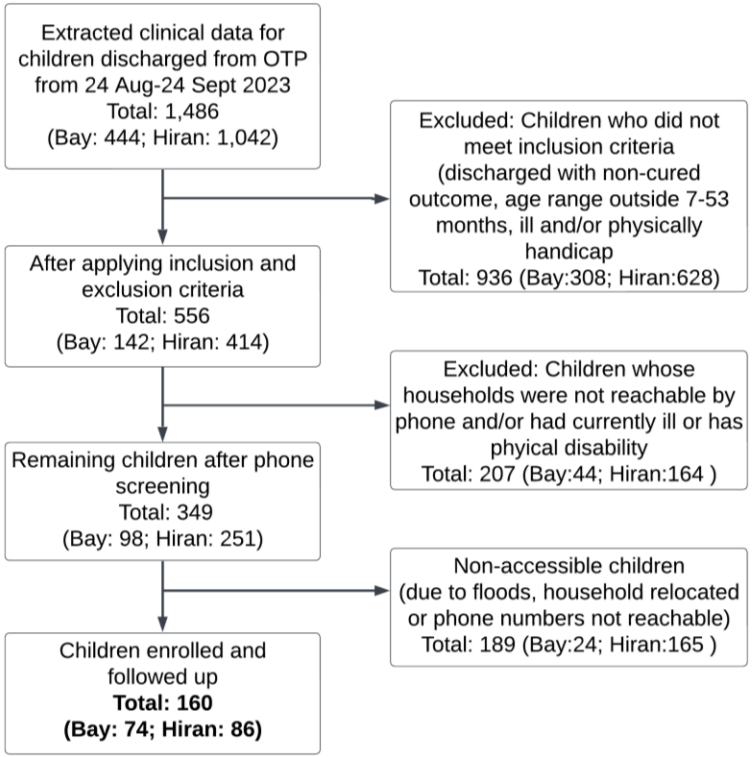
However, age-specific MUAC thresholds may be a practical way to accurately screen and refer more wasted children for treatment when measuring a child's weight-for-height is not feasible.

Relapse sub-study results

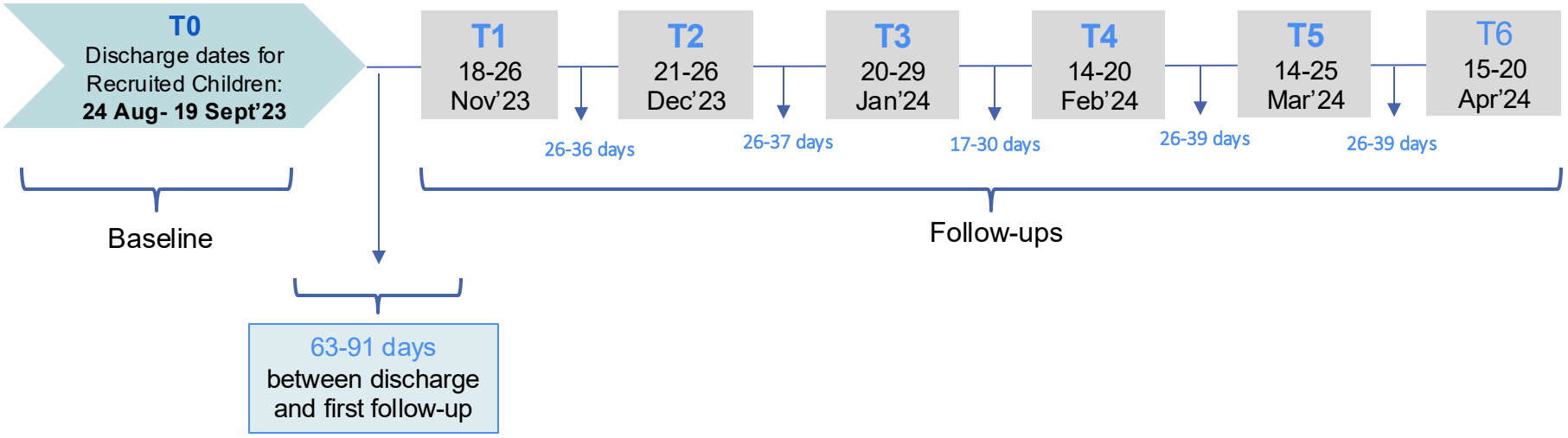
Objectives

1. Estimate the cumulative rates of relapse after treatment of SAM and MAM among children 6-59 months of age monthly for 6 months post-discharge

2. Identify child and household-level factors associated with relapse.



Data Collection Timeline



We used a +/-5 days for follow-up.
Range between: 25-35 days

Relapse Analysis Approach

Categories of children at Discharge/Exit	
Sample: N	160
Wasting by WHZ	
Normal	108 (67.5%)
MAM	26 (16.2%)
SAM	26 (16.2%)
Wasting by MUAC	
Normal	22 (13.8%)
MAM	138 (86.2%)

NOTE:

1. Programmatically transfer criteria from OTP to TSFP is at MUAC >=11.5cm
2. By WHZ, 26 children are in the SAM category. Excluded these children from analysis.

ANALYSIS COHORTS

1. **COHORT 1**: Normal + MAM cohort (n=108+26=134) followed up for **SAM** using WHZ (WHZ -3 SD) (RED)
2. **COHORT 2:** Normal + MAM cohort (n=22+138= 160) followed up for **SAM** using MUAC (GREEN)
3. **COHORT 3:** Normal cohort (n=108) followed up for **MAM** using WHZ (BLUE)

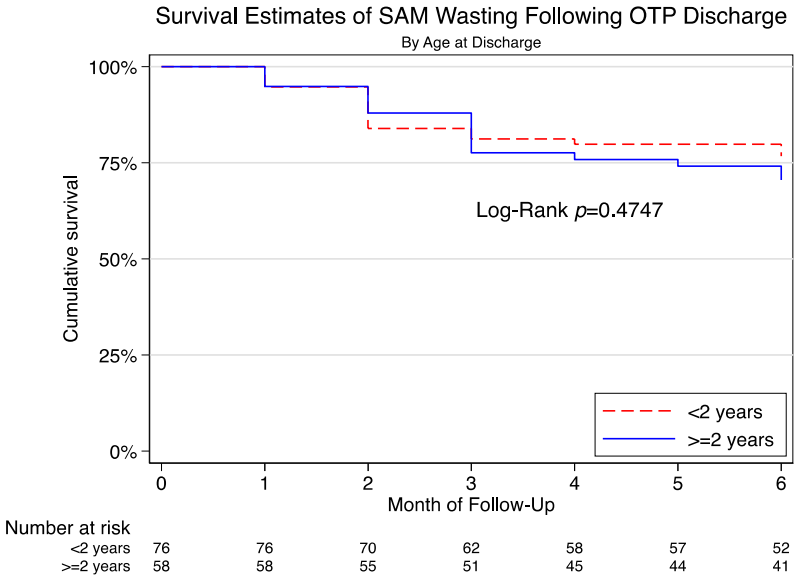
Relapse rates (Incidence & Cumulative)

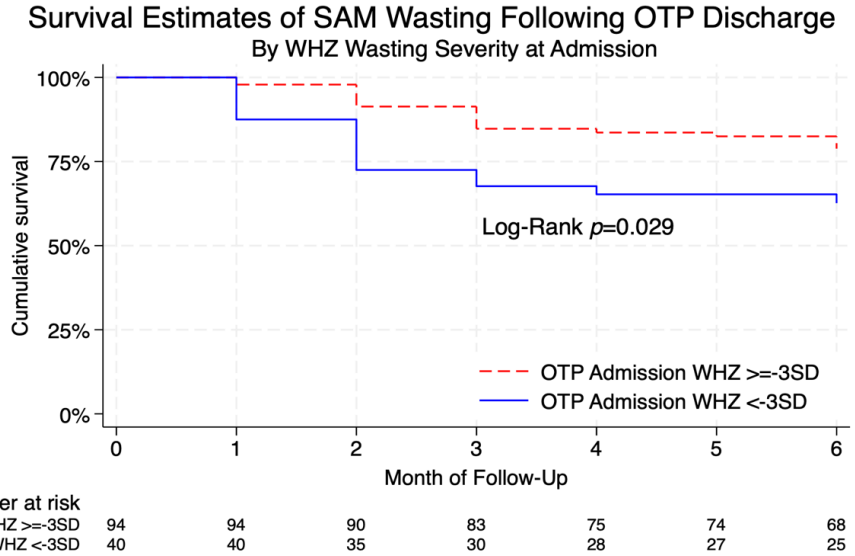
	Time	Relapse rate		95% CI	
		Incidence	cumulative		
COHORT 1					
Followed up for SAM by **WHZ** (n= 134)	T1 (2 months)	5.2%	5.2%	0.0253	0.1064
	T2 (3 months)	9.1%	14.3%	0.0938	0.2153
	T3 (4 months)	6.1%	20.4%	0.1446	0.2831
	T4 (5 months)	1.6%	22.0%	0.1580	0.3002
	T5 (6 months)	0.7%	22.7%	0.1648	0.3089
	T6 (7 months)	3.3%	26.0%	0.1934	0.3449
COHORT 2					
Followed up for SAM by **MUAC** (n= 160)	T1 (2 months)	8.8%	8.8%	0.0528	0.1433
	T2 (3 months)	2.5%	11.3%	0.0725	0.1729
	T3 (4 months)	1.2%	12.5%	0.0827	0.1875
	T4 (5 months)	0.0%	12.5%	0.0827	0.1875
	T5 (6 months)	0.7%	13.2%	0.0880	0.1949
	T6 (7 months)	0.0%	13.2%	0.0880	0.1949
COHORT 3	T1 (2 months)	26.9%	26.9%	0.1950	0.3628
	T2 (3 months)	9.3%	36.2%	0.2795	0.4607
Followed up for MAM by WHZ (n=108) **(>=-3 &<-2 SD)**	T3 (4 months)	2.9%	39.1%	0.3059	0.4899
	T4 (5 months)	4.9%	44.0%	0.3518	0.5395
	T5 (6 months)	4.0%	48.0%	0.3892	0.5785
	T6 (7 months)	2.1%	50.1%	0.4097	0.6001

Summary

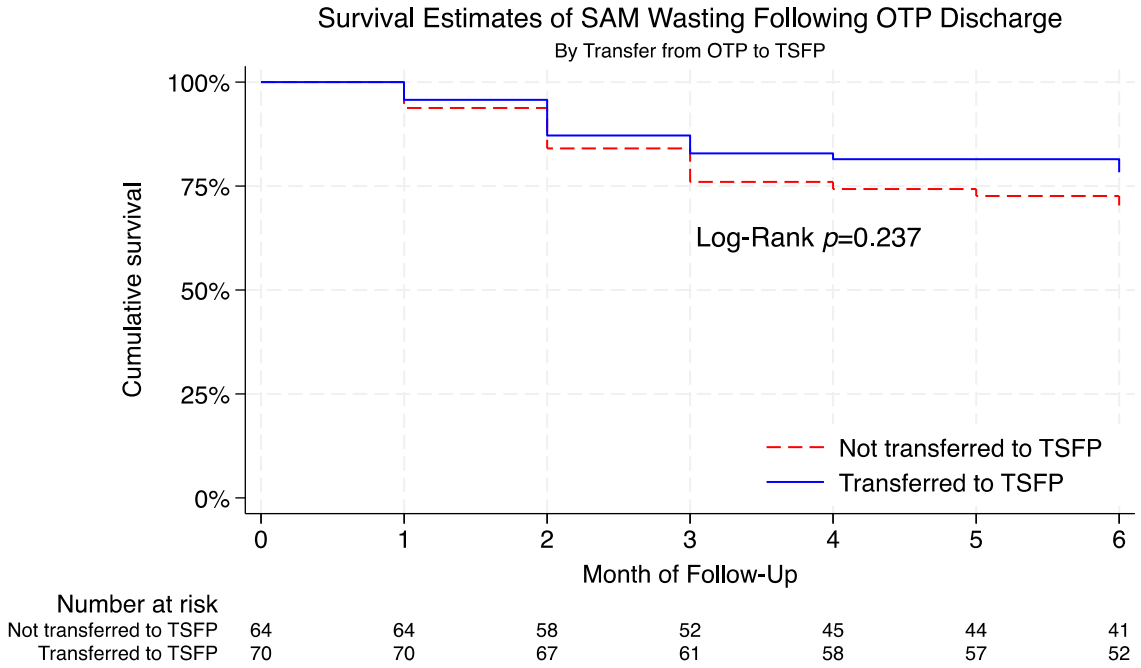
- SAM Relapse rate is 26% at 7 months post OTP exit
- MAM relapse rate is 50%

Survival Estimates of SAM Wasting Post-OTP Discharge:
By Age and by WHZ Wasting Severity





Survival Estimates of SAM Wasting Post-OTP Discharge:
By transfer from OTP to TSFP



Relapse risk factors

	Unadjusted		Adjusted+	
Relapse Factors	**Risk ratio (95% CI)**	**p-value**	**Risk ratio (95% CI)**	**p-value**
Admission factors				
Anthropometric at Admission				
WHZ < -3	2.05 (1.04-4.03)	**0.029**	2.22 (1.04-4.72)	**0.039**
MUAC < 11.5 cm	1.25 (0.52-3.03)	0.603	1.86 (0.63-5.48)	0.262
HAZ < -2	0.98 (0.49-1.95)	0.946	1.09 (0.51-2.32)	0.831
Length of Stay in OTP, days	1.02 (1.00-1.03)	**0.021**	1.02 (1.00-1.04)	**0.027**
Maternal characteristics				
Mother age (continuous)	1.02 (0.95-1.10)	0.560	1.03 (0.95-1.12)	0.455
Formal education	0.85 (0.16-4.36)	0.838	0.80 (0.15-4.19)	0.796
Mother is head of household	0.56 (0.12-2.48)	0.424	0.43 (0.09-2.03)	0.285
Mother is decision maker on income	0.65 (0.13-3.36)	0.597	0.58 (0.11-3.06)	0.517
Mother is decision maker on healthcare	0.74 (0.14-3.82)	0.712	0.76 (0.14-4.03)	0.750
Mother weight (continuous)	0.99 (0.97-1.02)	0.733	0.99 (0.97-1.02)	0.727
Mother MUAC measurement (continuous)	0.98 (0.90-1.07)	0.602	0.97 (0.89-1.06)	0.532
Maternal wasting, MUAC <23 cm	1.20 (0.53-2.72)	0.645	1.25 (0.55-2.83)	0.600

+ Adjusted for child age, sex, livelihood zone, and time to relapse)

Relapse risk factors

Relapse Factors	Unadjusted		Adjusted+	
	Risk ratio (95% CI)	p-value	Risk ratio (95% CI)	p-value
Child feeding indicators				
Acceptable FCS	0.52 (0.10-2.67)	0.413	0.54 (0.10-2.95)	0.474
Child vaccination & illness history				
Ever received a vaccination	0.87 (0.10-7.24)	0.897	0.93 (0.09-9.58)	0.949
Child was ill 2 weeks prior to survey	1.15 (0.56-2.38)	0.688	1.21 (0.58-2.51)	0.608
Child had access to care when ill				
Immediately (in the last 2 weeks)	0.65 (0.33-1.29)	0.201	0.65 (0.33-1.30)	0.224
Immediately (in the last 6 month)	0.95 (0.19-4.92)	0.954	1.20 (0.22-6.54)	0.835
Child was admitted in wasting program (in the last 12 months)-other than the last admission	0.63 (0.14-2.80)	0.528	0.53 (0.10-2.69)	0.443
Child household and environment				
Household was affected by a recent flooding	1.43 (0.58-3.56)	0.421	2.05 (0.69-6.07)	0.196
Received BHA cash assistance	0.52 (0.26-1.02)	**0.044**	0.44 (0.22-0.90)	**0.025**
Crowded Household (≥ 5 people)	1.49 (0.29-7.67)	0.625	1.56 (0.30-8.12)	0.594
Household with ≥3 U5 children	2.24 (0.50-10.00)	0.267	2.12 (0.47-9.54)	0.329
Uses improved toilet	1.40 (0.17-11.64)	0.748	1.66 (0.18-15.09)	0.653
Uses improved drinking water source	1.34 (0.16-11.13)	0.780	1.29 (0.15-11.36)	0.816
Lacked access to sufficient quantity of drinking water in last 30 days (≥ 2 times)	1.27 (0.28-5.66)	0.750	1.32 (0.28-6.14)	0.724
Have access to handwashing facility	0.95 (0.11-7.90)	0.961	0.76 (0.08-7.06)	0.810

+ Adjusted for child age, sex, livelihood zone, and time to relapse)

Summary

- Longer LoS and low WHZ at admission are statistically significant predictors of a higher risk for relapse
- The BHA program is protective

Summary & Next Steps

Overall summary –Main Takeaways

1. **Main Results:** Arm 2 (cash + SBCC) was the most effective in reducing prevalence and incidence of child wasting

2. **Qualitative:** The qualitative results help explain and contextualize the quantitative findings and provide insight into different levels of the UNICEF framework.

3. **Cost-Effectiveness:** Arm 2 (Cash+ SBCC) was cost-effective compared to Arm 1 , and Arm 3 was not. The additional cost of the SBCC component of Arm 2 was only $1 per HH/month.

4. **Drivers Across Arms:** The drivers across arm help to explain the main wasting outcomes. For example, Arm 3 did not achieve the same gains household food security overtime. This reinforces the importance of Cash plus SBCC in reducing prevalence and incidence of child wasting

5. **Concordance:** Using age-specific MUAC thresholds or MUACZ may be a practical way to accurately screen and refer more wasted children for treatment when measuring a child's weight-for-height is not feasible.

6. **Relapse:** Children are relapsing. SAM relapse rate is 26% and MAM relapse rate is 50% at 7 months post OTP exit. Longer LoS and low WHZ at admission are significant predictors of a higher risk for relapse. Livelihood programs, e.g the BHA program protective.

Next Steps – Results to Action

- Country wide dissemination activities planned – Q2 2025
  - Policy makers, donors, implementers
  - Discuss recommendations and priorities for policy given Somalia context
  - Inform upcoming policy and strategy documents on preventing SAM and MAM (+ relapse)

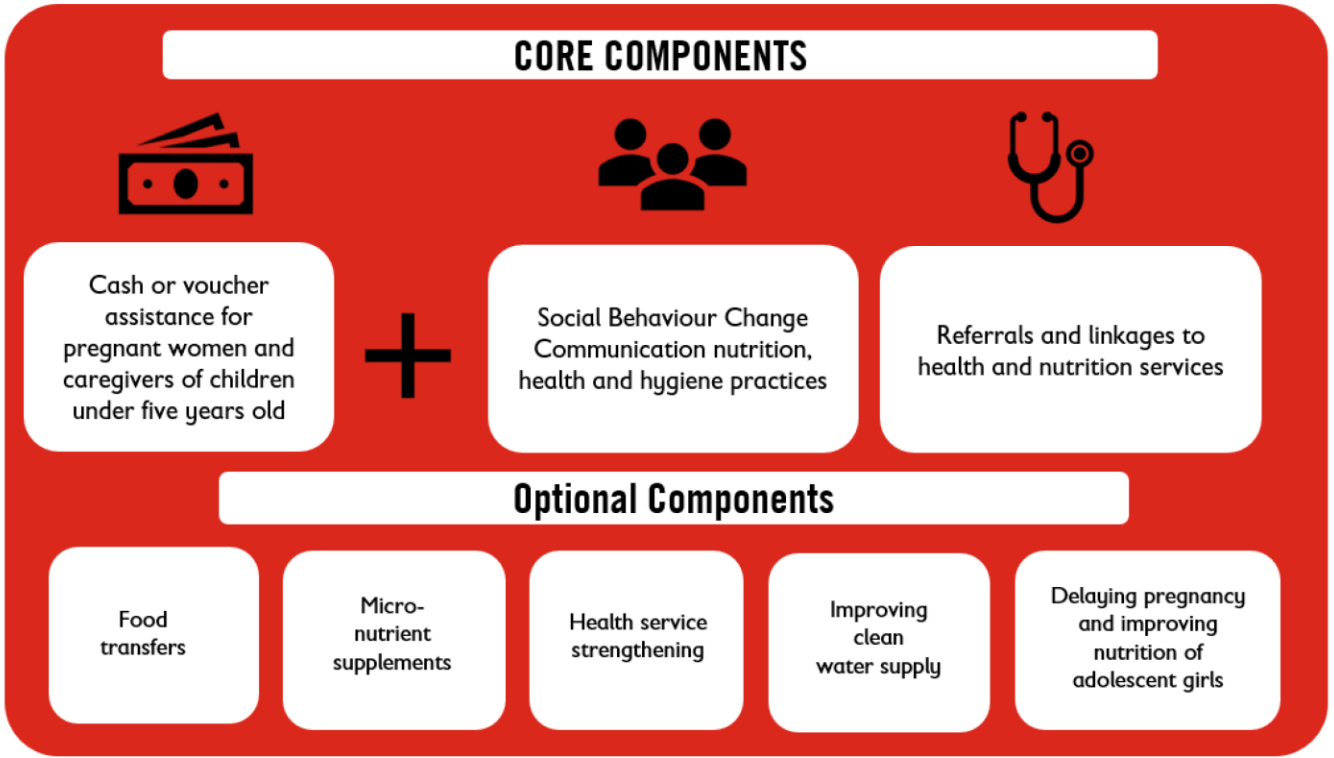
- Findings from these studies can be used widely beyond Somalia context, to other humanitarian settings by academia, guideline groups, technical groups on cash/social protection, food security & nutrition clusters, IPC

SESSION 2:

Lessons Learnt from the implementation of Cash and Nutrition

Yusuf Mahdi, Nutrition Specialist
Isaq Dahir, Social Protection Specialist
Save The Children -SOMALIA

Resourcing Families for Better Nutrition



Purpose: Improve nutrition outcomes for mothers and children through cash + SBCC during the project cycle

Implementation of SBCC program component

Site Coverage: The intervention was carried out across **11 sites** in the two target regions.

Support Groups Established: A total of **44 mother-to-mother support groups** were formed in the target locations.

Group Structure: each group consisted of **12 mothers**, with one **lead mother** overseeing

Beneficiaries: The program reached a total of 534 mothers.

Session Frequency: Weekly support group sessions of 45 minutes at location convenient for the participants.

Technical Support: Each lead mother was specifically trained, and each group was also assisted by a **trained IYCF promoter**.

Key Messages & Duration: The groups received **12 key messages** over **12 weeks cycle period.**

Doubling on M2MSG group: After the initial three-month cycle, **every mother joined a second 12-week MtMSG round** to reinforce learning and deepen their understanding.

Regular supervision: the mothers' attendance was monitored to ensure they fully attend all the sessions.

Strengthening IYCF Practices: Integrated Strategy

Awareness & Attitude: Heightened awareness of proper nutrition and its health impact through strategic messaging and education. Positive shift in attitudes toward optimal IYCF practices, health-seeking behaviors, and healthy eating by challenging cultural beliefs and reshaping social norms.

Access & Action: Improved access to nutritious, age-appropriate, locally available, and affordable foods through Cash support. Mothers are empowered with knowledge, creative recipe ideas, and practical food preparation skills.

Strategic Approaches: Community mobilization through leaders and influencers; context-specific SBCC to promote feeding, hygiene, and healthcare practices; caregiver and health worker training; integration into health and social services; and policy support for sustainable scale-up.

SBCC Activities

SBCC Activities

- Home visits with 1,000 days families
- Mother-to-mother support groups (M2MSG)
- Father-to-Father support groups (F2FSG)
- One session/week, four session/month
- 12 sessions throughout the programme for 3 moths
- Cooking demonstrations with mothers
- Community sessions with husbands and grandmothers
- Mobilization of local authorities & the health system
- Awareness raising on Health seeking behavior
- Mobilization of community elders, opinion leaders to take part SBCC activities in the community
- Mobilization and awareness-raising through a mobile messaging system delivered directly to beneficiaries' phones

MtMSG session

FtFSG with community leaders

IYCF individual counseling MCH.

IYCF group counseling in Baidoa, Hanano 2 site.

Effective Cash Delivery in Somalia

- SCI implemented CVA in Somalia for decades, building trust and understanding with communities
- SCI CVA Operational readiness capacity– SOPs, FRAs, Skilled staff, Partnership with MMOs, Presence across the country, coordination with CWGs and clusters.
- SCI Deep understanding of local context, culture, and needs shapes SCI's Cash program design and delivery
- Beneficiaries/communities are familiar with our Cash modality and delivery mechanism
- Engaging local leaders and community members in all stages promotes buy-in and accountability – helps acceptance, smoother implementation

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Effective Cash Delivery in Somalia

- Mobile Money ensured efficient disbursements of aid rapidly, at scale, and flexibly - Direct transaction (no need to cash out)
- Market Monitoring of food and nutritious food to monitor adequacy of transfer value
- Strong coordination with Nutrition teams enhance the effectiveness, optimized cost efficiency through shared resources (staff, logistics)
- Beneficiary Centricity - from transparent communication and community mobilization to data-driven decision-making and responsive feedback mechanisms

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THANK YOU

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SESSION 3: Q&A

Pool question

What do you think now, can cash be effective to prevent malnutrition?

- ☐ *Yes*
- ☐ *No*
- ☐ *Not sure*

Pool question

How would you use the results of this research in your setting?

- ☐ *Improve program design*
- ☐ *Strengthen implementation*
- ☐ *Integrate with other interventions*
- ☐ *Support funding decisions*
- ☐ *For further research*
- ☐ *Advocate for policy change*
- ☐ *Adapt social protection system*

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SESSION 4:
Discussion with Decision Makers

What does this project mean for future programming and policies on CVA for Nutrition?

From Omer, Meftuh, Head of Health, Nutrition and Wash, SC Somalia

- In 2025 around 1.8 million children (aged 6–59 months) are expected to experience acute malnutrition, including: 479,000 children suffering from SAM and 1,321,000 children facing MAM

The research highlight key drivers of acute malnutrition in Somalia

- Poor rainfall or erratic rain pattern
- Frequent drought , and Flooding due to climate change
- Conflict and insecurity leading to frequent displacements and loss of resilience gained
- High food prices/ high food insecurity(access, availability, affordability and quality)
- High disease burden and closure of health and nutrition services
- Low coverage of maternal and child primary health care(nutrition, immunizations, maternal continuum of care)
- Limited access to safe drinking water, sanitation, and hygiene services
- Poor IYCF practices
- Socioeconomic and Environmental Factors (Poverty and limited income opportunities, Gender inequality affecting access to resources & Environmental degradation, and climate change)

What this evidence mean for Future programing for SC Somalia?

- Cash presents valuable opportunities for addressing the underlying causes of acute malnutrition when properly integrated with social and behavior change (SBC) strategies. These considerations should be incorporated during project design in both humanitarian and development contexts.
- The cost of integrating SBC is minimal and enhances the impact and cost-effectiveness of cash programs compared to cash alone in addressing the underlying causes of acute malnutrition. This strategy should be prioritized in high-burden areas and to amplify impact
- Additionally, research evidence demonstrates that integrated programming of nutrition, WASH (water, sanitation, and hygiene), health, protection, and cash has a protective effect on children against malnutrition in humanitarian settings.
- As a country, there is a need to develop guidelines on the CASH plus SBC approach(specially with components of SBC, layering and sequencing of cash plush interventions) that can be easily adopted at scale by the government and partners. As a country to align Cash for Nutrition programming with national policies (like Somalia's multisectoral nutrition strategy).
- future Cash for Nutrition programming in Somalia should not just stop at transferring money but must intentionally integrate SBC to address the underlying causes of malnutrition, especially around feeding, care, and health behaviors.
- Need to tackle Wasting Relapse in our program by identifying underlaying causes - and prevention intervention models that address the causes and sustain the recovery of children discharged from treatment programs

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From Dr Osama Abdi Ali, Head of the Nutrition Program The Federal Ministry of Health (MoH) Somalia

The **Cash for Nutrition** project, specifically the **Cash Plus interventions** tested in Somalia, carries significant implications for future programming and policies aimed at addressing malnutrition in humanitarian contexts.

Shift Towards Cash-based Interventions

The success of Cash Plus programs in improving nutrition outcomes suggests that cash-based interventions can be an effective alternative or complement to traditional in-kind assistance. This allows beneficiaries to have more autonomy in purchasing the food and services they need

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From Dr Osama Abdi Ali, Head of the Nutrition Program The Federal Ministry of Health (MoH) Somalia

Evidence-Based Policy Development

The success of Cash Plus interventions, based on rigorous research, will encourage the adoption of evidence-based policies. Policymakers will be more likely to integrate cash transfers into national nutrition programs due to the solid data supporting their effectiveness in improving dietary diversity and food security.

Long-term Policy Shift

This research supports a shift from traditional food aid models to more sustainable, locally-driven solutions. Governments may start to develop national strategies that integrate cash-based transfers alongside other nutrition interventions to improve health outcomes.

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From Nick Anderson, Global Head of CVA, Save The Children

Cash alone is not enough, combining SBCC and Cash has synergistic effects, robust evidence across different settings

- Continue to invest in evidence generation on Cash+SBCC, as it's is cost effective and cost efficient
- Importance of access & utilization of Child & maternal Health services but.. those programs can drive increased demand for health services, need to looks at supply side
- Longer exposure- lead to greater impact: Project duration (at least 6, 9, 12 months) is key in improving outcomes(going beyond seasonal effects) and enable behavior changes
- Interest to look at changes in decision making on expenditure when project duration is longer and explore linkages with social protection
- Include Gender Analysis since project design, as gender dynamics (i.e: access & control of resources; secular trends for mothers, nutritious behaviors) can be a significant barrier
- ON SBCC: continue to use existing platforms for SBCC in humanitarian setting, to enable behavior change with limited timeframe;
- ON CASH: Setting transfer amounts- Balance between addressing nutritious diet affordability gap, …gender dynamics, control of cash and scalability

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From Nick Anderson, Global Head of CVA, Save The Children

- SC to continue successful partnership –with local research partners as Ministry of Health (MoH), National Bureau of Statistic- and global as JHU;
- Successful partnership with local actors facilitate introduction of the research to local communities and stakeholder, as well as research dissemination & uptake;
- Invest more in rigorous research, despite challenges and unforeseen
- Partnership with global research institute such as JHU ensure rigorous methods, strong technical support to country teams, experience in research management to overcome challenges and ensure smooth implementation;
- Include dedicated funding for research component since design

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From Kate Golden, Senior member of the CVA WG, GNC

- Highlights the complex factors driving child wasting:
  - Many are context and season-dependent
  - CVA can help address some but not all
- Reinforces that CVA on its own rarely improves nutrition ➔ need the 'plus' = SBCC in Somalia case
- Similar study – the Cash for Improved Nutrition in Somalia study (Concern & UCL 2019) – had different findings:
  - Cash + soft conditionality to register child at health centre
    - no impact on nutrition status
    - improved vaccination coverage …maybe due to study staff reinforcing soft conditionality while registering new study kids
  - Cash + same soft conditionality + SBCC via e-messaging on phone (soap opera)
    - no impact on nutrition status
- Using CVA to support access to malnutrition treatment urgently requires more learning & guidance
  - Many actors experimenting with this 'non food route' to improve nutrition with CVA but largely undocumented)
- Age-based MUAC could offer a practical solution to the WHZ vs. MUAC dilemma (e.g. dragging height boards and scales to remote areas)

Priorities for CVA-Nutrition WG

Simple tools to analyse drivers in each context & which ones CVA can help address

More guidance on SBCC approaches linked to CVA - Tip sheet coming soon…

Priority for Nutrition sector:

More research on age-based MUAC accuracy & feasibility, different contexts

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Next steps and closing!

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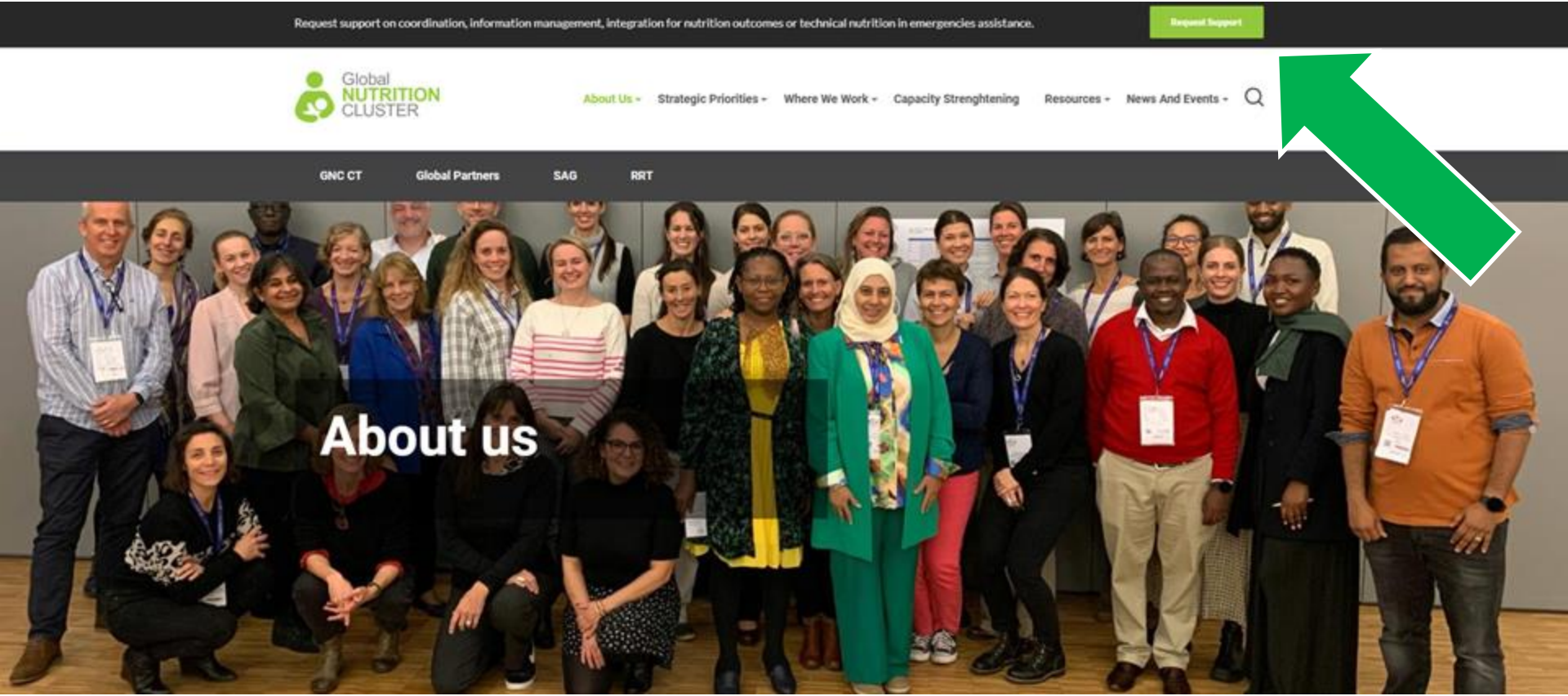
Looking for support in Nutrition in Emergencies?

	Type of supported needed	Provider
1	I want remote or in-country technical support	GNC
2	I want to hire a consultant directly	GNC
3	I want quick technical advice	GNC
4	I want peer support	www.en-net.org

Visit: https://nutritioncluster.net/ to Request Support or scan the QR code

How to Access Support



nutritioncluster.net

Comparing effectiveness and cost-effectiveness of Cash Plus interventions in preventing Acute Malnutrition in Somalia

Key Resources

Research Study Overview:
Comparing Effectiveness and Cost Effectiveness of Cash Plus SBCC in Somalia

Research study articles available in pre-printing:
https://www.medrxiv.org/content/10.1101/2025.02.21.25322679v1
https://www.medrxiv.org/content/10.1101/2025.02.21.25322675v1
https://www.medrxiv.org/content/10.1101/2025.02.19.25322555v1

Intervention model: Resourcing Families for Better Nutrition (RF4BN)
Brief:
https://resourcecentre.savethechildren.net/document/resourcing-families-better-nutrition-common-approach
MEAL toolkit and RF4BN Pilot in humanitarian setting
https://www.informedinternational.org/rf4bn-meal

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(*it will pop up when you close the webinar)*