



Cash plus and nutrition outcomes

Overview

CARE has been working in Somalia for over three decades, providing both humanitarian response and developmental programs. The agency puts women and girls in the center of its work, and much of the programming in Somalia is focused on providing breakthroughs for these women and girls – which may also benefit their families and communities overall.

In Somalia, CARE’s humanitarian responses focus on the needs of the most vulnerable populations, including internally displaced persons (IDPs), pastoral and agro-pastoral populations affected by disasters, and returnees from neighboring countries, particularly women and girls. CARE takes a comprehensive approach to emergencies, with programming expertise in: food security and livelihoods; water, sanitation, and hygiene (WASH); nutrition; health; distribution of essential relief commodities/non-food items

(NFIs); protection; and education in emergencies (EIE). At present, CARE reaches approximately 1.2 million people in Somalia through emergency programming.

Since 2016, Somalia experienced cyclical severe droughts affecting close to 50% of the country’s population. In response to this, and as part of intersectoral responses, CARE Somalia takes a “cash first” approach using cash and voucher assistance (CVA) at scale including unconditional and conditional cash transfers and food and water vouchers. CARE provided CVA to about 60,000 households in Sool, Sanaag, Banadir, Galgadud, Lower Jubba, Togdheer, Mudug, Nugal, and Bari regions of Somalia and Somaliland. On average, the agency disbursed approximately USD 1.8 million monthly for the last three months. CARE uses mobile money as a cash transfer delivery mechanism that is widely accessible to the majority of the population of Somalia.

Integration of CVA and Nutrition Services

CARE conducted need assessments and focus group discussions with caregivers of children. Through these processes, CARE identified that economic barriers to improving maternal and child nutrition and the adoption of healthy eating practices. Since malnutrition is multifaceted, CARE wanted to understand which combination of modalities and services are most effective at preventing or reducing the rate of malnutrition among the targeted populations.

CVA has been shown to contribute to improvement in maternal and child nutrition through three pathways¹:

- Access to CVA can improve access to food, health, water, medication, and transportation to feeding centers;
- Cash recipients receive social and behavior change communication (SBCC) on optimal infant and child feeding and the importance of a balanced diet, which can in turn improve their household dietary diversity;
- Empowering women in their access and control over dietary decisions can facilitate better and informed decisions over what they want to eat without thinking of the economic pressures.

CARE decided to combine CVA with SBCC and individual feeding assistance – such as Outpatient Therapeutic Programmes (OTP) or Targeted Supplementary Feeding (TSFP) Programs – to improve maternal and child nutritional status. CARE's theory of change was that CVA would better facilitate access to food and that, coupled with SBCC on infant and young child feeding (IYCF), caregivers will make better food choices for their children and for themselves.

Projects of Focus

CARE, with support from United States Agency for International Development (USAID) Food for Peace, implemented a twelve-month project, Emergency Food Security Program (EFSP II) August -2019 – July 2020 with the objective of improving vulnerable households' food consumption scores over the project period in twelve districts in the Sool, Sanaag, Mudug, and Galgadud regions.

The project provided CVA for food security outcomes as well as complementary nutritional support. The results showed that the project helped increase food access for nearly 52,000 households (316,452 individuals; 60% women and 40% men). Project participants received three cycles of CVA through mobile money transfers. The monthly transfer values were based food transfer value as recommended by the Somalia Cash Technical Working Group, which is a portion of the Minimum Expenditure (MEB). At the time the values were USD \$85, \$78, \$76, and \$67 in Galgadud, Mudug, Sanaag, and Sool regions, respectively.² These transfer values were expected to meet the food security needs in sufficient minimum daily calorie requirements for an average family of six.

The nutrition activities sought to prevent and treat acute malnutrition in children and pregnant and lactating women (PLW). SBCC on IYCF were implemented in two districts in the Sanaag region where participants were also receiving CVA.

The Somalia Response and Recovery Program in Somalia/ Somaliland project (SRP) was funded by USAID Office of Foreign Disaster Assistance (OFDA) from October 2019 to September 2020. The project aimed to increase access to basic services, reduce suffering, and enhance community resilience for drought affected communities in Somalia. It targeted children and women from drought affected vulnerable households in Bari, Galgadud, Lower Juba, Mudug, Sanaag, and Sool regions with activities in WASH, economic recovery, health, nutrition, and protection.

Comparing Project Outcomes on Nutrition

CARE completed a trend analysis of malnutrition outcomes for the different approaches of these two projects. Since – for ethical reasons – CARE could not have a control group, CARE compared results of the two packages to understand if there were differences in the nutritional statuses of the targeted populations.

For EFSP II, the nutrition services were targeted at the same households receiving the CVA in the Sanaag region only³. CARE provided monthly incentives to one mobile team in the region, serving a total population of 28,100 from 16 villages in

1 Global Nutrition Cluster, August 2020. "[Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies](#)".

2 Somalia [Cash and Markets Quarterly Dashboard](#) July - September 2019

3 CARE was not able to use this approach in all regions because of the wide geographical coverage of the project.

the two districts (Erigavo and Celafweyn). These mobile teams were technical nutrition staff from the Ministry of Health consisted of five members. In the villages where CARE was implementing the project, 5,620 children under five years of age were targeted as were 2,529 PLW.

The participants in these villages received either unconditional or conditional CVA, based on their vulnerability as determined through consultation with their communities⁴. In addition, the project participants received nutrition curative and preventative services, such as treatment for severe and moderate acute malnutrition, micronutrient and Vitamin A supplementation, deworming, nutrition and health education, and IYCF counseling for caregivers with children under two years of age.

The selection of participants in the nutrition programming was distinct across the three phases:

- In the first phase (October to December 2019), CARE targeted six villages, with the eligible households receiving CVA selected at the same time as the nutrition beneficiaries in each village. The CARE nutrition team received a list of households selected for CVA and conducted nutritional screening on children under five and the PLW in those households. Once malnutrition cases were identified among these households, they were admitted into the appropriate treatment programs (OTP or TSFP) in which they received treatment for an average of 60 days before recovering.
- In the second phase (January to March 2020), CARE began nutrition services in ten villages that had already completed three rounds of CVA. The participating households were screened for malnutrition and provided treatment and preventative services post-CVA.
- In the final phase (April to May 2020), nutrition services continued in the same villages. During this phase, no new households were selected for CVA due to the COVID-19 outbreak in Somalia and the new containment measures enacted

SBCC topics included: the importance of exclusive breastfeeding; early initiation of breastfeeding; timely and appropriate complementary feeding; dietary diversification focusing on nutrient rich locally available foods; and



the use of fortified foods and micronutrient powders to improve the nutrient quality of complementary foods. All of the households with nutrition beneficiaries in the OTP and TSFP received three months of CVA at different phases of the program.

In the OFDA funded project the nutrition beneficiaries were selected on a rolling in basis every month through mass and facility level screening as they only received nutrition with health services and no CVA.

At the onset of the COVID-19 pandemic, IYCF counseling was modified. The messaging emphasized handwashing before and after feeding the infant; routinely cleaning the surfaces around the home that the mother has been in contact with soap and water; signs and symptoms of COVID-19 and what to do if symptoms develop; continued breastfeeding even with suspected COVID-19 to promote better immunity for the infant; the use of a face mask for a mother with suspected or confirmed COVID when feeding or caring for the infant; maintaining at least 1.5m/6ft between people; and avoiding touching the eyes, nose, and mouth.

Project Reach and Achievements

The nutrition workers screened all households in the villages where CARE implemented the CVA without discrimination. Interestingly, 100% of the malnutrition cases came from families already selected for CVA, which confirms the vulnerability of the selected households compared to the non-selected households.

⁴ The distinction was based on vulnerability criteria reviewed with and validated by CARE and community representatives. Households that were more food insecure and/or labor poor received unconditional cash transfers.

A total of 6,150 households received CVA between August 2019 and July 2020. Among these households, 8,037 children under five years and PLWs were screened (3,052 boys; 2,993 girls; and 1,992 women). Among the screened, 866 (10.7%) suffered from acute malnutrition, which shows that the nutrition situation in the area was quite serious. Between October 2019 and May 2020, CARE admitted 793 moderately malnourished (MAM) cases into the TFSP and 73 severely malnourished (SAM) children into the OTP.

Following treatment for two to three months, 90 to 96% of targeted individuals recovered. The remaining 2.5 to 7% defaulted and 1.5 to 2.4% were non-responders. There was no death of patients in the programs during the project period, which is excellent as it shows that treatment was successful, with an acceptable level of defaulters and non-responders indicative of good quality programming⁵.

Trend Analysis of the Malnutrition Rates

Girls and Boys

Based on CARE's screening, the overall rate of malnutrition during the project period was 11.4%, which shows a serious nutrition situation in the target area according to the World Health Organization (WHO) classification. In October 2019, when the project started, the malnutrition rate among boys and girls under five was critical (24.8%). However, during the project period the global acute malnutrition (GAM) rate dramatically decreased below 10% from October 2019 to March 2020.

In April, the GAM rate increased again to a critical level (17.2%) for children under five years of age. The peak in malnutrition rates between April and May is common in this part of Somalia as this is the time of the *Gu* rains and increases in childhood morbidity are common. However, it is important to note that this may have been exacerbated because of suspension of CVA in April and May as a result of the COVID-19 outbreak. During that period, food prices also increased while household incomes declined, which made them more vulnerable to food insecurity.

On average, the GAM rate of children under five enrolled in the OFDA funded project, which did not receive CVA was

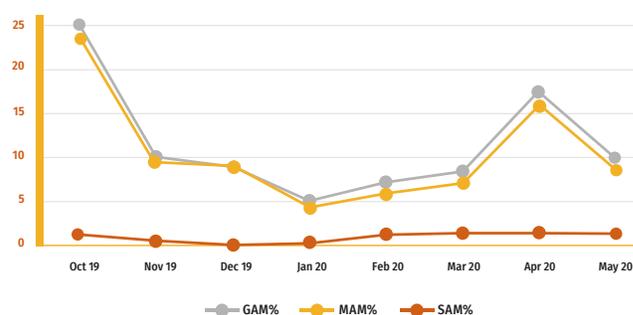


Figure 1: Prevalence of malnutrition in children under 5 / ESFP II in %

16.3% during the project period— 4.9% higher than among participants who received CVA and nutrition services in the ESFP project. On average, the GAM rates among children in households who received CVA was lower than among children in households that did not receive CVA support.

Data revealed that children in the households that received CVA and nutritional support in the ESFP II project had, on average, lower rates of GAM across the project period when compared to participants in the SRP project, which had no CVA. It was particularly interesting to note that children whose families were participants in the ESFP II project experienced fewer peaks of malnutrition compared to those in the non-CVA group. Malnutrition rates peaked in November, February, and April in the non-CVA group. For the participant households that received CVA plus nutrition services, the rates of GAM were on a downward trend until the normal seasonal peak in April to May 2020.

PLW: Comparison across Projects

In the implementation areas for both projects, CARE recorded a consistently high rate of malnutrition with rates for PLW (17.5% for ESFP II vs. 12.2% SRP) showing a critical and serious nutrition situation, respectively. Data show that there was no positive impact on malnutrition status amongst PLW who received CVA versus those who did not. In comparison to the SRP/OFDA project, the malnutrition rate among mothers who received CVA was, on average, higher than among mothers who did not receive it. However, in both projects malnutrition rates peaked during the same period (December to January and April to May). As these are the typical seasonal trends in Somalia, the data suggest that the malnutrition rate among PLW was not so much affected by the cash transfers, but

5 According to the SPHERE standards, the TSFP should have a recovery rate of >75%, a defaulter rate of <15%, and a death rate of <5-10%). The CARE nutrition program successfully achieved these rates.



Figure 2: GAM children CVA vs. non-CVA recipients in %

rather by other factors. Maternal access to health might play a role, since beneficiaries in the SRP-funded project also received basic health care services while those in the ESFP II did not.

A factor in the lower rates of malnutrition among the non-CVA PLW could be the fact that they received almost two years of consistent integrated nutrition, WASH, health services, and IYCF counseling. In contrast, the ESFP II project participants only received support for three to five months. There is a potential contribution of these services to lower GAM rates in the non-CVA PLW group.

CARE saw that mothers from the CVA recipient group had a higher rate of malnutrition than the under five-year olds in the same households. This may be due to cultural factors; Somali mothers tend to eat last, choose to eat the leftovers, and, when food is scarce in the home, prioritize feeding children over themselves.

What Did CARE Learn?

The improvement in the malnutrition rates among children under five years of age in ESFP II was encouraging with an almost 5% reduction in GAM rates. However, it not possible to know if this difference is significant or if it can be attributed

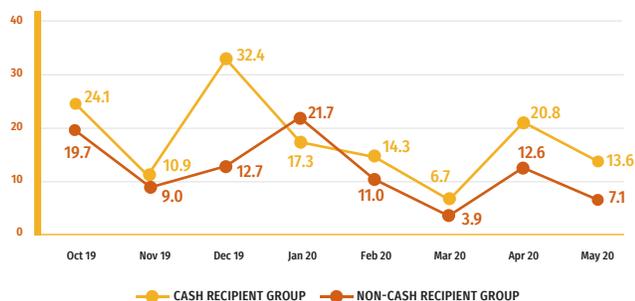


Figure 3: PLW GAM rate CVA vs. non-CVA recipients in %

to receiving CVA. CARE acknowledges that there were many other variables, such as the mothers’ knowledge, access to health services, feeding, and care practices at home. Nevertheless, the declining trend in GAM rates in the two groups is a good starting point for further analysis. CVA may have cushioned the children whose households received CVA from the seasonal peaks of malnutrition.

For the households that received CVA, CARE’s screening showed that most were both food insecurity and malnourished; thus, the paired offering in EFSP II was appropriate. The malnutrition statuses of children and PLW were one of the criteria for selection to receive CVA; it did seem to help prioritize recipients based on degrees of vulnerability.

The trend observed among children did not translate to PLW. The malnutrition rate was consistently higher in PLW than in children throughout the project and there was not a great difference between the CVA versus non-CVA group. In fact, in project areas where there was CVA and only nutrition and health services, PLW experienced a smaller reduction in malnutrition rates when compared to PLW in the ESFP project receiving both cash and nutrition services.

There is always a fear of intensifying malnutrition due to the receipt of CVA. However this was not observed in ESFP II. The number of children and PLW who stayed in the program for more than three months without obtaining the required weight gain (the non-respondent rate) was very low, at 1.5 to 4% during the project period. This shows that no one stayed in the program for the sake of receiving CVA, as households were only entitled to only three months of transfers in each phase. The project also recorded a high recovery rate among both children and PLWs (>90%), which is also an indication of good quality programming since most of the beneficiaries for nutrition recovered within the project period, usually within two months of receiving nutritional support.

This study raises the idea of using the food portion of the MEB as a basis for nutritional programming. The MEB makes general recommendations on average food needs of households in the livelihood zone. However, children under five years of age and PLW have specific needs for more nutrient dense foods. Young children and PLW have different physiological needs for growth and require more nutritionally dense food for healthy growth. When analyzing the micronutrient value of the food basket contents of the MEB, there is a paucity of micronutrient rich foods like milk,

vegetables, fruits, and protein rich foods. When using CVA for nutritional outcomes, the transfer value should be informed by such foods to facilitate energy and healthy weight gain for malnourished children and adults because of their different physiological needs.

Furthermore, nutritionally dense and micronutrient rich foods are often expensive and, in some cases, unavailable in certain markets. SBCC will not solve the market availability issue, nor will CVA. As a result, a robust response will need to include aspects of working with supply or production of such foods at local levels, complemented by SBCC and CVA.

How Will This Change CARE's Programming?

CARE is convinced that CVA can help to unlock some issues contributing to malnutrition in communities like those studied in Saanag and reveal that it should be paired with nutrition services. Alternately, nutrition services are best paired with CVA. CARE wants to lead with a "cash plus" approach when this is appropriate and feasible. This seems

to benefit children under five years of age.

Further studies are needed to understand what may help determine if these programs can improve PLW malnourishment rates or not, but other variables – such as decision-making regarding the household income, food practices at home, and access to health care – may influence her nutritional status more.

Additionally, using more market-based approaches appear to be necessary to make longer-term change in the availability and habits of these populations. This will require working with local vendors and understanding supply chains concerning what could be locally grown, easily procured, or imported.

CARE will work with CWG partners to review the appropriate transfer values to ensure nutritional adequacy in future programs where CVA is used for nutritional outcomes. This is a critical analysis for CARE, other agencies, and donors so that project design best reflects those needs.

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