

# EVIDENCE BRIEF

## YEMEN CASH-PLUS FOR NUTRITION (RF4BN), 2025–2026

Focus: Household food security, maternal diet, nutritional recovery, caregiver knowledge & practices

QUICK FACTS

	Cohort 1	Cohort 2
Population	Children at risk of malnutrition (no recent treatment)	Recently discharged children (treated for SAM/MAM)
Sample	500 HHs	181 HHs
Transfer Value	150 USD × 6 months	150 USD × 5 months
SBC Focus	Preventive care, maternal and child dietary diversity, complementary feeding and hygiene care	Sustaining recovery, relapse prevention, dietary diversity
Data Collection	BL + EL + PDM	BL + EL + FGDs
Geography	Taiz & Lahj	



March 2026

### KEY FINDINGS

#### Cohort 1

MPCA + Nutrition Education for at-Risk Children

**Crisis-level food insecurity dropped sharply:**

Households exhibiting rCSI levels associated with IPC3+) fell from 55% → 10% (-45.2 pp).

**Maternal diet diversity improved dramatically:**

mothers consuming at least five food groups increased from 6% → 72% (+66 pp).

**Child diets improved**, with strong gains in diverse and nutrient-dense food groups and breastfeeding continuation.

**Hygiene practices strengthened among caregivers**, especially handwashing after stool handling (+18.5 pp) and before feeding (+17.8 pp).

**Household capacity to meet basic needs increased:** 61% met all/most needs at endline compared to 7% at baseline.

**Expenditures on nutritious foods** such as eggs, lentils, and vegetables rose significantly, indicating enhanced food access, awareness and improved dietary choices.

#### Cohort 2

MPCA + Nutrition Education Post-Wasting Treatment to Prevent Relapse

**First 90 days after discharge shown to be a high-risk period:** 46% children relapsing into acute malnutrition within 90 days without any post-treatment support.

**MAM relapse to SAM/MAM decreased significantly:** 46% → 21% (-25 pp).

**Cash+ Nutrition tailored SBC helps sustain recovery and prevent relapse:**

- 46% relapse at baseline without post-treatment support;
- only 10% relapse during follow up (cash and nutrition tailored SBC);
- recovery sustained (↑ MUAC, weight, height)

**Sharp reductions in acute malnutrition:** SAM: 18% → 4% (-13 pp) MAM: 46% → 21% (-25 pp)

**Household food consumption and children's dietary diversity improved dramatically:** acceptable food consumption rose from 2% → 94%; dietary diversity increased by +48pp.

**Water availability and access to handwashing facilities improved** (+37 pp and +21 pp, respectively).

### POLICY AND PROGRAM IMPLICATIONS

#### Cohort 1

Cash + nutrition tailored SBC (counselling, support groups, SBC messaging) **reduce crisis level food insecurity** in highly constrained settings; predictable cash assistance is essential for improving food intake and support hygiene practices. Strong MDDW improvements indicate that **cash + nutrition tailored SBC** drives healthier food choices even amid severe poverty.

Targeted **hygiene SBC** should be maintained to reinforce fecal-oral risk reduction.

#### Cohort 2

Cash + nutrition tailored SBC (counselling, support groups, SBC messaging) appear to **protect post-treatment nutritional recovery**, reducing relapse risk and sustaining anthropometric gains.

In contexts with high food insecurity and elevated risk of malnutrition, MPCA appears to effectively support vulnerable households' access to food and WASH commodities, and help sustain nutrition treatment gains.

Systematically link CMAM discharge to RF4BN (Cash + SBCC) support as a post-treatment safety net to protect the early recovery window and reduce relapse risk, where feasible.

Monitoring systems need clearer tracking of treatment timelines and relapse episodes.

Yemen faces one of the world's most severe food insecurity and nutrition crises, with over 80% lacking access to adequate food, safe water, and health services. Acute malnutrition and child stunting remain widespread, driven by conflict, displacement, collapsing markets, climate shocks, and eroded health systems. RF4BN introduced a cash-plus model combining predictable MPCA with targeted SBC on nutrition, hygiene, and childcare, delivered through community.

## STUDY OVERVIEW

**Design:** Longitudinal studies (Cohort 1: two stage cluster sample, non-panel; Cohort 2: SRS, panel).

**Timeline:** 6-month intervention (Jan–Dec 2025).

**Data sources:** BL, EL, PDM surveys; Cohort 2 includes child anthropometrics and FGDs.

**Indicators assessed:** rCSI, FCS, MDD-W, MDD-C, hygiene behavior, WASH access, basic needs, and anthropometry (Cohort 2).



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## Selected results

	Cohort 1 – Malnutrition Prevention	Cohort 2 – Relapse Prevention
<b>Household Food Security</b>	<ul style="list-style-type: none"> <li>rCSI fell by &gt;15 points.</li> <li>IPC Phase 3+ dropped 45 pp.</li> <li>Lahj: 99% of HHs in IPC Phase 1 at endline.</li> </ul>	<ul style="list-style-type: none"> <li><b>Acceptable Food Consumption Score (FCS): 2% → 94% (near-universal).</b></li> </ul>
<b>Maternal Diets (MDD-W)</b>	<ul style="list-style-type: none"> <li>MDD-W improved 6% → 72%.</li> <li>Lahj: 9%→90%; Taiz: 2%→60%.</li> <li>Large increases in eggs (+55pp), meat/fish (+40 pp), dairy (+35 pp).</li> </ul>	N/A.
<b>Child Diets (MDD-C / quality)</b>	<ul style="list-style-type: none"> <li>Improvements in animal-source foods, legumes, vitamin A-rich foods.</li> <li>Stronger breastfeeding &amp; complementary feeding practices.</li> </ul>	<ul style="list-style-type: none"> <li><b>Dietary diversity +48 pp.</b></li> <li>Gains in eggs, dairy, legumes, flesh foods, fruits, vegetables.</li> <li>Caregivers link improvements to MPCA + clear SBC messages.</li> </ul>
<b>Anthropometry</b>	N/A	<ul style="list-style-type: none"> <li>Weight +0.87 kg; Height +4.1 cm; MUAC +0.52 cm.</li> <li>WHZ, WAZ, HAZ stable (no regression).</li> </ul>
<b>Wasting Outcomes</b>	N/A	<ul style="list-style-type: none"> <li>SAM: 18% → 4%. MAM: 46% → 21%.</li> <li>Underweight &amp; stunting stable (structural indicators).</li> </ul>
<b>Wasting Relapse</b>	N/A	<ul style="list-style-type: none"> <li>MAM relapse to SAM/MAM 46% → 21% (p&lt;0.001).</li> <li>SAM relapse: Decline but not significant (small sample).</li> </ul>
<b>Basic Needs</b>	<ul style="list-style-type: none"> <li><b>HHs meeting all/most basic needs 7% → 61%.</b></li> <li>Food, hygiene, and health needs became more affordable.</li> </ul>	N/A
<b>Hygiene Knowledge &amp; Practice</b>	<ul style="list-style-type: none"> <li>Handwashing before feeding: +18 pp.</li> <li>After stool handling: +18pp.</li> <li>Persistent gaps in food-related handwashing.</li> </ul>	<ul style="list-style-type: none"> <li>Water availability 59% → 96%.</li> <li>Handwashing facilities (soap+water): 55% → 76%.</li> </ul>

## CONCLUSION

**Both cohorts demonstrate the effectiveness of the cash-plus (MPCA + SBC) model:**

**Cohort 1:** Improved household food security, dietary diversity (women & children), and hygiene practices—laying a stronger foundation for malnutrition prevention.

**Cohort 2:** Sustained posttreatment recovery, reduced relapse (especially MAM relapse to SAM/MAM), improved child diets, and strengthened household food access during the vulnerable post discharge period.

While structural determinants of chronic malnutrition persist, predictable cash combined with context specific SBC consistently improved nutrition enabling behaviors and outcomes across both cohorts.