Yemen Nutrition Cluster Bulletin

Oct– Dec 2017 **Issue 4**

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Key facts

$ 182.2 mln required in 2017 to cover priority nutrition humanitarian needs in Yemen by 28 Cluster partners

$125.3 mln (68.8%) was received by Nutrition Cluster to date

From the Yemen Nutrition Cluster Coordinator

Dear partners,

It has been almost a year since I joined the Yemen Nutrition Cluster and as we usually take a calendar year to evaluate our progress, I think this is a good time to see what were our progress and challenges and what we can do in future better. We had very inspiring targets in 2017 for the treatment and prevention of malnutriton, but unfortunately, we were not able to reach all of them, as the article on our achievements described below. We all know the reasons and the challenges we faced (such as collapsing health systems and non-payment of salaries to health workers, lack of access, bureaucratic barriers, lack of up-to-date nutrition data, etc.), and it is my hope that we will be able to jointly identify better ways of addressing them next year, and to ensure that all of us, NGOs, MoPHP, UN agencies and donors will be able to put the differences in opinion aside in the next year and work together for the better present and future of the most nutritionally vulnerable groups. Some of our 2017 achievements include, treatment of 255,023 children with SAM, 360,163 children with MAM and 248,225 pregnant women with acute malnutrition and reaching 862,398 women with the IYCF counselling. A first time in Yemen a MUAC screening mass campaign has been conducted by MoPHP with UNICEF support. There are a lot of initiatives that were started, but are still continuing such as updating the CMAM guideline, development of the adapted Yemen SMART guideline and the guidance and toolkit for the Accountability to the Affected population and it is my hope that we will be able to finalise and implement all of them in 2018. It is my pleasure to introduce this year the 2018 Nutrition Cluster work plan, that brings together all the streams of work we are doing in one document with clear interventions, responsibilities, budget and monitoring indicators. The plan incorporates all our CMAM and IYCF scale up plans, capacity development plans, nutrition assessments and analysis plan and action plans for improvement of our performance as a cluster. It is my hope that it will be our guiding document for the current year to ensure that we are all working together to achieve better future for all children in Yemen! There are many new expiring projects that we are planning for 2018, including development and implementing of the cluster advocacy strategy to ensure that we identify our main advocacy concerns and find the way to address them, conducting the CMAM bottleneck analysis to ensure that we identify all barriers to successful CMAM programmes and the ways to addressing them, development of the Social Behavior Change strategy to contribute to our malnutrition prevention activities and piloting integrated approach for the famine risk reduction. And of course, we are all striving to treat and prevent all forms of malnutrition in children and pregnant and lactating women of Yemen through different approaches and interventions, to ensure that all Yemeni children fulfill their right to survive and thrive. And let me just remind you that it is estimated that about 100,000 of children under age of five years will die in Yemen in 2018 from malnutrition related causes if all treatment and prevention activities stop.

Pic 1. A Yemeni child who is not malnourished – an ultimate goal of Nutrition Cluster partners

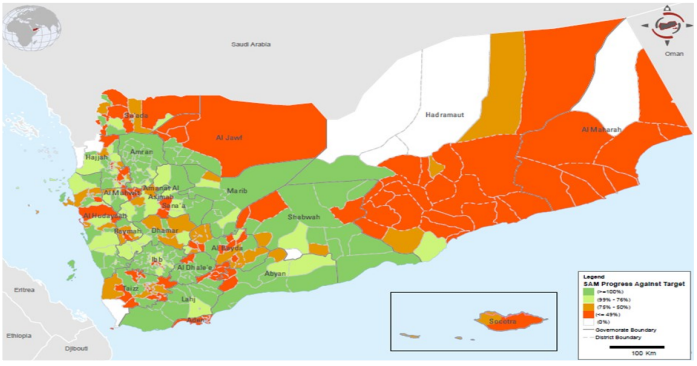
Best wishes to all of you and your families in 2018,

Dr. Anna Ziolkovska, Yemen Nutrition Cluster Coordinator

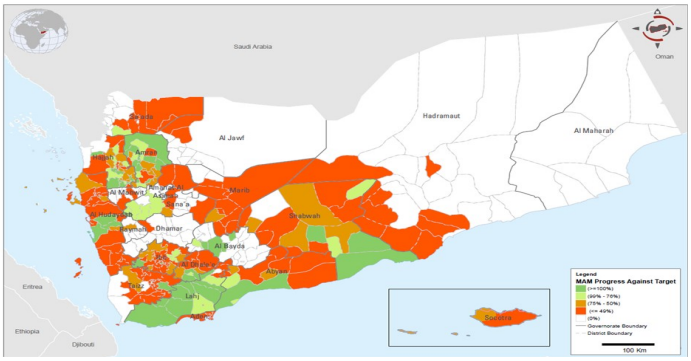
59 SCs 3,304 OTP	**2349 TSFPs**	**2349 TSFPs**	**826 IYCF programmes**	**931 MNP programes**	**627 BSFP**	**12,050 CHVs**
257,877 Children admitted to SC/OTP this year	**360,163** Children admitted to TSFP this year	**248,225** PLW admitted to TSFP this year	**864,487** Caretakers and PLW participated in IYCF sessions this year	**405,135** Children received MNPs this year	**121,168** Children received BSFP this year	**4,361,059** Children screened this year
323,197 Target this year	**1,067,533** Target this year	**643,632** Target this year	**1,355,280** Target this year	**584,524** Target this year	**347,771** Target this year	**4,543,121** Target this year

Nutrition Cluster Response in 2017

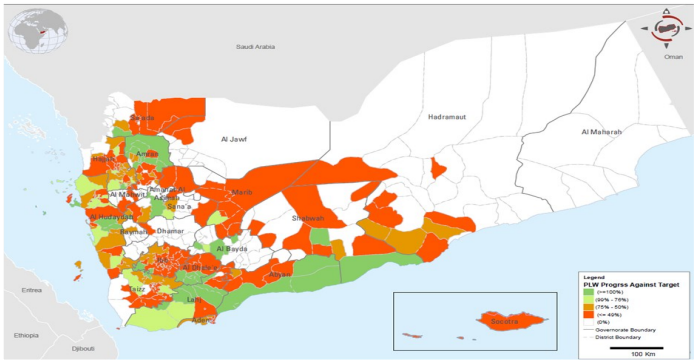
Cluster Objective 1: Deliver quality lifesaving interventions for acutely malnourished girls, boys and pregnant and lactating women



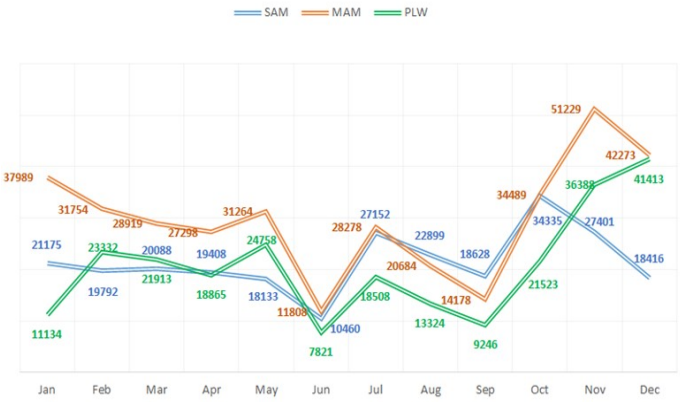
Pic 2. Gap analysis: achievements towards targets of the SAM treatment in Yemen in 2017 per district



Pic 3. Gap analysis: achievements towards targets of the MAM treatment in Yemen in 2017 per district



Pic 4. Gap analysis: achievements towards targets of the acute malnutrition treatment of PLW in Yemen in 2017 per district



Pic 5. CMAM admissions per month in Yemen in 2017

CMAM scale up in 2017. By the end of 2017 a number of additional SCs, OTPs and TSFPs were opened on a way to ensure scale up of CMAM treatment. This was demonstrated by establishment or maintenance of 59 stabilization centers, 3304 outpatient therapeutic feeding programmes (OTPs) for the management of SAM, and 2349 targeted supplementary feeding programmes (TSFP) for the management of MAM, as well as 113 mobile teams.

The treatment for SAM children has been established in 324 districts and in 182 districts partners achieved more than 75% of the target (pic. 2). TSFPs to provide MAM treatment for children and PLW is ongoing in 220 districts, with 63 districts achieved at least 75% target for MAM treatment and 55 districts achieved 75% target for treatment of PLW (pic. 3 and 4)

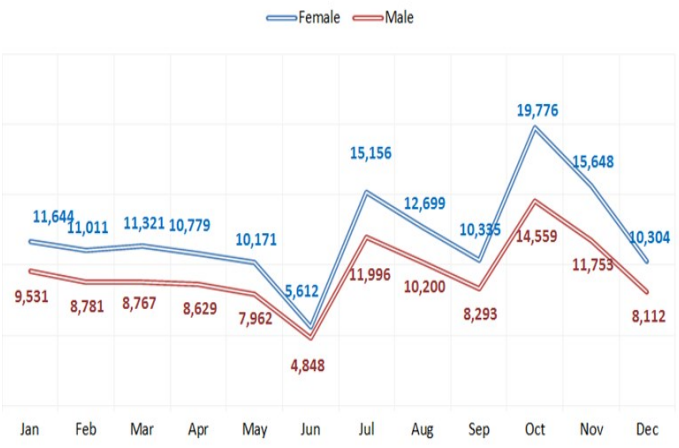
The SAM treatment strategy for the 2017, largely implemented by UNICEF, was to establish treatment in as many districts as possible, trying to achieve having OTPs in all 333 districts with up to 84% coverage of all SAM cases. Similarly, the initial WFP strategy was to establish MAM treatment throughout the country with about 60% coverage in each district, however at the beginning of 2017 WFP has decided to change the strategy, covering instead a limited number of districts (120 districts for the scaling up TSFPs and prevention activities through Blanket Supplementary Feeding programmes). The agreements reached by the WFP and cluster partners was that in additional 133 districts where WFP had TSFPs by the beginning of 2017 they will not be closed and will continue to operate, however no additional TSFPs will be open in these 133 districts, as well as in remaining districts where there are no TSFPs at all. Cluster partners and NCC advocated to WFP to increase number of TSFPs in Yemen countrywide, however as of end 2017 this agreement still has not been reached. There is willingness by Cluster partners to scale up the TSFPs, however at this point it is not feasible without WFP's engagement due to following reasons:

* The donors do not fund NGOs to procure supplies for the TSFPs as there is a perception that they are funding the cost of all supplies through the WFP that should be able to distribute them throughout the country,
* Even if funding for supplies become available to the partners, it is very difficult to bring small quantities of supplies to the country due to bureaucratic impediments, and the cost of such deliveries would increase the cost of treatment. Besides WFP, currently only ACF brings TSFP supplies to Yemen.

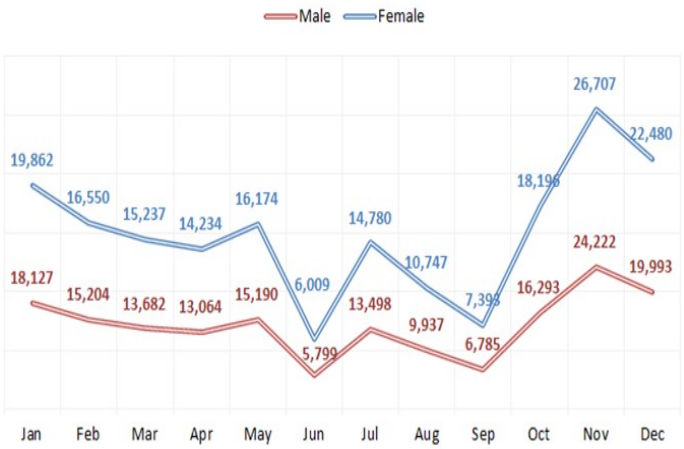
Partners and NCC continue advocacy to WFP and to UNICEF as a provider of last resort to find a solution to the situation and to ensure TSFPs' scale up in line with the OTPs' scale up.

Screening and referral. Since January 2017 4,361,059 children aged 6-59 months were screened for acute malnutrition (some children repeatedly through routine screening as well as through the mass campaign conducted in October) and referred for treatment where needed. In total, 65,656 of severely acutely malnourished children aged 0-59 months (20 % of 323,197 children targeted in 2017) and 227,125 moderately acutely malnourished children aged 6-59 months (21 % of 1,067,533 targeted) were identifies and referred for treatment through routine screening or campaign, which is way below the target of 90%. This reflects overall situation with low coverage of CHVs in the country and limited outreach activities.

CMAM new admissions. In 2017, 257,877 children with SAM were admitted for treatment (80% of target), as well as 360,163 children with MAM (34% of target) and 248,225 of PLW (39% of target) (pic.5). Analyzing monthly admissions, there is a substantial drop in new admissions to CMAM (as well as to prevention programs) in June, as well as in September. This is explained by the Ramadan and Eid holidays - as people in Ramadan are not prioritizing going to HFs unless it is an emergency. Working hours



Pic.6 - Monthly admissions to OTPs in 2017 for boys and girls



Pic.7 - Monthly admissions to TSFPs in 2017 for boys and girls

in the OTPs are also reduced during Ramadan and Eid. On the other hand, there was substantial increase in the numbers during the months of October – November after the national MUAC screening campaign. Despite the blockade, no stock outs of supplies for SAM and MAM management were reported during 2017, that further contributed to scaling up CMAM programs in 2017. The cluster is receiving consistent, reliable gender-disaggregated data to monitor differences on ongoing basis, that shows that there is generally more admissions of girls than boys to both SAM and MAM treatment programs (pic. 6 and 7).

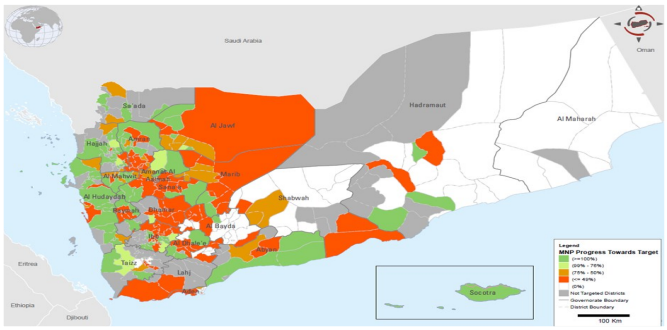
SPHERE standards. The cure rate of the SAM and MAM treatment programs are on average within the SPHERE minimum standards, while generally defaulter rates are higher than the 15% as maxim defaulter rate per SPHERE standards, that reflects the escalating conflict, worsening economic situation, multiple operational hurdles. The SAM cure rate in 2017 was 76.5 percent, and the death rate was 0.3 percent. The defaulter rate was 20.6 percent, which exceeds the 15 percent SPHERE minimum standard, this was attributable to number of factors, including far distances of health facilities and transport costs, which is a result of limited coverage of services in communities far from health facilities. The cure rate for MAM children was 77.6 percent, the death rate was 0.1 percent and the defaulter rate was 21 percent, again exceeding the SPHERE minimum standards due to same reasons as above. 248,225 of acutely malnourished pregnant and lactating women were admitted to treatment in 2017 (39% of 643,632 targeted). The cure rate for the treatment of the acute malnutrition in pregnant and lactating women was 74.4%, death rate was 0% and, similarly, defaulter rate was 25%.

Objective 2: Contribute to prevention of malnutrition by enhancing BSFP, micronutrient support, deworming and IYCF

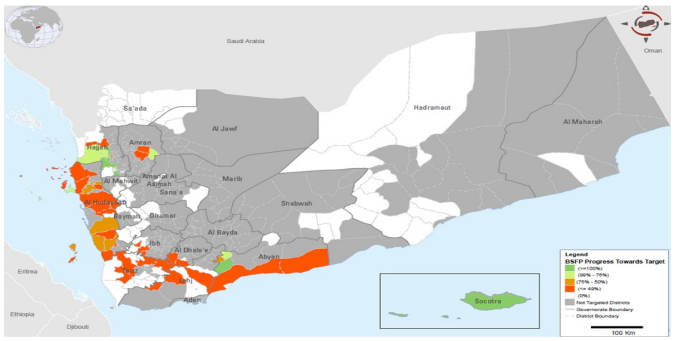
Micronutrient supplementation. Micronutrient interventions continued as one of the interventions to prevent malnutrition in Yemen. The scale of different activities under this intervention varied in 2017 from one activity to another. At least three main activities were implemented at national scale, namely vitamin A supplementation for children under five, micronutrient powder supplementation for children under two and Iron folate supplementation for pregnant and lactating women. These three program were implemented mainly through fixed health facilities, community health volunteers, mobile teams and integrated outreach rounds.

Vitamin A supplementation for children 6-59 months of age was implemented in the country through two approaches, one through the routine programs and the other through a campaign mode. Vitamin A supplementation is linked with national polio vaccination campaigns. Two national campaigns were implemented during March and October 2017 along with the two polio National Immunization Days of 2017. A total of 4,407,845 children received Vitamin A in 2017.

In 2017, 405,135 children aged 6-24 months received multiple micronutrient powders (70 % of target for 2017) – see pic. 8 and 10 - and 847,687 pregnant women of 644,000 targeted (more than 100%) in 2017 received iron-folic acid supplement. MoPHP with support from UNICEF are working on development of national micronutrient policy that will include all micronutrient interventions including iodine, vitamin D and zinc supplementation. The draft has been prepared and will be discussed in a consultative workshop with all stakeholders from government and NGOs to come up with the final policy in 2018. Furthermore, micronutrient interventions need multi-sectoral commit-

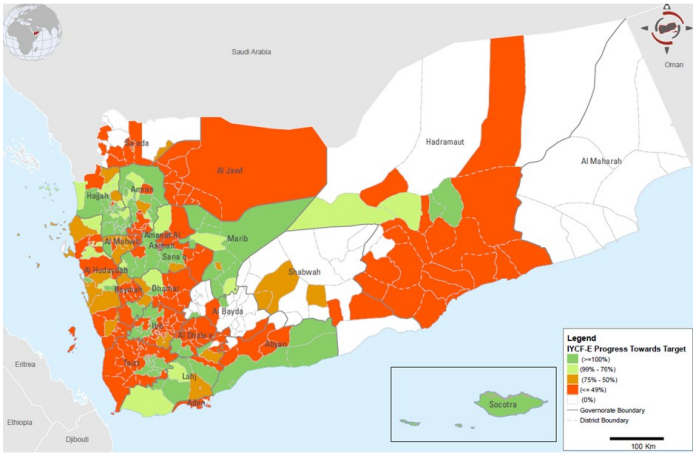


Pic.8. Gap analysis: achievements towards targets of the MNPs distribution in Yemen in 2017 per district



Pic.9. Gap analysis: achievements towards targets of the BSFP for children 6-23 months in Yemen in 2017 per district

Pic. 10. New admissions to BSFP (children), IYCF consultations and MNPs distributed to children aged 6-23 months - per month in 2017



Pic.11. Gap analysis: achievements towards targets of the IYCF counseling in Yemen in 2017 per district

ments to ensure the implementation of the national legalization of food fortifications.

BSFP. WFP is supporting prevention program in 94 districts, in 16 Governorates, through 15 partners (pic 9 and 10). In 2017, 121,168 children under 2 and 39,620 pregnant and lactating women have been reached with BSFP. Children under 2 received daily ration of 50g of Plumpy Doz, medium quantity lipid -based nutrient supplement, during a period of minimum 3 months; pregnant and lactating received daily ration of 200g of Wheat Soya Blend + during a period of minimum 6 months. Community volunteers are responsible to identify the children and pregnant and lactating women at community level, the ones who are identified acutely malnourished are referred to the nearest health facility for a proper treatment .

IYCF. 864,487 out of about 1.4mln targeted in 2017(64% of target) mothers and caregivers of children aged 0-23 months received counseling or messaging on appropriate infant and young child feeding. (pic. 11)

IYCF interventions has been scaled up during 2017 in comparison with the previous years. The number of mothers reached with IYCF counseling and education services during 2017 was 150% of 2016 results. This was due to a few contributing factors such as the deployment of dedicated IYCF focal points in all GHOs, the increasing number of CHVs and IYCF corners. The delivery approaches of IYCF remain the same where community health volunteers and community midwives are the large service providers for IYCF counseling in the community. Fixed health facilities (through IYCF corners and OTPs/TSFPs), mobile teams and integrated outreach rounds are the other service delivery modalities.

Although the scale up of IYCF programs in 2017 was substantial compared to 2016, the program still facing many obstacles. In addition to the general cross cutting challenges that affecting all programs such as salary crisis for the health workers and security constraints, IYCF has some additional specific challenges such as below.

* IYCF interventions are not recognized as priority by different sectors and health authorities at the central and governorate levels.

* The ongoing fragile situation hinder the enforcement, implementation and updating the national legislations to protect breastfeeding. The efforts of MoPHP to implement the international code of BMS marketing are not enough without collaboration of other governmental sectors.

The quality of IYCF services is one of the areas that need more efforts from MoPHP and partners to improve IYCF practices in Yemen. In 2017 IYCF monitoring indicators were added to CHVs, MTs and CMAM monitoring tools to contribute to strengthen monitoring system and quality of IYCF services.

Cluster Objective 3: Strengthen capacity of national authorities and local partners, to ensure effective, decentralized nutrition response

CHVs and HWs training.

Cluster partners achieved training target, with 9,585 (of 9,001 targeted) CHVs and HWs trained in 2017. 6,951 of community health volunteers were trained on screening and referral, IYCF and health education (including 2,640 as a refresher training and 4,311 as a basic training). 2,634 health workers were trained on the management of CMAM and IYCF (including 1,201 as a refresher training and 1,433 as a basic training).

Trainings for cluster partners.

Several trainings were delivered specifically to cluster partners in 2017 to improve their capacity in planning and responding to the emergencies, such as an IYCF-E training, a training on Cluster approach (two in Sanaa in one in Hodeidah), SMART survey manager training, protection mainstreaming training, training on proposal writing to Aden sub -cluster. An orientation on the IYCF-E was conducted to the Nutrition, WASH, Health, FSAC and Protection clusters) to ensure understanding of humanitarian partners of harmful IYCF practices in emergencies and sensitization of them on the BMS Code.

Pic 12. IYCF-E training, 16 –20 July 2017

Cluster Objective 4: Ensure a predictable, timely and effective nutrition response through needs analysis, monitoring and coordination

SMART surveys. While there were plans to conduct 22 SMART surveys in Yemen in 2017 (one in each governorate), the cluster achievements are way below this due to different challenges MoPHP and partners are facing, including access constraints and the permissions nessessary to obtain from different bodies to conduct assessments. Limited capacity remains a challenge despite a number of SMART training conducted in since December 2016. The SMART surveys conducted in 2017 include surveys in Ibb (MoPHP with UNICEF support), Shabwa (MOPHP with UNICEF support), Lahj (ACF) governorates and Taiz highlands (SCI). Additionally, SMART surveys in Raymah and Aden governorates were conducted by the MoPHP (with UNICEF support) and IRC respectively, but the data have not yet been shared for validation. The AWG has approved additional 11 SMART protocols, however the surveys have not yet been conducted and were postponed to 2018.

MoPHP decree on SMART surveys. MoPHP has issued a decree establishing two committees (supervisory and technical) for SMART nutrition surveys. The Supervisory committees consists of representatives from MoPHP, CSO, MoPIC, SUN secretariat and UNICEF at managerial level, while the Technical Committee consists of technical representatives of same entities, and additional representatives from ACF, FAO and WHO. The functions of the Supervisory Committee are to

* Review and approve the annual SMART survey plan at the national level;
* Oversee the progress of SMART surveys in targeted governorates, takes necessary decisions to facilitate conducting the survey in different stages and approves reports and minutes presented to it;
* Review and approve survey related documents;
* Communicate with relevant entities to facilitate the operations of the survey;
* Supervise the implementation of the annual SMART survey plans in targeted governorates;
* Approve final reports of surveys referred from the Technical Committee;
* Any other tasks assigned to it.

The functions of the Technical Committee are to

* Develop the annual SMART Survey plan at the national level and refer it to the Supervisory Committee;
* Develop evidences for the implementation of SMART surveys in Yemen;
* Develop the questionnaire currently in use, as needed, and reviews it on annual basis;
* Provide necessary training on SMART methodology for entities concerned with implementation;
* Review and approve survey protocols in different governorates before implementation starts;
* Communicate with relevant entities to facilitate the implementation of surveys and informs the Steering Committee of any obstacles or issues to take necessary actions;
* Discuss field procedures for completed surveys, reviews data quality before approval for analysis and writing the final report;
* Discuss survey final reports and refers the same to the Supervisory Committee;
* Attend the Nutrition Cluster meetings;
* Any other tasks assigned to it.

As there is an overlap with some of the tasks that are currently assigned to the Assessment Working Group, there is an ongoing discussion on the implications of the decree to the Nutrition Cluster and how to redefine the role of the Assessment Working group in 2018

Mass MUAC screening. A MUAC polio campaign was conducted by the MoPHP with support from UNICEF at the end of October 2017. This is the first time in Yemen that the MUAC data were added to the polio vaccination campaign in Yemen and following the success of it, it is planned to conduct two MUAC-polio campaigns in 2018.
The campaign was implemented in 21 governorates (excluding Sadaa due to security/ access issues) with generally good coverage. Excluding 15 districts of Sa'ada that didn't implement the campaign, of remaining 318 districts, 9 districts had coverage below 25%, and further 45 districts had coverage between 25-50%. 190 districts had coverage above 75%. To note, that the number of children aged 6-59 months in each district was estimated, therefore in some districts the number of children screened was higher than the total number of children expected to reside in the district. The reason for sometimes low coverage is that in order not to delay campaign, people who screened would leave the village if the polio vaccinators finished their job in order not to delay the campaign.

According to preliminary data, total of 3,229,594 children 6 – 59 months were screened for malnutrition by MUAC (74% of the target), 292,820children with acute malnutrition were identified as malnourished and referred for treatment, including 65,695 severely acutely malnourished children. The screening campaign not only provided additional information on the nutritional status of children, but also resulted in a database of all cases identified with GAM so that each HF is able to follow up on the malnourished children who did not come for the treatment. The results of the MUAC screening campaign are presented in the table 1. The AWG is currently reviewing how the data can be used by partners to enhance current situation analysis.

Lessons learned workshop is planned by the MoPHP and UNICEF in 2018, that would result in the improvements of the following campaigns. District level data and accompanying presentation are available from the link below.

Data analysis and sharing. A quarterly Nutrition Cluster bulletins and monthly analysis of the program data were established in 2017 that improved information sharing and response monitoring within and outside the country and led to reduction of an ad-hoc information requests four-folds. All Cluster information is now available on the Nutrition Cluster website. The Cluster has switched to the online contact lists, ensuring that everyone is on the distribution list to receive the latest updates from the Cluster Coordination Team.

HPF allocations management. The Nutrition Cluster technical review committee, consisting of the two UN agencies, two INGOs and two LNGOs under the leadership of the Nutrition Cluster Coordinator has participated in the two Humanitarian Pooled Funds (HPF) allocations with 27 projects reviewed and total of 13 mln received by the Cluster partners from the HPF for Nutrition activities in 2017.

A Cluster Coordination performance exercise was conducted in April 2017 to jointly develop an action plan for the Cluster performance with 26 actions identified required to be taken in collaborative manner to improve performance of the cluster as a collective. As of end of the year 16 of them were achieved/completed and 10 are ongoing (on track). Some of the examples include:

* ongoing development of the guidance on the Accountability to Affected Population specific to the Yemen Nutrition Cluster
* coordination of all project proposals with the DHO/GHO and sub-national coordinators, that resulted in avoiding potential duplication, ensuring availability of supplies from the start of each project and support to the projects from the Ministry of Public Health and Population.
* increased availability of the nutrition assessment information to all partners through multiple mechanisms, such as posting all reports on the website, extracting data to a freely available cluster database (that also facilitates trend analysis), presenting data at the Cluster at national and subnational levels, etc.
* joint prioritization of districts for response planning (as nutrition cluster and at inter-cluster level) using a methodology that was specifically adapted to Yemen, that resulted in focusing limited cluster resources and capacity in the most in need locations

Governorate	Estimated number of children aged 6 - 59 Month	Total Children Screened	% of children 6-59 screened of total population	Children with MUAC less than 115 mm	% of children with MUAC less than 115	Children with MUAC less 115-125 mm	% of children with MUAC 115-125 mm	Children with MUAC less than 125 mm	% of children with MUAC less than 125 mm
Abyan	65,351	72,946	112%	967	1.30%	3,887	5.30%	4,854	6.70%
Aden	148,175	74,035	50%	635	0.90%	3,135	4.20%	3,770	5.10%
Al Bayda	114,131	99,624	87%	1268	1.30%	5,105	5.10%	6,373	6.40%
Al Dhale'e	113,665	108,313	95%	1818	1.70%	8,570	7.90%	10,388	9.60%
Al Hudaydah	529,727	300,869	57%	18601	6.20%	44,771	14.90%	63,372	21.10%
Al Jawf	101,057	46,037	46%	2282	5.00%	4,562	9.90%	6,844	14.90%
Al Maharah	27,758	14,824	53%	25	0.20%	171	1.20%	196	1.30%
Al Mahwit	98,071	102,831	105%	1805	1.80%	7,575	7.40%	9,380	9.10%
Amanat Al Asimah	595,433	225,224	38%	1034	0.50%	6,322	2.80%	7,356	3.30%
Amran	174,186	179,915	103%	3620	2.00%	15,049	8.40%	18,669	10.40%
Dhamar	351,264	293,027	83%	6393	2.20%	24,197	8.30%	30,590	10.40%
Hadramaut Sahel	103,322	85,639	83%	422	0.50%	1,295	1.50%	1,717	2.00%
Hadramaut Wadi	95,361	67,878	71%	192	0.30%	1,180	1.70%	1,372	2.00%
Hajjah	329,251	285,223	87%	8100	2.80%	27,916	9.80%	36,016	12.60%
Ibb	403,488	400,273	99%	3651	0.90%	16,696	4.20%	20,347	5.10%
Lahj	131,137	132,766	101%	2048	1.50%	9,082	6.80%	11,130	8.40%
Marib	47,856	44,363	93%	468	1.10%	2,145	4.80%	2,613	5.90%
Raymah	91,748	78,382	85%	1807	2.30%	7,112	9.10%	8,919	11.40%
Sana'a	241,236	156,413	65%	2264	1.40%	9,451	6.00%	11,715	7.50%
Shabwah	99,590	73,136	73%	638	0.90%	3,373	4.60%	4,011	5.50%
Socotra	11,222	7,826	70%	63	0.80%	627	8.00%	690	8.80%
Taizz	488,723	380,050	78%	7594	2.00%	24,904	6.60%	32,498	8.60%
Total	**4,361,752**	**3,229,594**	**74%**	**65695**	**2.00%**	**227,125**	**7.00%**	**292,820**	**9.10%**

Table 1. Data on mass MUAC screening in Yemen per governorate, October 2017

* training on protection mainstreaming
* strengthening data analysis and its utilization for the decision making, working with the Assessment Working Group and the Information Management Officer on development of the set of regular dashboards, info graphics and analyses.
* development of the capacity building plans at national, sub-national, governorate, district and health facility level for 2018, that is budgeted for and with clear responsibilities among partners on fundraising and delivering specific trainings, etc.

More information:

Monthly analysis of nutrition cluster response:

October 2017: https://goo.gl/CibTAK

November 2017: https://goo.gl/BgC8en

December 2017: https://goo.gl/wuVdJi

Monitoring and mentoring cards: https://goo.gl/WhEg3H

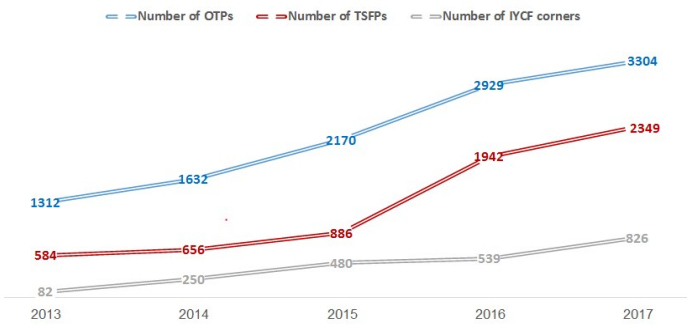
IYCF and cholera messages: https://goo.gl/u7agZk

CHV docs: guideline, rates, meeting plan: https://goo.gl/3oU7m3

MUAC campaign data, October 2017: https://goo.gl/42rFqz

Pic.13. During the screening campaign

Analysis of the 2017 response in past and future perspectives

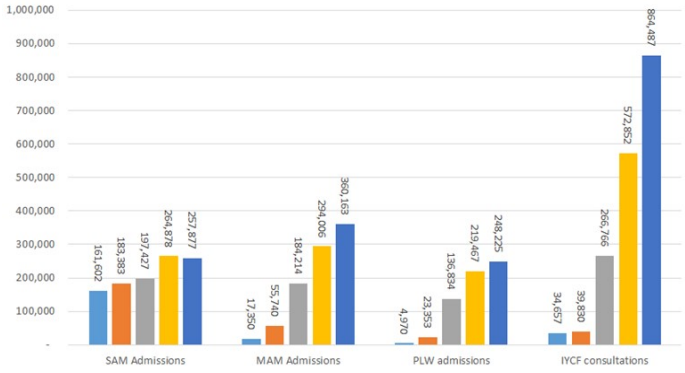


Pic.14- Nutrition Cluster Scale up of OTPs, TSFPs and IYCF corners (2013-2017)

Compared to the previous years, there was a substantial scale up of the CMAM and IYCF programs in the past few years as demonstrated on the pic. 12. Thus, in 2017 330 (11% more) of additional OTPs and 412 (21%) of additional TSFPs were open, while this is still not enough to ensure universal coverage of CMAM programs in Yemen. While there is a substantial scale up in geographical presence of CMAM programs, a number of admissions remains similar to those in 2016 for both SAM and MAM treatment programs as per the data we currently have (pic. 13).

There are several contributing factors: first of all, not all reports for CMAM treatment are received so far (there is still 117 reports missing from OTPs and 30 reports from TSFPs from MoPHP), that are expected to increase the number of the new admissions to the CMAM. Secondly, the outreach services in Yemen are weak, with less than 25% of needed CHVs currently in place and limited number of mobile teams. Thirdly, the HWs have not received salaries for more than a year, and lastly other competing priorities as cholera outbreak . The polio-MUAC screening campaign conducted in October 2017 has allowed to increase the admissions to CMAM in the past months, but sustainable approach for the mass screening campaigns is needed. The plans for 2018 are aimed at addressing some of these constraints that are in the reach of the Nutrition Cluster partners, including two planned national MUAC screening campaigns a year, scaling up of mobile teams from 113 to 200, training and supervision of additional 15,000 CHVs. Additionally, UNICEF, WHO and UNDP projects, funded by the World Bank, aiming to support functioning of the health facilities, that indirectly will contribute to the better coverage of CMAM services and support CMAM scale up.

Additionally, if analyzing a number of admissions per OTP/TSFP program, it shows that the peak of number of admissions per program was reached in 2015/2016, with the numbers of admissions per program falling in 2017, due to scaling up of the number of programs and children and PLW having a better access to treatment programs (Table 2).

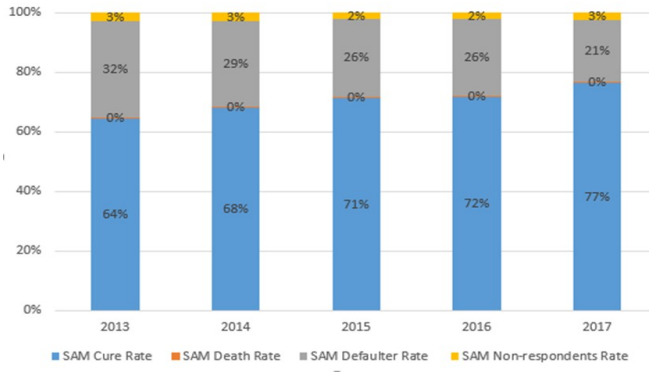


Pic.15- Nutrition Cluster scale up of new admissions of children with SAM, MAM and number of IYCF consultations per year (2013-2017)

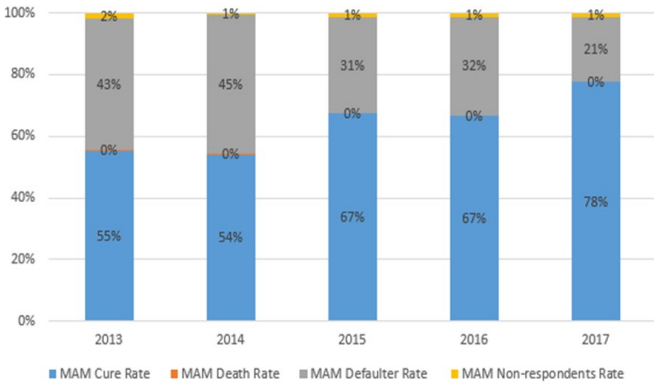
Admissions per program	2013	2014	2015	2016	2017
SAM admissions per OTP program	123	112	91	90	78
MAM admissions per TSFP prorgam	30	85	208	151	153
PLW admissions per TSFP prorgam	9	36	154	113	106

Table 2. Analysis of admissions per program per year

As for the quality of the CMAM programs, while there are still quality issues remains (such as high defaulter rates for all programmes), it has improved for both SAM and MAM treatment over the years. The SAM cure rates increased significantly from 64% in 2013 to 77% in 2017, while reducing number of defaulters and death among children (pic. 14). Similarly, for MAM treatment, the cure rates increased from 55% to 78% in the districts where the programs are implemented, also due to decreased number of defaulters (pic. 15), which is as well related to less stock outs of supplies. In 2018 the cluster aims to improve the quality of monitoring and supervision visits by the GHOs and DHOs and implement the monitoring and mentoring process as developed by the MoPHP with technical support from UNICEF, aiming for each monitoring visit to contribute to increasing quality of the CMAM programmers by providing immediate mentoring to the identified problems. A number of capacity building activities is also planned in different Nutrition in Emergencies program areas and to different levels of cadres. IYCF activities were also scaled up year by year (pic. 12 and 13) with increased number of IYCF consultations from 34,657 in 2013 to 864,487 in 2017 with a matching increase in IYCF corners from 82 to 826 over the past five years. Currently IYCF counselling sessions are primary delivered in the Health Facilities and in the community through CHVs/CMWs, MTs and outreach rounds. The IYCF WG of the Nutrition Cluster is planning to develop a guidance on the baby corners in the HFs in 2018 to standardize the services, as well as increase the number of CHVs trained in IYCF by more than double to ensure that the health education is provided in communities as well.



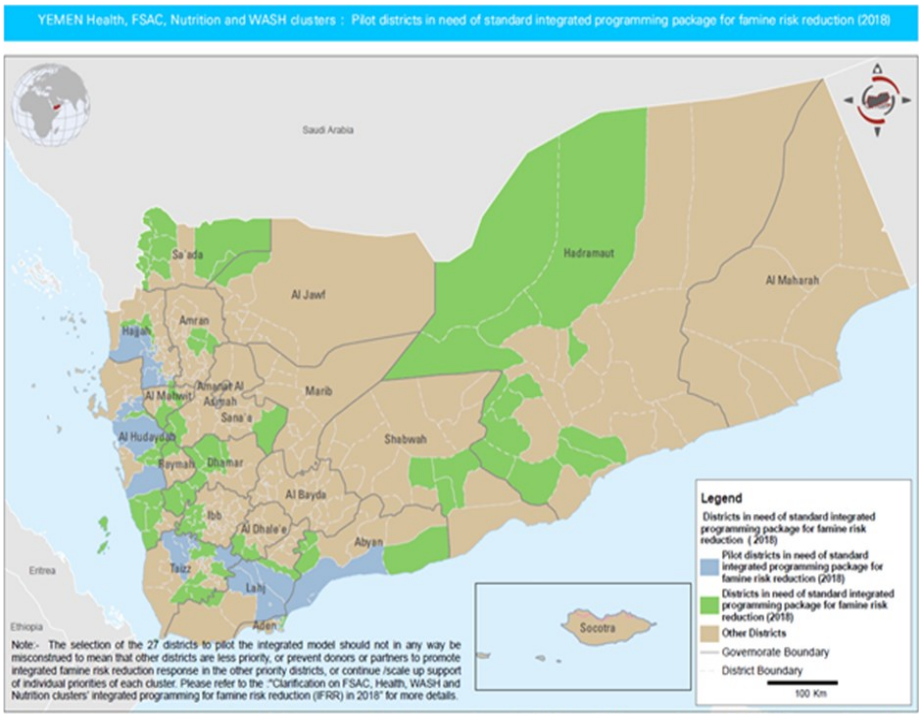
Pic.16- SAM performance indicators (2013-2017)



Pic.17– MAM performance indicators (2013-2017)

Nutrition Cluster plans for 2018

The nutrition cluster partners have worked together on development of the Humanitarian Needs Overview, Humanitarian Response plan and the work plan for the Nutrition Cluster in 2018, available from the links at the end of the article. You can find more information on the nutritional needs in 2018 in the previous issue of the Bulletin, but to summarise five governorates (Al Hudeidah, Lahj, Taizz, Abyan and Hadramaut) have acute malnutrition rates above 15%, and seven governorates have GAM rate of 10-15% with aggravating factors, thus classifying 12 of 22 governorates as emergency. Estimated 7.0 mln people are in need of nutrition assistance, with 2.9 million people who will require treatment for acute malnutrition in 2018, from those 1.8 million are children under age of 5 and 1.1 mln pregnant and lactating women (PLW). 2.3 mln of PLW and caretakers of children 0-23 months will require infant and young child feeding counselling.



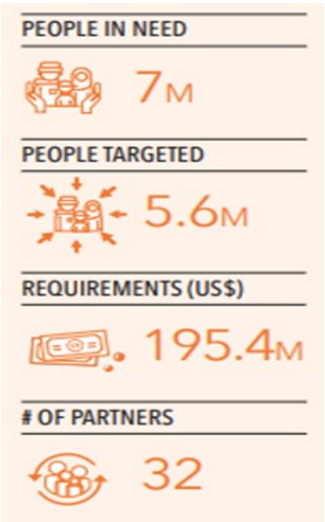
Pic18. Priority and pilot districts for the IFRR package pilot in 2018

To address this, Nutrition Cluster partners identified four Cluster objectives for 2018 as below:

- CO1. Reduce the prevalence of acute malnutrition through systematic identification, referral and treatment of acutely malnourished boys, girls under five and PLWs
- CO2. Strengthen humanitarian life-saving preventive nutrition services for vulnerable population groups focusing on appropriate IYCF practices in emergency, micro-nutrient, BSFP interventions and optimal maternal nutrition
- CO3. Strengthen capacity of national authorities and partners to ensure effective decentralised nutrition response
- CO4. Ensure a predictable, timely and effective nutrition response through strengthening robust evidence based system and nutrition needs analysis and advocacy, monitoring and coordination

To track joint progress by the cluster partners in the achieving the Cluster objectives, the main activities and respective targets were selected as presented on the dashboard.

In 2018, partners will target 840,000 children with acute malnutrition, including 276,00 with severe acute malnutrition (SAM), and 525,000 pregnant and lactating women with acute malnutrition. While SAM treatment is planned to scale up in all 333 districts of Yemen, reaching 70 per cent of people in need, the targeted supplementary feeding programs (TSFP) will only be undertaken in 212 districts reaching 60 per cent of children and women in need, and only in 120 of them a number of HFs providing MAM treatment will be scaled up to match SAM treatment geographically. The decrease in targets compared to 2017 is based on the analysis of the response in 2017 and capacity of partners to scale up. Additionally, nutrition cluster plans to reach 1.4 million PLW and caregivers of children 0-24 months with infant and young child feeding (IYCF) counselling (60 per cent of need) throughout the country; 360,000 children aged 0-23 months and 240,000 PLW (60 per cent of in need) in the 120 districts will enroll in the blanket supplementary feeding programs; 730,000 children will receive multiple micronutrient powders; 4.1mln of children under the age of 5 will receive vitamin A supplementation throughout the country.



The total funding requirements for the nutrition Cluster plan for 2018 195.4 mln USD, with about 60 mln of funding received so far.

Additionally, Nutrition, Health, WASH and FSAC clusters worked together to develop the overview of needs and proposed response for the famine risk reduction. 107 districts (32% of all districts in the country) are currently estimated to be at heightened risk of sliding into famine. This is an increment of 13% in the number of districts facing precarious food security, nutrition, WASH and Health conditions (an additional 12 districts at high risk compared to 95 districts that were at risk 6 months ago). An estimated 70 per cent of the population (7.3 million individuals) in these 107 districts need urgent life-saving food and livelihoods assistance; 5.9 million people are in need of WASH support; 7.4 million people are in need of health services; and 2.4 million children under the age of five and PLW need nutrition assistance. To effectively address these needs, it is imperative to design integrated, coherent, and well-coordinated approaches that combine interventions from the Food Security and Agriculture Cluster, the Water, Sanitation and Hygiene Cluster, Nutrition Cluster and Health Cluster. It is planned that the integrated famine risk reduction (IFRR) package will be developed and piloted in 2018 in the 27 districts (pic 16) in Aden, Ibb and Hodeidah hubs. More information on the work completed in the development of the IFRR package is available from the link at the end of the article. The next issue of the Nutrition Cluster Bulletin will be dedicated to the progress and discussion on the IFRR

More information:

2018 YHNO: https://goo.gl/i36xDn

2018 YHRP: https://goo.gl/gSU9qE

2018 Nutrition Cluster work plan: https://goo.gl/4vW9hU

Integrated famine risk reduction documents: https://goo.gl/pFFZ8X

2018 YEMEN NUTRITION CLUSTER HUMANITARIAN RESPONSE PLAN AS OF January 2018

FUNDING

Required: $ 195.4mln

Total Number of Partners: 34

CLUSTER OBJECTIVES & ACTIVITIES

CLUSTER OBJECTIVE 1

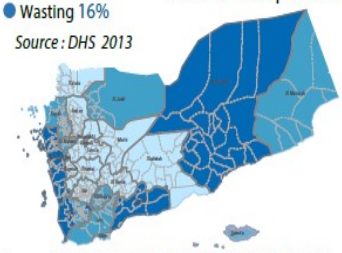
Reduce the prevalence of acute malnutrition through systematic identification, referral and treatment of acutely malnourished boys, girls under five and PLWs.

BASELINE DATA:

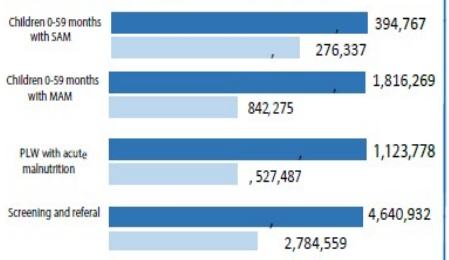
- Stunting 47%
- Wasting 16%

Source : DHS 2013

GAM in Yemen per district



Sources : SMART 2016-2017, CFSS 2014, EFSNA,2016



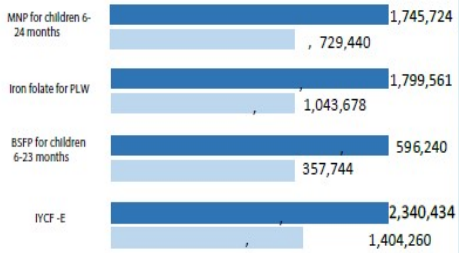
CLUSTER OBJECTIVE 2

Strengthen humanitarian life-saving preventive nutrition services for vulnerable population groups focusing on appropriate IYCF practices in emergency, micro-nutrient, BSFP interventions and optimal maternal nutrition.

BASELINE DATA:

- Exclusive BF 10 %
- Timely introduction of complementary food 65%
- Vitamin A supplementation coverage 55%
- Iron deficiency anaemia in children 86%
- Iron deficiency anemia in women of repreoductive age 71%
- Deworming coverage 21%

Source : DHS 2013



CLUSTER OBJECTIVE 3

Strengthen capacity of relevant authorities and local partners to ensure effective, decentralized nutrition response.

BASELINE DATA:

- Number of CHVs in the country : 12,050

Source : MoPHP 2017

- Estimated number of CMAM HWs in the country by the end of 2018 : 7,482

CLUSTER OBJECTIVE 4

Ensure a predictable, timely and effective nutrition response strengthening robust evidence based system and nutrition needs analysis and advocacy, monitoring and coordination

BASELINE DATA:

- SMART surveys conducted in 2017 in 4 governorates. (Shabwah, Ibb, Taiz highlands, Lahj)

Legend for graphs

- People in need
- People targeted

Legend for the map (GAM rate per district)

- Poor Situation (5% - 9.99%
- Serious Situation (10% - 14.99%)
- Critical Situation (15% and above)

Partners

ACF, ADO, ADRA, BFD, CSSW, FMF, HAD, IMC, INTERSOS , IOM , IRC, IRY, MC, MDM, MMF, MoPHP, PU-MAI, RDP, RI, RRD, SAJAYA, SAWT, SCI, SHS, SOUL, TAYBA, TFY, UNCHR, UNICEF, VHI, WFP, WHO, YDN, YFCA

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SAM management of severe acute malnutrition in children 0-59 months

MAM management of moderate acute malnutrition children 0-59 months

PLW management of malnutrition in pregnant and lactating women.

MNP Provide micronutrient supplementation for children (6-24 months)

PLW_MNP Provide micronutrient supplementation (iron folate) for pregnant and lactating mothers and stunting

BSFP Prevent acute malnutrition in children (6-23 months) via blanket supplementary feeding Programmes

IYCF-E Provide counselling for mothers or care-takers of children under 2 on infant and young child feeding

Screening and Referal . Screen for and detect malnutrition in children under 5, and provide referral to treatment programmes

Training Develop capacity of health staff and community volunteers

CHVs Community health volunteers to be trained

HWs Health workers to be trained

Upcoming events

The Nutrition Cluster will continue regular meetings according to the agreed schedule.

* 24 January: Proposal writing workshop
* 29-30 January: Inter-cluster workshop for integrated programming to prevent famine in priority districts in Hodeidah (Joint Nutrition, WASH, Health and FSAC workshop)
* 31 January: AWG meeting (once a month)
* 5 February: IYCF WG meeting (once a month)
* 7 February: CMAM WG meeting (once a month)
* 26 February: Nutrition Cluster meeting (every two weeks)
* 6-7 March (tbc): Inter-cluster workshop for integrated programming to prevent famine in priority districts in Aden (Joint Nutrition, WASH, Health and FSAC workshop)
* Dates tbc: Inter-cluster workshop for integrated programming to pre-vent famine in priority districts in Ibb (Joint Nutrition, WASH, Health and FSAC workshop)
* SAG meetings are held on a need basis.
* Sub-national Nutrition Cluster meetings are held in each coordination hub - Al Hudaydah, Aden, Sa'ada, Sana'a and Ibb - on a monthly basis. Please contact sub-national cluster coordinator (contact list at the end of the bulletin) for the schedule

Key contacts

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About Yemen Nutrition Cluster

https://www.humanitarianresponse.info/en/operations/yemen/nutrition

The nutrition cluster approach was adopted in Yemen in August 2009, immediately after the break-out of the sixth war between government forces and the Houthis in Sa'ada governorate in northern Yemen. Since then Yemen has continued to face complex emergencies that are largely conflict-generated and in part aggravated by civil unrest and political instability with the Nutrition Cluster being constantly active. Following the escalation of the conflict in March 2015, a Level 3 system-wide emergency was declared in Yemen, which is still in place.

The vision of the nutrition cluster is to safeguard and improve the nutrition status of emergency affected populations by ensuring an appropriate response that is predictable, timely, and effective and at scale. The primary purpose of the nutrition cluster is to support and strengthen a coordinated multi-sectoral approach in nutrition strategic planning, situation analysis and response both in emergencies and non-emergency situations.

The Nutrition cluster is currently established at national level, with five sub national clusters at the zonal level in Hodeidah, Ibb, Aden, Saada and Sanaa.

The Cluster is co-led by the MoPHP and UNICEF and consists of 34 partners. A Strategic Advisory group provides strategic directions to the Cluster, while three technical groups (IYCF WG, CMAM WG and AWG) were established to support partners in IYCF, CMAM and Assessments, respectively.

Cluster Core Functions are:

1.Supporting service delivery
2.Informing strategic decision-making of the HC/HCT for the humanitarian response
3.Planning and implementation of cluster strategies
4.Monitoring and evaluating
5.Building national capacity in preparedness and contingency planning
6. Advocacy + Accountability to Affected Population

More information:
Nutrition Cluster ToR: https://goo.gl/apl2GL

Partners

ACF, ADO, ADRA, BFD, CSSW, FMF, HAD, IMC, INTERSOS , IOM , IRC, IRY, MC, MDM, MMF, MoPHP, PU-MAI, RDP, RI, RRD, SAJAYA, SAWT, SCI, SHS, SOUL, TAYBA, TFY, UNCHR, UNICEF, VHI, WFP, WHO, YDN, YFCA

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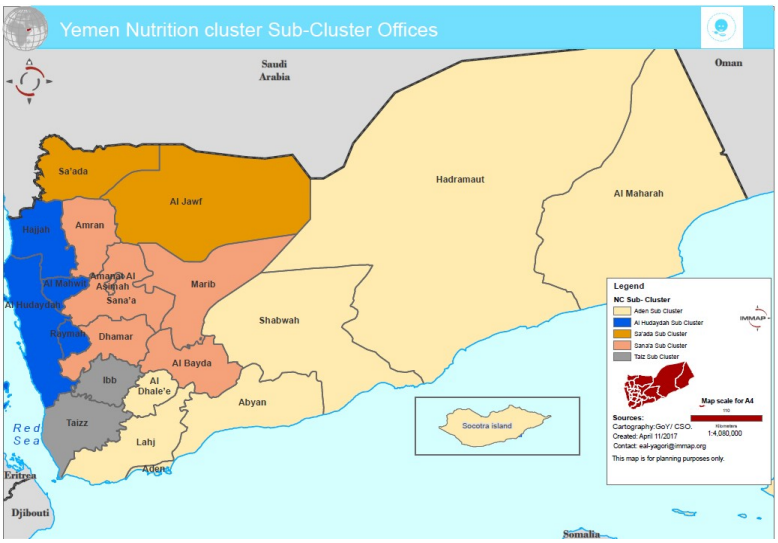

Pic 19. Sub-national clusters and governorates