Yemen Nutrition Cluster Bulletin

Apr-Jun 2018 **Issue 6**

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Funding

$ 210 mln required in 2018 to cover priority nutrition humanitarian needs in Yemen by 39 Cluster partners

$117 mln (56%) was received by Nutrition Clus-

Nutrition Cluster revision of the 2018 YHRP

The nutrition cluster has revised the 2018 YHRP based on the latest evidence available. Nutrition Cluster partners have conducted SMART assessments in six governorates (see more information on page 6) , which has allowed to recalculate the needs and targets for CMAM interventions based on the latest evidence. The updated estimated number of children aged 0-59 months in need of SAM treatment is 383,000 with cluster targeting 70% of them (268,000). Additionally, in coordination with WFP, Blanket (BSFP) and Targeted supplementary feeding programs (TSFP) have been modified to align them with the cluster priorities and to ensure additional scale up in the districts most in need. The TSFP will be further scaled up, covering additional 50 districts with the target coverage of 60% for both children and pregnant and lactating women in need, thus increasing the total target to 910,000 children aged 6-59 months old and 564,000 pregnant and lactating women with acute malnutrition. According to the new updated strategy, BSFP will be provided to 100% children in need in 107 Integrated Famine Risk Reduction (IFRR) priority districts, thus increasing target to 530,000 children aged 6-23 months and 368,000 pregnant and lactating women. The summary of changes is available in the Table 1.

More information:
2018 Nutrition Cluster caseloads and targets, mid-year revision: https://goo.gl/yVnjUS
2018 Nutrition Cluster work plan and mid-year progress: https://goo.gl/eNzYjY

Table 1. Summary of Nutrition Cluster 2018 YHRP changes at the mid-year revision

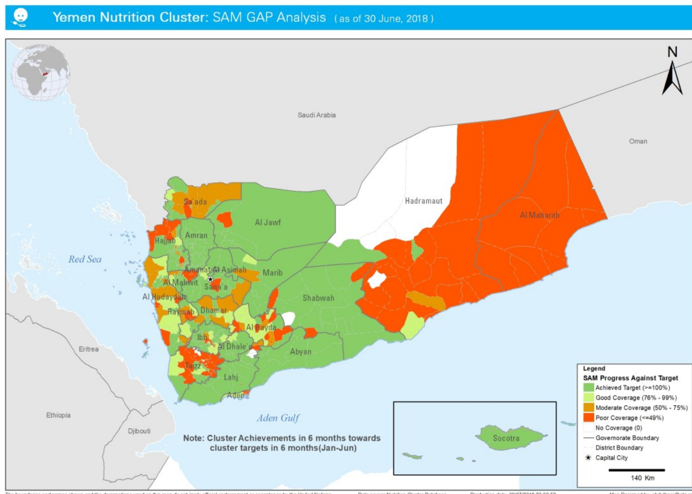
Activities	People in need (initial → revised)	People targeted (initial → revised)	Justification
Treatment of severe acute malnutrition in children	395 K → 383 K	276 K → 268 K	Updated data from the SMART assessments in 6 governorates, that provide better quality data than used initially in the 2018 YHRP to estimate the needs. The target remains 70% of need.
Treatment of moderate acute malnutrition in children	1.8 mln → 1.8 mln	842 K → 910 K	Updated data from SMART assessments in 6 governorates, plus additional scale up in the 50 districts where no TSFP was planned as per initial YHRP. The target remains 60% of need.
Treatment of acute malnutrition in PLW	1.1 mln → 1.1 mln	528 K → 564 K	Additional scale up in the 50 districts where no TSFP was planned as per initial YHRP. The target remains 60% of need.
Blanket Supplementary Feeding Program - children	596 K→ 530 K	348 K → 424 K	Realignment of the priority districts with IFRR 107 priority districts and scaling up of coverage from 60 to 100%
Multiple Micronutrient Program (MNP) – children	tbc	751 K → 663 K	Realignment of BSFP and MNP programs, to ensure that children do not receive double dosage of micronutrients. The target remains 60% of need.
Blanket Supplementary Feeding Program – PLW	398 K→ 368 K	239 K → 368 K	Realignment of the priority districts with IFRR 107 priority districts and scaling up of coverage from 60 to 100%.

Nutrition Programmes' Progress, January—June 2018

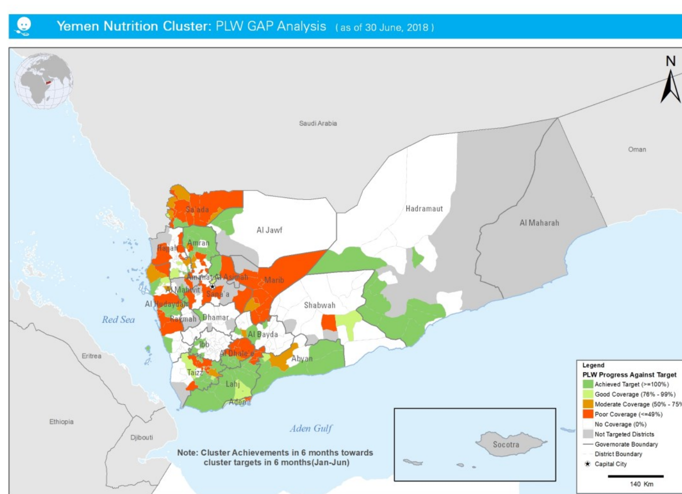
3501 OTPs	2590 TSFPs		901 IYCF Programmes	1559 MNP Programmes	627 BSFPs	
134,600 Children Admitted to OTPs	184,478 Children Admitted to TSFPs	148,829 PLW Admitted to TSFPs	868,961 Caretakers and PLW participated in IYCF ses-	229,771 Children received MNPs	200,702 Children received BSFP	244,598 Children received BSFP
267,912 Target for 2018	910,921 Target for 2018	564,312 Target for 2018	1,404,256 Target for 2018	663,118 Target for 2018	424,109 Target for 2018	368,371 Target for 2018

Nutrition Cluster progress towards targets, as of 30 June 2018

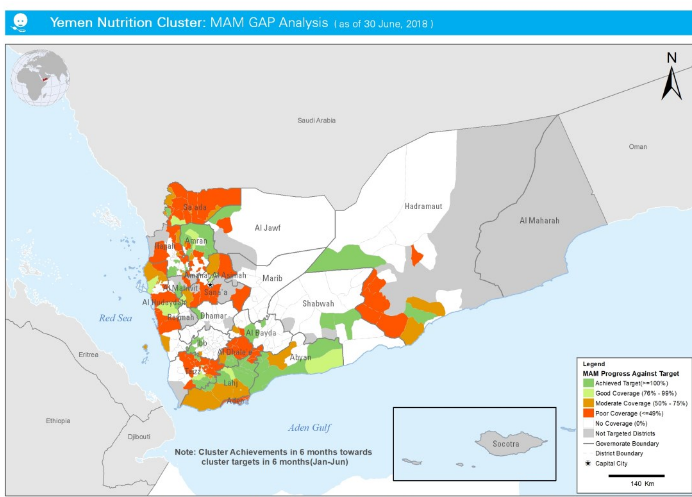
Cluster Objective 1: Deliver quality lifesaving interventions for acutely malnourished girls, boys and pregnant and lactating women



Map 1: Yemen Nutrition Cluster SAM Gap Analysis as 30 June 2018



Map 3: Yemen Nutrition Cluster AM PLW GAP Analysis as 30 June 2018



Map 2: Yemen Nutrition Cluster MAM Gap Analysis as 30 June 2018

As of 30th of June, the CMAM programmes are available in 325 districts (with SAM treatment programmes ongoing in 325 districts and MAM/AM PLW treatment in 232 districts). 459,887 boys and 469,538 girls aged 6-59 months were screened for acute malnutrition and referred for treatment where needed since January 2018, which covers 33% of a target. This will be further increased after conducting MUAC polio screening camapaign planned for the second half of the year.

134,600 of severely acutely malnourished children aged 0-59 months (50 % of 268,000 children targeted in 2018) and 184,478 of moderately acutely malnourished children aged 6-59 months (20 % of 910,000 targeted in 2018) were admitted for treatment since the beginning of 2018. [As of 26 July 2018, the OTP and SC reporting rate for the Q1&2 was 76 percent, and the TSFP reporting rate was 58 percent.] Referral for admissions and success of treatment appears approximately equal for boys and girls; the cluster is receiving consistent, reliable data that ensures this can be monitored on an ongoing basis.

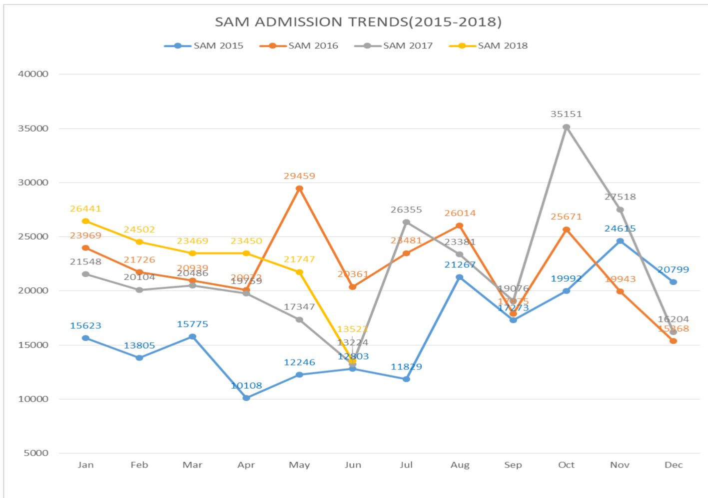
The quality of the SAM and MAM treatment programmes are on average within the SPHERE minimum standards during the first six months of the year, however this significantly varies per district (for example, for SAM treatment programmes in two districts (Shahan and Hat districts of Al Maharah governorate) reported the highest defaulter rate as 100%; for MAM treatment the 5 Districts (Sibah, Al Maghrabah, Sharas,Bani Qais, Najrah) reported defaulter rates of 100%). The defaulter rate impacts other SPHERE indicators, and thus in the 68 district with the defaulter rates above 15%, the cure rates are also below SPHERE indicators. There is a number of factors that impact the defaulter rates, including IDP movements throughout the country without attending health Facility to be transferred, access constraints due to escalation of fighting, dispersed population with long travel time to the nearest treatment programs, transportation cost, limited follow up visits, etc. The partners with the GHO/DHO are identifying bottlenecks and finding solutions for each particular scenario, thus the defaulter rate nationwide has improved in the past year from 22.3% in June 2017 to 15.3% in June 2018 nationwide. The SAM cure rate on average was 82.3 percent, and the death rate was 0.6 percent.

The cure rate for MAM children was 83.6 percent, the death rate was about zero percent and the defaulter rate was 14.9 percent, in line with the SPHERE minimum standards.

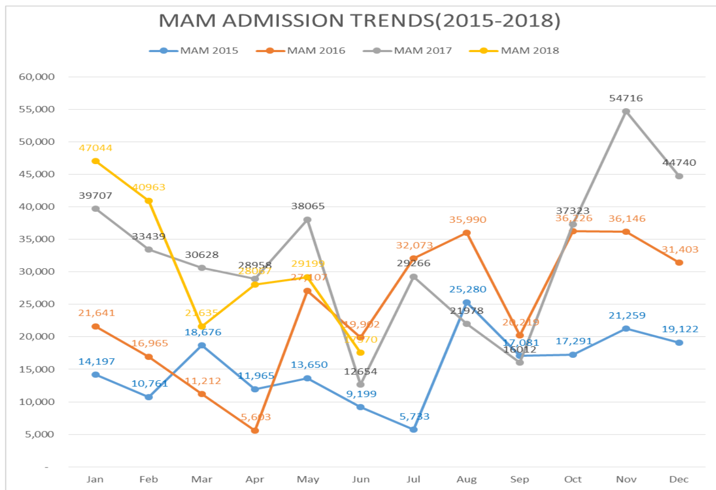
148,829 of acutely malnourished pregnant and lactating women were admitted to treatment in 2018 (26% of 564,000 targeted in 2018). The cure rate for the treatment of the acute malnutrition in the pregnant and lactating women was 87%, death rate was 0 % and defaulter rate was 10.7 %, with variations per district.

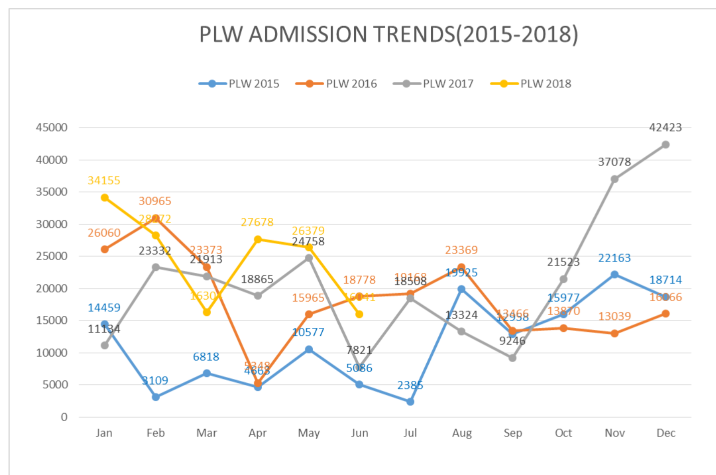
The monthly analysis of the performance indicators and gaps in coverage for the CMAM programmes is available from the links below.

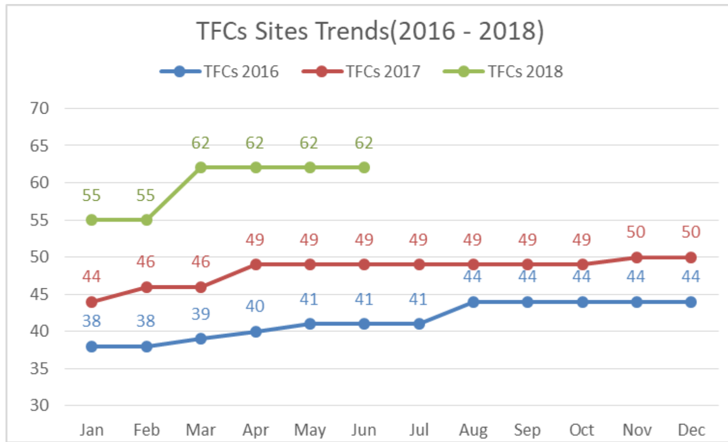
The analysis on the admission trends for the SAM, MAM, and acute malnutrition treatment for the PLWs (as presented on the next page), shows increased admissions to all programmes in 2018 compared to 2017, if we factor into account the reporting rates (79% for SAM treatment and 58% for MAM treatment). To support this conclusion, a number of the OTP sites has increased from 3,342 in January to 3501 in June, but the increased number of admission is also due to the improvement of functionality of OTPs especially with the support of the World bank project. The TSFP number of sites remained the same throughout the year, which is explained by the WFP strategy of opening new sites simultane-

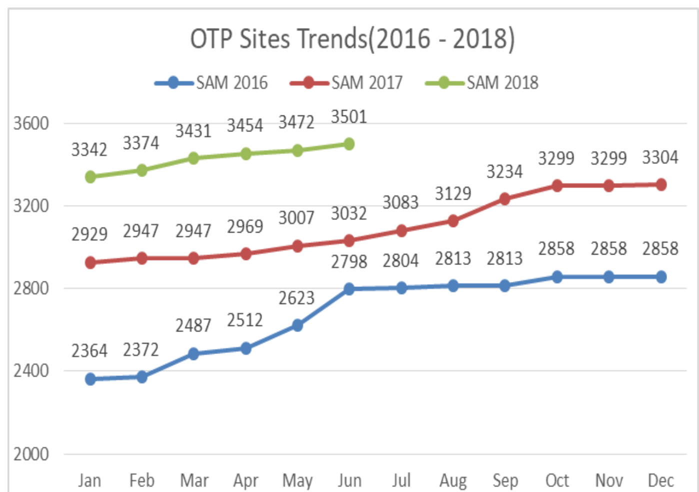


ously in all districts each time when the new internal strategy is launched. It is expected an increase of TSFP sites in August, as per the agreed scale up plan. In terms of admissions to the TSFP programs, compared to the previous years and taking into account the low reporting rate as of now (53 to 60% reporting rate per month), there is an increased number of admissions to TSFP programs for both children and women. There is a drop in admissions for the TSFP in March-April, and the WFP with partners is looking into reasons for this.

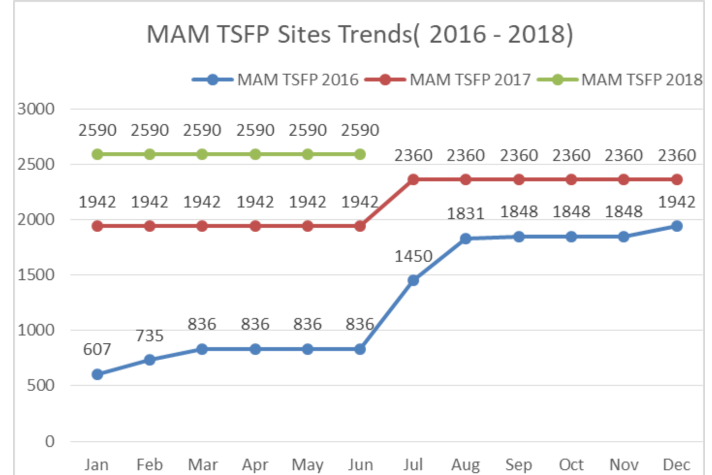








Considering the low number of TFCs in the country at the end of 2017 (50), a TFC scale up plan was developed to increase number of functional TFCs to 91 in 2018, based on the needs, capacities of partners and availability of functional HFs where it is possible to open new TFCs. The process is led by WHO and UNICEF with a number of partners contributing as per the developed TFC scale up plan. As of now, 62 TFCs are operational in Yemen, with more to be opened this year. The main reasons of slow opening of the TFCs is low readiness of the health facilities for the TFCs, as not many of them satisfy WHO requirements for opening a TFC (such as working hours, availability of space, etc.), meaning that



certain modifications are to be done before a TFC can be open.

Additionally a Nutrition Cluster **scale up plan** was developed, covering a full range of the nutrition activities at district level, which is now at national level for final verification. All five hubs completed the exercise to a certain degree, with workshops held with all partners and GHOs/DHOs to agree on the most pressing gaps and a way forward to address them.

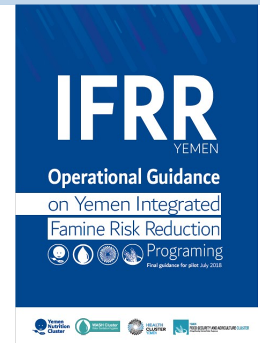
The WASH, Health, Nutrition and FSAC clusters are working further on the pilot of the **Integrated Famine Risk Reduction (IFRR)** package in Yemen. As of now, all consultations were finalized and the guidance is final for pilot, and is now being translated to Arabic. The final version is available from the link below. The gap analysis exercise was completed for Ibb and Aden hubs with most vulnerable locations and leading partners identified for each of the 20 priority districts, as well as exact gaps that needs to be covered to ensure prevention of famine is those locations.

More information:

Monthly analysis of Nutrition Cluster response, June 2018: https://goo.gl/28qLLa

TFC scale up plan as of March 2018: https://goo.gl/ZfZJk6

Final IFRR guidance (English): https://goo.gl/rm5BoN



Picture 1. Yemen IFRR guidance

Objective 2: Contribute to prevention of malnutrition by enhancing BSFP, micronutrient support, deworming and infant and young child feeding

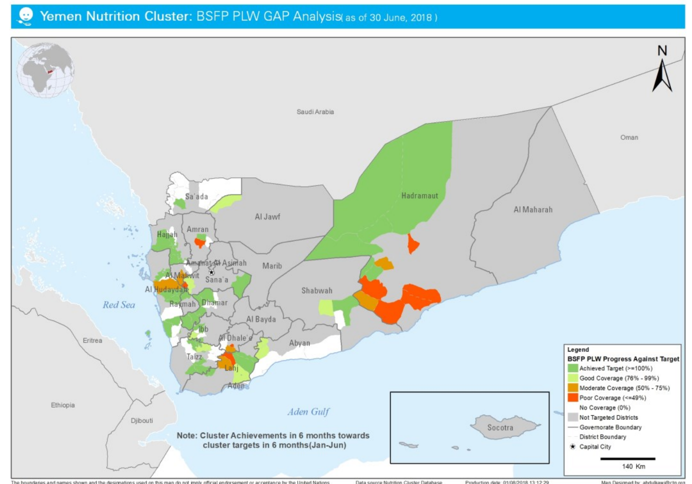
The Cluster is expanding prevention activities, due to high burden of malnourished children and women in Yemen and limited capacity of the health system and current humanitarian response to deal with the increased numbers of undernourished people. The main prevention activities include:

- Infant and Young child feeding counselling of caregivers of children 0-23 months and pregnant women in all 333 districts – 60% of people in need;
- Blanket supplementary feeding programmes (BSFP) for children 6-23 months and PLW in the 107 districts of risk of famine – 100% of children and PLW in need;
- Supplementation of children 6-23 months with multiple micronutrients in the remaining 263 districts – 60% of children in need;
- Deworming of children 12-59 months;
- Supplementation of PLW with iron-folic acid.

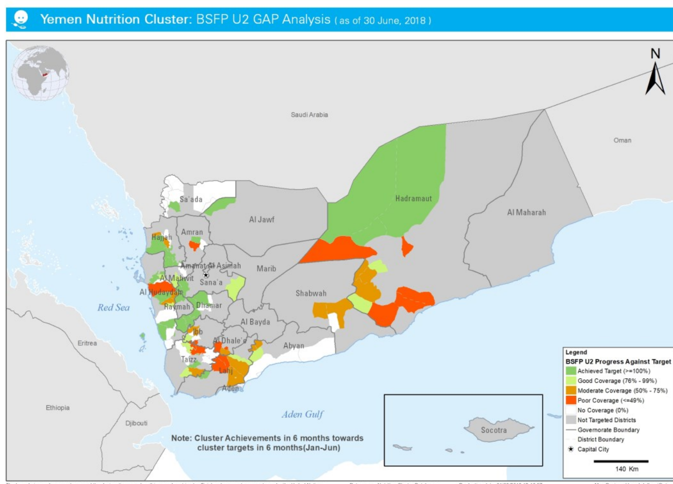
According to the most recent data in the Nutrition Cluster, 868,961 pregnant women and caretakers of children aged 0-23 months received counselling or messaging on appropriate infant and young child feeding, out of 1,404, 256 targeted (62%). The first integrated outreach activities/ round to reach PLWs in the second & third level of coverage started beginning of July and the data should be Available in August. Additionally three more rounds are planned for the coming months, which would substantially increase number of the caregivers of children 0-23 months reached with IYCF-E interventions.

Since 1st of January 2018, 229,771 children aged 6-24 months received multiple micronutrient powders (updated target for 2018: 663,000), 117,664 children received deworming and 514,115 pregnant women received iron-folic acid (target for 2018: 1,078,696).

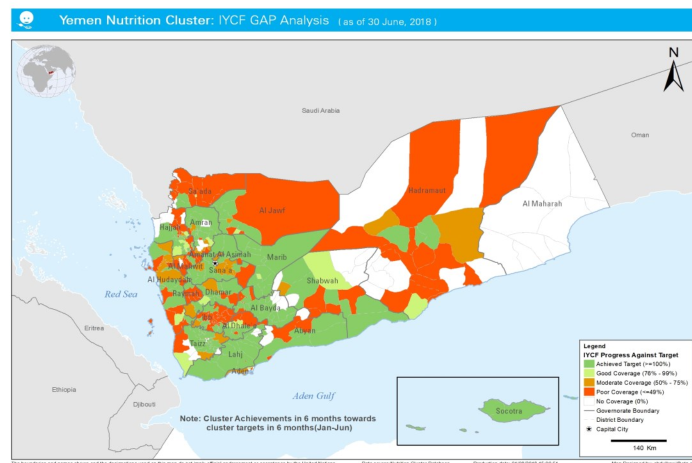
In the first six months of the year WFP with partners has reached 200,702 children aged 6-23 months and 244,598 PLW with BSFP in 107 districts of Yemen (47% of targets of 424,000 children and 66% of 368,000 PLW).



Map 4 : Yemen Nutrition Cluster BSFP in PLW gap analysis (as of 30 June, 2018)



Map 4 : Yemen Nutrition Cluster BSFP in children gap analysis (as of 30 June, 2018)



Map 6: Yemen Nutrition Cluster IYCF gap analysis (as of 30 June 2018)

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

Picture 2. CCPM and Cluster training in Aden hub, 23-25 July 2018

Picture 3. CCPM and Cluster training in Ibb hub, 9-11 July 2018

Cluster partners realize the need to strengthen technical and coordination capacity of partners and government at sub-national level, and therefore in 2018 a training on **Cluster Approach and Cluster Coordination Performance monitoring exercise** is being conducted in each of the five coordination hubs. A training and a Cluster Coordination Performance Monitoring exercise were conducted in Ibb in July of 2018, with a training in Aden planned at the end of July. It will be followed by the trainings in Sadaa, Sanaa and Hodeidah sub-clusters in August-September. The plans developed after each of these exercises will be used by each sub-cluster to monitor improvement on coordination functions of the sub-national clusters.

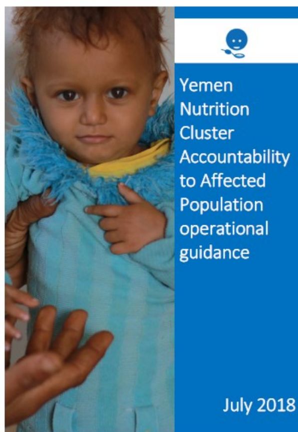
The **training of the CHVs and HWs** on CMAM is currently ongoing with 5,152 of community health volunteers trained on the screening and referral, IYCF and health education (including 4709 as a refresher training and 443 as a basic training); and 1,541 health workers trained on the management of CMAM and IYCF (including 700 as a refresher training and 841 as a basic training).

More information:

Cluster awareness training ppt, English: https://goo.gl/NrdbrW

Cluster Objective 4: Ensure a predictable, timely and effective nutrition response through strengthening robust evidence based system and nutrition needs analysis and advocacy, monitoring and coordination

A number of the **SMART surveys** were conducted since the development of the YHRP at the end of 2017. The current GAM/SAM data that are used in the Cluster are presented in the Table 2, however not all SMART reports already available.



Picture 4. Yemen Nutrition Cluster Accountability to Affected Population Operational Guidance and a Toolkit

An **advocacy strategy** is being developed for the Nutrition Cluster for the 2018-2020, with a workshop to finalize the development of the strategy conducted 24-25 July. The Advocacy strategy objectives focus on the supporting delivery of nutrition interventions and are as below:

1. The MoPHP and other nutrition actors in Yemen promote and scale up a comprehensive nutrition package with the prioritization of both treatment and preventive direct specific nutrition interventions

2. The Ministry of Planning and International Cooperation (MOPIC), the MoPHP and the Nutrition Cluster work with relevant ministries and clusters, including those working on health, agriculture, WASH and education for the inclusion and effective implementation of nutrition-sensitive objectives in relevant government sectoral policies and cluster plans

3. Improved national capacities at all levels for nutrition action

The draft Advocacy strategy is being reviewed and it is planned to finalize it in August-September.

An Accountability to Affected Population (AAP) TF has developed and **AAP Operational Guidance and AAP Toolkit** for Cluster partners, and is currently working on the development of the monitoring and reporting tools and AAP training package. The

Picture 5. Advocacy workshop, 24-25 July, Sanaa

Table 2. Current sources of nutrition data in the nutrition cluster as of 30 June 2018 (in yellow—updated compared to the beginning of the year)

Note: combined SAM prevalence can be used only for caseload and targets calculations and not a “SAM prevalence” which is based on WFH Z-score only and still to be used in all other cases

Governorate	GAM rate (revised June 2018 based on SMART 2016-2018, EFSNA, CFSS2014)	SAM rate (revised June 2018 based on SMART 2016-2018, EFSNA, CFSS2014)	Combined GAM (for caseloads only)	Combined SAM (for caseloads only)	Data source to be used until new SMART assessment data available
Abyan	Lowlands 10.0%, Highlands 5.3%	Lowlands 1.7%, Highlands 0.6%	Lowlands 11.1%, Highlands 6.9%	Lowlands 1.9%, Highlands 0.6%	SMART 2018 (Jan)
Aden	14.0%	2.5%	17.6%	3.9%	EFSNA 2016
Al Bayda	7.3%	0.6%	9.2%	2.3%	SMART 2018 (Apr)
Al Dhale'e	11.0%	1.3%	14.3%	1.8%	EFSNA 2016
Al Hudaydah	25.2%	5.0%	27.0%	6.2%	EFSNA 2016
Al Jawf	9.2%	0.8%	12.5%	1.5%	SMART 2018 (Apr)
Al Maharah	11.4%	2.2%	19.2%	5.1%	CFSS2014
Al Mahwit	12.1%	2.1%	17.2%	4.0%	EFSNA 2016
Amanat Al Asimah (Sanaa city)	6.1%	0.8%	7.6%	0.8%	EFSNA 2016
Amran	7.4%	0.7%	10.9%	1.1%	SMART 2018 (Apr)
Dhamar	9.0%	1.6%	14.5%	2.9%	EFSNA 2016
Hadramaut	20.3%	2.1%	20.3%	2.5%	EFSNA 2016
Hajjah	Lowlands 14.9%, Highlands 8.9%	Lowlands 3.3%, Highlands 0.8%	Lowlands 17.2%, Highlands 12.6%	Lowlands 3.3%, Highlands 1.2%	SMART 2018 (Mar)
Ibb	Western Highlands 5.6%, Eastern Highlands 3.9%	Western Highlands 0.7%, Eastern Highlands 0.6%	Western Highlands 10.5%, Eastern Highlands 6.7%	Western Highlands 1.6%, Eastern Highlands 1.2%	SMART 2017
Lahj	Lowlands 25.3%, Highlands 10.1%	Lowlands 4.8%, Highlands 1.7%	Lowlands 27.4%, Highlands 11.5%	Lowlands 5.2%, Highlands 2.1%	SMART 2017 (July)
Marib	8.1%	0.4%	10.1%	1.0%	EFSNA 2016
Raymah	9.6%	2.1%	14.5%	2.7%	SMART 2017 (Aug)
Sa'ada	Highlands 9.9%, lowlands 8.7%	Highlands 0.7%, lowlands 2.6%	Highlands 20.3%, lowlands 15.8%	Highlands 5.4%, lowlands 3.8%	SMART 2016
Sana'a	5.6%	0.7%	10.1%	2.4%	EFSNA 2016
Shabwah	Plateau 6.2%, lowland and coastal 8.5%	0.7% in all zones	Plateau 9.8%, lowland and coastal 7.4%	Plateau 1.2%, lowland and coastal 1.4%	SMART 2017
Socotra	9.6%	1.1%	11.4%	1.2%	SMART 2018 (Mar-Apr)
Taizz	City 17%, highlands 14.4%, lowlands 25.1%	City 1.9%, highlands 1.6%, lowlands 5.3%	City 19.6%, highlands 18.1%, lowlands 27.9%	City 4.1%, highlands 3.1%, lowlands 7.7%	SMART 2016

purpose of the guidance is to facilitate AAP implementation for all Nutrition Cluster partners throughout the project cycle. It is developed in line with the Yemen Humanitarian Response plan and Yemen accountability framework. The AAP guidance and Toolkit are being translated to Arabic.

To improve coordination efforts at the field level, the Nutrition Cluster partners selected **co-coordinators from NGOs** for the sub-national nutrition clusters as below: Sanaa – BFD, Saada – SCI, Hodeidah – ACF, Ibb – SOUL, Aden—IRC. The ToR for the Sub-national coordinators is available from the link below. They are to start their support to clusters in August.

More information:

Hajjah SMART survey report, March 2018: https://goo.gl/RscYbi
Abyan SMART survey report, January 2018: https://goo.gl/X58Pum
Lahj SMART survey report, July 2017: https://goo.gl/YzZTpr
AAP Operational Guidance and toolkit (English): https://goo.gl/a42o3Q
AAP quarterly reporting tool: https://goo.gl/YiiH45
ToRs for the sub-national Cluster coordinator, GHO co-chair and Cluster co-coordinator: https://goo.gl/1i1gnK

Key contacts

Title / Responsibilities	Location	Organization	Focal Point	Phone number	Email
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Information Management Officer	Sana'a	UNICEF	Abdulkawi Moharram	+967 772103652	abdulkawi@ctg.org
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Co-chair of the IYCF WG	Sana'a	MoPHP	Eaman Jahf	+967 736238178	jahhaf2006@gmail.com
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Co-chair of the CMAM WG	Sana'a	MoPHP	Abdulkareem Alfuhidy	+967 771206062	alfuhidy@gmail.com

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 37 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:

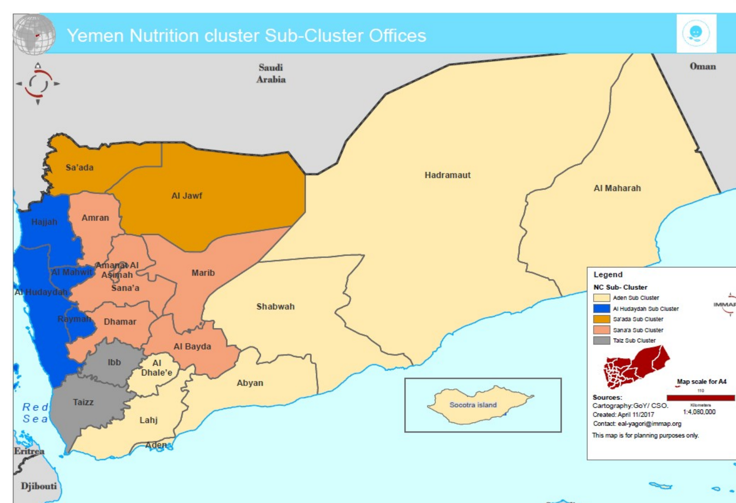
1.Supporting service delivery
2.Informing strategic decision-making of the HC/HCT for the humanitarian response
3.Planning and implementation of cluster strategies
4.Monitoring and evaluating
5.Building national capacity in preparedness and contingency planning
6. Advocacy
+ Accountability to Affected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

More information:

Nutrition Cluster ToR: https://goo.gl/apl2GL
2018 YHRP: https://goo.gl/gSU9qE
2018 HNO: https://goo.gl/i36xDn

Partners

ACF,ADO,ADRA,BFD,CSSW,DEEM,EDF, FMF,HAD,IMC,INTERSOS,IM,IRC, IRY, MC,MdM,MMF,PU-AMI,QRCS, Response Network,RI,SAJAIA ,SAWT, SCI,SHS, SOUL,TFD,TYF,UNHCR, UNICEF,VHI,WFP,WHO,YDN,YFCA



Pic 7 Sub-national clusters and governorates