



Yemen Nutrition Cluster Bulletin

Oct-Dec 2018

Issue 7

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Overview of Nutrition Cluster Performance in 2018

At the end of 2018, the nutrition cluster comprised of 38 partners (5 UN agencies, 1 government, 15 international NGOs, and 17 local NGOs) that collectively recorded significant achievements. Some of the key achievements included:

- Outpatient therapeutic feeding program (OTP) was scaled up from 324 districts in 2017 to 329 districts in 2018. Similarly, the number of districts with TSFP increased to 276 districts by the end of 2018 from 221 districts in 2017. Meanwhile, the coverage of OTP and TSFP sites increased to 3,623 (83%) and 3,082 (70%) health facilities respectively during reporting period.
- The number of children with severe acute malnutrition admitted in OTPs sites reached 345,463 representing 129% of the 2018 annual target. Moreover, 14,252 children were suffering from Severe Acute Malnutrition (SAM) with complication that were treated in Therapeutic Feeding Centers (TFCs).
- Targeted supplementary Feeding Program (TSFP), enrolled a total of 566,699 moderately acute malnourished (MAM) under-five children representing 77% of the 2018 annual target. The corresponding figure for PLW was 408,148 representing 72% of the annual target.
- Performance on preventive interventions were also impressive. The number of children reached with micronutrient

supplementation reached 855,054 representing 129% of the annual target and twice the number reached in 2017. Vitamin A supplementation was provided to a total of 3,422,260 under-five children most of them through national campaign organized by MOPHP in collaboration with UNICEF and partners.

- Meanwhile, 345,096 children and 454,225 pregnant and lactating women were enrolled in blanket supplementary feeding program (BSFP) representing a 185% increase compared to under-two children reached in 2017. Summary of key interventions against 2018 targets are presented in table2 below.
- In addition, nutrition education on improving exclusive breast feeding in the first 6 months, IYCF counselling and supplementary feedings for children under two years was provided to 1,778,853 pregnant and lactating women and care givers.

Finally, with respect to capacity building, a total of 9,714 health workers and community health volunteers were trained on basic nutrition package on CMAM, IYCF and TFCs etc. For more understanding on the 2018 responses and coverage compared to 2017, please see tables below

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Funding

\$ 210.3 million required in 2018 to cover priority nutrition humanitarian needs in Yemen by 38 Cluster partners

\$ 163.8 million (77.9%) was received by Nutrition Cluster up to Dec2018

Note: 2019 HNO and HRP updates will be published in the 2019 first quarterly bulletin.

Table 1: Coverage of key nutrition interventions in 2018 against targets

Activity	2017 Progress	Changes in 2018			2018 Targets	2018 Progress	Achievements against 2018 Targets
SAM	263,313	↑	31%	90,440	267,913	345,463	129%
SAM with Comp	7,819	↑	82%	6,433	13,027	14,252	109%
MAM	360,163	↑	57%	206,536	734,479	566,699	77%
PLW AM	248,225	↑	64%	159,923	564,312	408,148	72%
MNP	393,673	↑	117%	461,381	663,118	855,054	129%
Vit A	4,407,991	↓	-22%	985,731	4,176,839	3,422,260	82%
BSFP U2	121,168	↑	185%	223,928	424,109	345,096	81%
BSFP PLW				454,225	368,371	454,225	123%
FEFO	848,942	↑	40%	342,075	1,078,696	1,191,017	110%
IYCF	862,389	↑	106%	916,464	1,404,256	1,778,853	127%
Training	9,561	↑	2%	153	10,000	9,714	97%

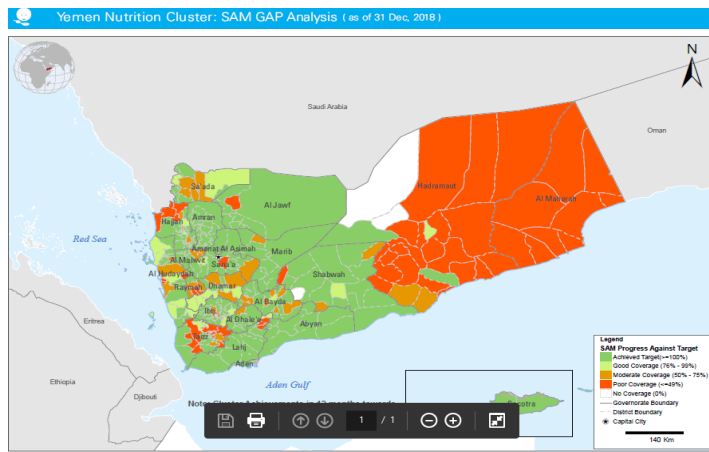
Table2: Nutrition Programmers' Progress, From January till December, 2018

3,623 OTPs	3,028 TSFPs		1,081 IYCF Program	1,739 MNP Programmes	627 BSFPs	
345,463 Children Admitted to OTPs	566,699 Children Admitted to TSFPs	408,148 PLW Admitted to TSFPs	1,778,853 Caretakers and PLW received IYCF counselling	855,054 Children received MNPs supplement.	345,096 Children received BSFP	454,225 PLW received BSFP
267,912 Target for 2018	734,479 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 performance towards targets, as of 31 December 2018

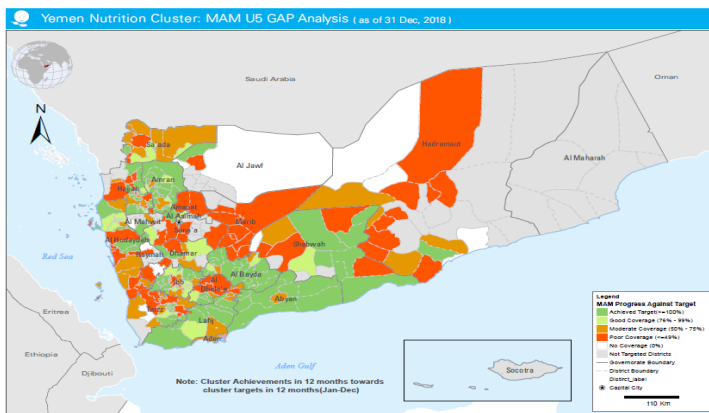
Cluster Objective 1: Deliver quality lifesaving interventions for acutely malnourished girls, boys and pregnant and lactating women

As of 31st of December 2018, the CMAM programmes was implemented in 329 districts (with SAM treatment in 329 districts and MAM treatment in 276 districts). A total of 1,289,956 boys and 1,315,292 girls aged 6-59 months representing 121% of the annual target were screened for acute malnutrition and acutely malnutrition children were referred for treatment accordingly.



Map 1: Yemen Nutrition Cluster SAM Gap Analysis as of 31 December 2018

During the same period, a total of 345,463 severely acutely malnourished children aged 0-59 months (129% of 267,913 children targeted in 2018) representing about 90% of the 382,733 SAM in need were treated in Outpatient feeding programme (OTP). About of 4% of the total SAM cases had medical complications and therefore were admitted and treated in therapeutic feeding centers that increased from 49 sites in 2017 to 83 sites in 2018. Targeted supplementary feeding programme (TSFP) enrolled and treated a total of 566,699 of moderately acutely malnourished children aged 6-59 months representing 77 % of 734,479 targeted in 2018 and about 38% of the MAM in need. While the 2018 reporting rate of 83% for OTP was relatively similarly to 2017 levels, the TFSP reporting rate increased from 59% in 2017 to 81% in 2018. Referral for admissions and completion of treatment in OTP and TSFP is approximately equal for both boys and girls, implying that no differences in accessing nutrition services for boys and girls, based on the information submitted to the cluster on monthly basis.



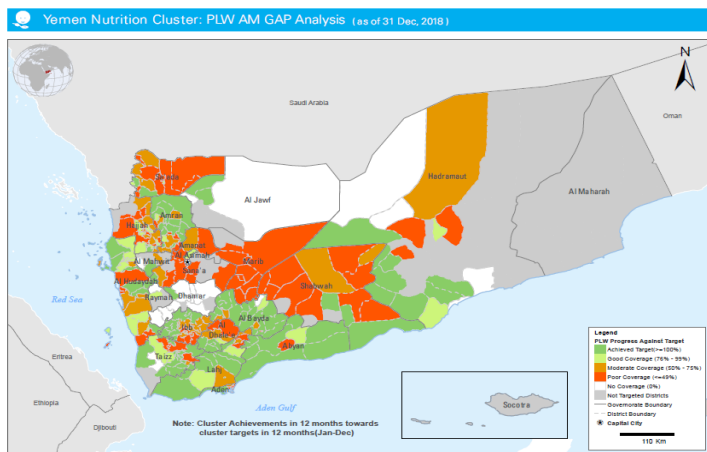
Map 2: Yemen Nutrition Cluster MAM Gap Analysis as of 31 December 2018

When compared to the 2017 performance, the 2018 SAM and MAM new admissions increased by 31% and 57% respectively attributed to scale up of num-

ber of nutrition sites (see table 1).

The 2018 quality of the OTP and TSFP treatment programmes (cure, death and defaulter rates) were on average within the SPHERE minimum standards the entire 2018 reporting period. The OTP cure rate on average was 83 percent which is exceeding the minimum standard of SPHERE standard of cure rate of 75 percent. Death rate was 0.3 percent and defaulter rate was 14.1 percent which is lower than the sphere standard threshold of 15 percent. With respect to TSFP The cure rate for MAM children was 83 percent, the death rate was about zero percent and the defaulter rate was 16.3 percent.

While defaulter rate met the Sphere minimum standard for SAM at national level, it also varied significantly across the districts. For example, for SAM treatment programmes in 7 districts: 5 districts in Hadramout (Al Qatn, Tarim, Ash Shihri, Shahan, Hat) and 2 districts in Almaharah governoartes (Sayhut, Qishn) reported the highest defaulter rate of more than 75%. Similarly, in MAM treatment, there were also 7 districts that reported defaulter rates more than 75%: 3 in AL hudaidah (As Salif, Az Zaydiyah, Al Khawkhah) and 4 in Hajjah (Sharas, Najrah, Bani Al Awam, Hajjah). There is a number of factors that impact the defaulter rates, including IDP movements, access constraints due to escalation of fighting in some of the locations, dispersed population with long travel time to the nearest treatment programs, transportation cost, low engagement of the community health volunteers and limited follow up visits, etc. The partners with the GHO/DHO are identifying bottlenecks and finding solutions for each particular scenario.

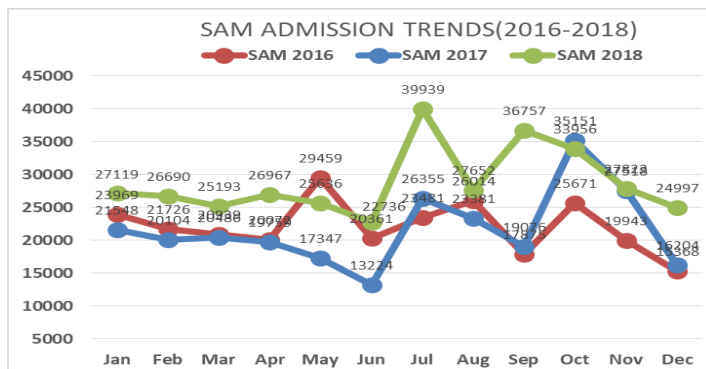


Map 3: Yemen Nutrition Cluster AM PLW GAP Analysis as of 31 December 2018

Meanwhile, a total of 408,148 of acutely malnourished pregnant and lactating women were admitted and treated in 276 nutrition sites across the country representing 72% of 564,312 targeted in 2018). There was no significant difference in performance indicators between TSFP indicators among PLWs and under-five children. Scale up of TSFP services contributed to 64% increase in PLW admitted and treated for acute malnutrition compared to the same period in 2017. (see Table 1)

The monthly analysis of the performance indicators and gaps in coverage for the CMAM programmes is available on the Nutrition cluster website on the link: <https://www.humanitarianresponse.info/en/operations/yemen/document/nutrition-cluster-update-december-2018>

The analysis on the new admission trends for the SAM, shows increased admissions trend from January to September after which it depicted a decreasing trend in the last quarter of 2018, a similar pattern observed in 2017. The trend also indicate high admissions in 2018 compared to 2017. This could be partly explained by 12% increase in number of reporting sites in 2018 compared to 2017. Moreover, the number of OTP sites increased from 3342 in December 2017 to 3623 in December 2018.



Admission trend for under-five MAM indicated an increasing trend during the last quarter of 2018 due to scale up of TSFP sites that was implemented by WFP in collaboration with its partners. For example, about 560 TSFP sites were opened during the last quarter of 2018 that contributed to the observed increasing admissions trend observed in TSFP. The overall increase in TSFP sites from 2349 in December 2017 to 3028 in December 2018 partly explain the high admissions reported in 2018.

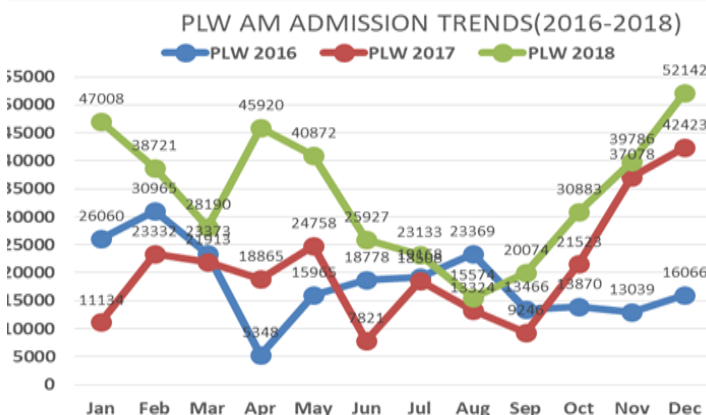
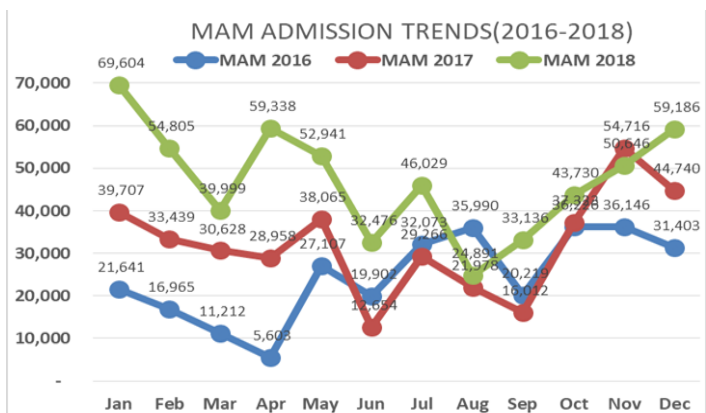
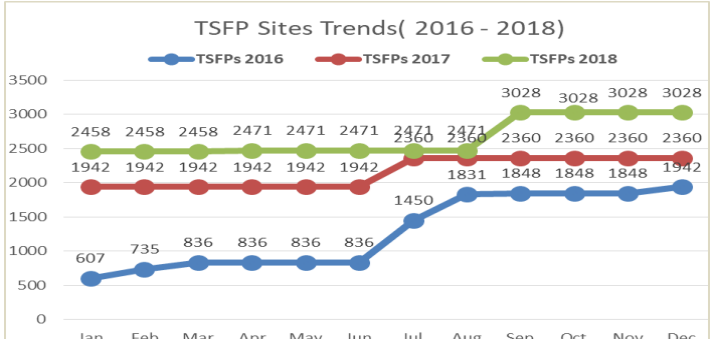
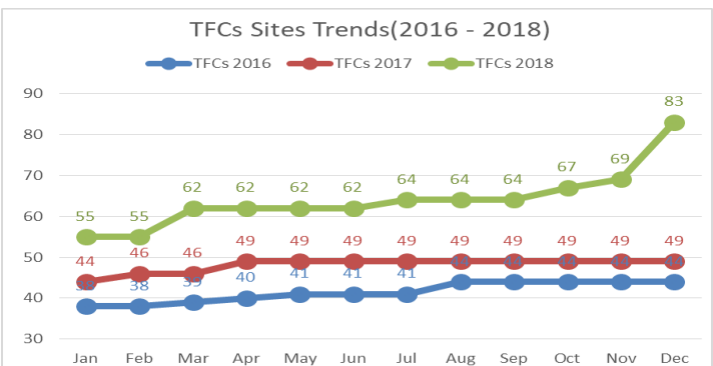
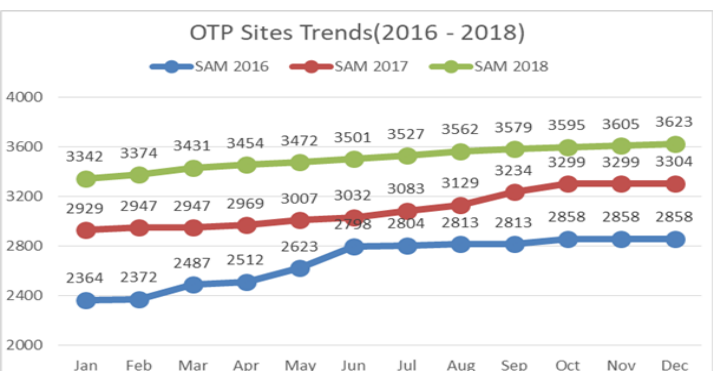


Table 3, scale up of nutrition services sites in 2017-2018

Site	2017	Change in 2018		2018
Functional OTP sites	3,304	↑	10%	3,623
Functional TFC/ SC sites	53	↑	57%	83
Functional TSFP sites	2,349	↑	29%	3,028
Sites with IYCF services	852	↑	27%	1,081
Sites with MN supplementation	921	↑	89%	1,739

Considering the low number of TFCs in the country at the end of 2017 (49), a TFC scale up plan was developed to increase number of functional TFCs to 91, 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 in collaboration with a number of partners contributing as per the developed TFC scale up plan. As of Dec 2018, 83 TFCs were operational. The main reasons of slow opening of the TFCs was 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 needed to be done before a TFC is open.

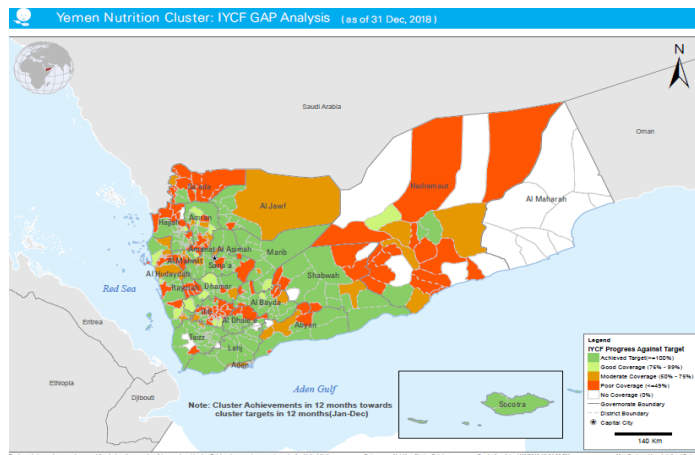


Objective 2: Contribute to prevention of malnutrition by enhancing BSFP, micronutrient support, deworming and infant and young child feeding

Given the high burden of chronic and acute 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, partners in 2018 focused on scaling up the following preventive interventions:

- Infant and Young child feeding counselling of caregivers of children 0-23 months and pregnant women in all 333 districts;
- Blanket supplementary feeding programmes (BSFP) for children 6-23 months and PLW in the 107 districts of risk of famine;
- Supplementation of children 6-23 months with multiple micronutrients .
- Vitamin A supplementation for children 6-59 months,
- Deworming of children 12-59 months,
- Supplementation of PLW with iron-folic acid.

According to the most recent data in the Nutrition Cluster, as of 31 December 2018 , a total of 1,778,853 pregnant women and caretakers of children aged 0-23 months received counselling or messaging on appropriate infant and young child feeding practices out of 1,404,256 targeted (127%). Such high coverage was achieved through combination of health facility and community based interventions .

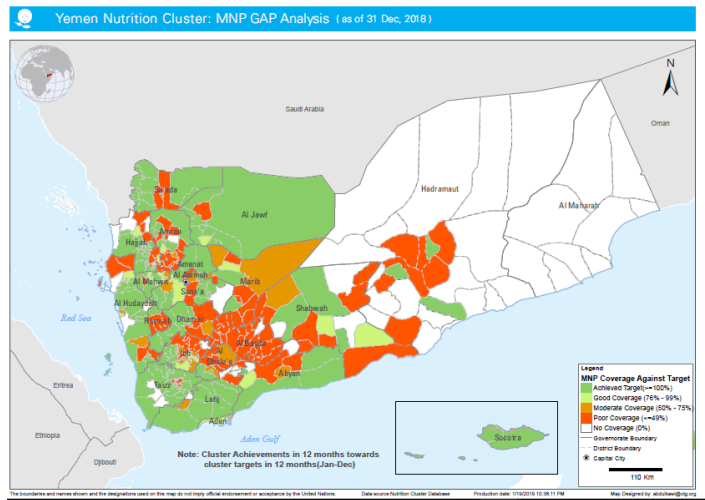


Map 4: Yemen Nutrition Cluster IYCF Analysis (as of 31 December 2018)

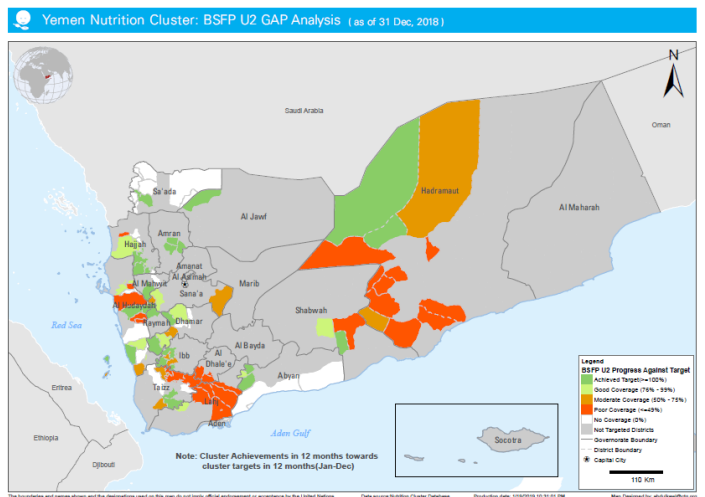
By the end of December 2018, with UNICEF & its partners efforts, a total of 855,054 children aged 6-24 months received multiple micronutrient powders that was 129% of the 2018 annual target estimated at 663,118. Moreover, 729,006 children were dewormed while 1,057,044 pregnant women were supplemented with iron-folic acid representing 98% of the revised 2018 annual target of 1,078,696.

BSFP coverage also improved significantly. WFP and its partners reached a total of 345,096 children aged 6-23 months and 454,225 PLW with BSFP in 89 districts of Yemen representing 81% and 123% of their respective annual targets.

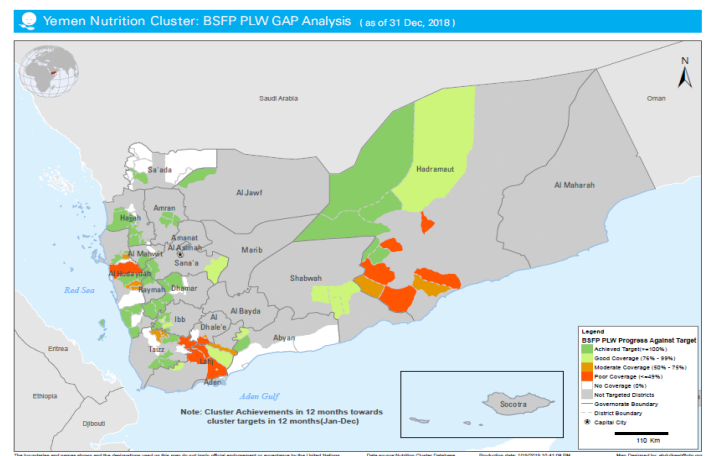
The coverage of nutrition services for IYCF, BSFP and Micronutrient supplementation is depicted in Map 4-7 above with varying level of coverage at district level. The reasons for differential coverage across the districts is associated with limited access, insecurity and limited geographical coverage in some of the districts.



Map 5: Yemen Nutrition Cluster MNP Analysis (as of 31 December 2018)



Map 6 : Yemen Nutrition Cluster BSFP U2 Analysis (as of 31 December, 2018)



Map 7: Yemen Nutrition Cluster BSFP PLW Analysis (as of 31 December, 2018)

IFRR: Integrated Famine Risk Reduction

The nutrition cluster coordination team analyzed the nutrition situation in the 107 districts that were at risk of famine in 2017-18 where a famine risk reduction intervention was scaled up by the four clusters (Health, WASH, FSAC and nutrition) individually. Since there was limited monitoring of the implementation of the integrated response, the nutrition cluster has analyzed nutrition situation and response coverage based on the scale up of nutrition services that were implemented by nutrition cluster partners.

Nutrition situation- of the 107 districts, SMART survey information extrapolated at district levels was obtained for 61 districts. The results indicated that nutrition situation improved in 15 (24.5%) out of the 61 districts where the nutrition situation changed from critical to serious or from serious to poor. Moreover, 29 out of the 61 districts indicated a numerical/relative decrease in GAM prevalence ranging from 1.4 to 11 percent.

The cluster did analysis of the coverage of OTP services in the districts where GAM level relatively decreased and noted that; OTP sites (overall for all the 29 districts) increased from 310 to 367 in 2017 and 2018 respectively. The percentage increase in OTP sites coverage in 29 districts that reported relative decrease GAM prevalence was 18.4% compared to 8% in the 29 districts that indicated an increase in acute in acute malnutrition. Similarly, the overall

increase in number of TSFP sites in 29 districts where there was relative decrease in prevalence of acute malnutrition was 29.6% compared to just 13% in districts where there was relative increase in GAM levels.

The overall increase in OTP sites /services in 49 districts where no survey was conducted during 2018 in nutrition situation (i.e no survey conducted in those districts in 2018) also increased by 13% from 510 sites to 568 in 2017 and 2018 respectively. Meanwhile the TSFP sites increased by 10% during the same period.

Out of the 27 districts that were considered pilot, 11 districts indicated a numerical/relative decrease in GAM levels when 2017 and 2018 absolute levels are compared. However, only five (5) of them changed nutrition status: from critical to poor-2 and from serious to poor 3. Increase in OTP and TSFP sites coverage in the 27 districts was generally low (4% for OTP and 2.4% for TSFP) because most of the health facilities had already been covered with OTP and TSFP services.

The analysis above indicates, partners scaled up nutrition responses in all the 107 districts regardless whether the districts was a pilot for IFRR or not. The impact of the integrated IFRR was not easy to assess due to failure to implement robust monitoring system at field and national level.

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

Strengthening partners and MOPHP/MOPIC capacity was one key strategic objective of the nutrition cluster in Yemen. While partners help build the technical capacities of MOPHP/MOPIC, the nutrition cluster oriented and trained partners and MOPHP at national and subnational levels on cluster approach and cluster coordination performance.

Training /orientation of partners at hub level on cluster approach focused on the following topics:

- Cluster Coordination Performance Monitoring.
- Humanitarian Reform, Transformative Agenda and Cluster Approach and Activation and De-activation of the Cluster
- Responsibilities of Cluster Actors, and commitments for Participation in Cluster ,
- Humanitarian Programme Cycle, Preparedness, Evaluation, Needs Assessment, Strategic Response Planning, Resource mobilisation, Supply, Human Resources
- Implementation, Monitoring, Coordination, and the Information management.

The training also covered the 7 core nutrition cluster functions as mentioned below:

- Supporting service delivery
- Informing strategic decision-making of the HC/HCT for the humanitarian response
- Planning and implementation of cluster strategies
- Monitoring and evaluating
- Building national capacity in preparedness and contingency planning
- Advocacy + Accountability to Affected Population Sana'a (11 – 13) November of 2018, the training was conducted at national level

Orientation on the Cluster coordination

performance monitoring (CCPM) at national level focused on why the CCPM is important.

- To ensure efficient and effective coordination.
- To take stock of what is functional areas worked well and need improvement.
- Raise awareness of the support needed from the HC/HCT, cluster lead agency, global cluster and partners.
- Opportunity for self reflection
- Strengthen partnership and transparency within the cluster and Show the added value and justify the costs of coordination

By the end of December 2018, SMART surveys were conducted in 17 out of 22

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

governorate that were planned. Of the 17 that had been conducted, 15 governorates' surveys were validated by the Assessment working group. Five governorates (Al Hudaydah, Lahj, Taizz, Aden and Hadramaut) continued to be classified with critical levels of acute malnutrition prevalence above 15 per cent- the WHO emergency threshold in two years in a row. The total number of districts classified with critical levels of acute malnutrition increased from 79 in 2017 to 91 in 2018 out of the 333 districts.

Based on results from SMART surveys conducted in 2018 in 15 governorate and 2017 survey results for the remain 7 governorates, the nutrition situation in Yemen was classified as either serious or critical in about 44% of the 333 districts in the country.

The graph below shows the distribution of districts with varying nutrition situations in 2018 and 2017. Table 4 summarizes governorate level survey results used in estimating nutrition cluster SAM and MAM caseload for 2019.

Graph 1: GAM Severity prevalence classification 2017- 2018

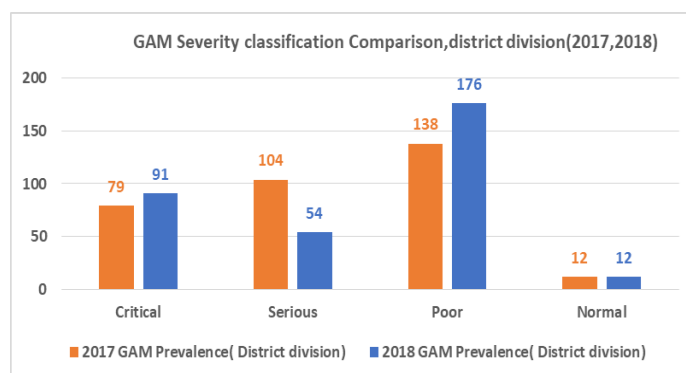


Table 4. Current sources of nutrition data in the nutrition cluster as of 31 December 2018, out of 22 governorates, 15 governorates have an update data of SMART Surveys which conducted and validated in 2018, 4 governorates their data based on SMART Surveys conducted in 2016, and 2017, and the rest of three governorates based on EFSNA 2016,

Note: GAM prevalence presented below is WHZ (uncombined GAM).

Governorate	Survey zone	Data Source	Survey End Date	GAM Prevalence	Severity classifications
Abyan	Highland	SMART Survey	February-18	5.3%	Poor
Abyan	Lowland & coastal	SMART Survey	February-18	10.0%	Serious
Aden	Whole	SMART Survey	November-18	15.5%	Critical
Al Bayda	Whole	SMART Survey	April-18	7.3%	Poor
Al Dhale'e	Whole	SMART Survey	September-18	12.1%	Serious
Al Hudaydah	Whole	EFSNA Survey	November-16	25.2%	Critical
Al Jawf	Whole	SMART Survey	April-18	9.2%	Poor
Al Maharah	Whole	SMART Survey	July-18	9.9%	Poor
Al Mahwit	highlands	SMART Survey	October-18	5.5%	Poor
Al Mahwit	lowlands	SMART Survey	October-18	11.8%	Serious
Amanat Al Asimah	Whole	EFSNA Survey	November-16	6.1%	Poor
Amran	Whole	SMART Survey	April-18	7.4%	Poor
Dhamar	Eastern	SMART Survey	May-18	5.9%	Poor
Dhamar	Western	SMART Survey	April-18	10.1%	Serious
Hadramaut	Whole	EFSNA Survey	November-16	20.3%	Critical
Hajjah	Highlands	SMART Survey	March-18	8.9%	Poor
Hajjah	Lowlands	SMART Survey	March-18	14.9%	Serious
Ibb	Eastern Lowlands	SMART Survey	April-17	3.9%	Normal
Ibb	Western Highlands	SMART Survey	March-17	5.6%	Poor
Lahj	highlands	SMART Survey	August-18	12.0%	Serious
Lahj	lowlands	SMART Survey	August-18	22.2%	Critical
Marib	City (TC)	SMART Survey	August-18	10.1%	Serious
Marib	Rural	SMART Survey	August-18	10.0%	Serious
Raymah	Whole	SMART Survey	August-17	9.6%	Poor
Sa'ada	highlands	SMART Survey	May-16	9.9%	Poor
Sa'ada	lowlands	SMART Survey	June-16	8.7%	Poor
Sana'a	Dry (SAD)	SMART Survey	May-18	5.6%	Poor
Sana'a	Temperate (SAT)	SMART Survey	April-18	7.0%	Poor
Shabwah	Lowland & coastal	SMART Survey	January-17	8.5%	Poor
Shabwah	Plateau	SMART Survey	January-17	6.2%	Poor
Socotra	Whole	SMART Survey	April-18	9.6%	Poor
Taizz	City (TC)	SMART Survey	November-18	15.4%	Critical
Taizz	Highland	SMART Survey	November-18	15.0%	Critical
Taizz	lowlands	SMART Survey	November-18	22.6%	Critical

For More information:

Please go through the link below for Nutrition Assessments summary, 2018:

<https://www.humanitarianresponse.info/en/operations/yemen/document/nutrition-smart-surveys-summary-2018>

Key contacts

Title / Responsibilities	Location	Organization	Focal Point	Phone number	Email
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About Yemen Nutrition Cluster

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-chaired by the MoPHP and UNICEF and consists of 37 partners. A Strategic Advisory group provides strategic directions to the Cluster,

while four technical groups (IYCF WG, CMAM WG and AWG and AAP TWG) were established to support partners in IYCF, CMAM and Assessments as well integration of accountability to affected population into nutrition responses.

Cluster Core Functions are:

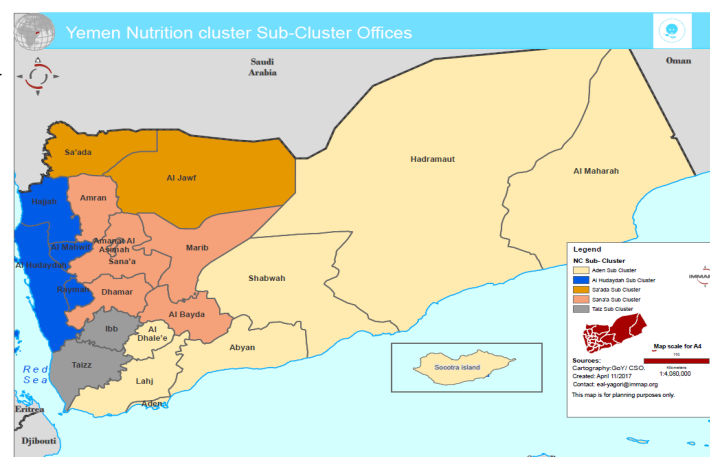
1. Supporting service delivery
2. Informing strategic decision-making of the HC/HCT for the humanitarian response
3. Planning and implementation of cluster strategies
4. Monitoring and evaluating
5. Building national capacity in preparedness and contingency planning
6. Advocacy
7. Accountability to Affected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

More information:

Nutrition Cluster ToR: <https://goo.gl/apl2GJ>
 2018 YHRP: <https://goo.gl/gSU9qE>
 2018 HNO: <https://goo.gl/i36xDn>

Partners

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



Map 8: Sub-national clusters and governorates

Data source: 2018 HNO, HRP, GoY CSO, Nutrition cluster databases
 Date: 10 March, 2019
 NC Website: <https://www.humanitarianresponse.info/en/operations/yemen/nutrition>

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