Yemen

Nutrition
Sectoral and OR+ Thematic Report

January - December 2018

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Prepared by:
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Abbreviations and Acronyms

CHV	Community Health Volunteer
CMAM	Community Management of Acute Malnutrition
DHO	District Health Office
IPC	Integrated Food Security Phase Classification
IYCF	infant and young child feeding
MoPHP	Ministry of Public Health and Population
MQSUN	Maximising the Quality of Scaling Up Nutrition
MUAC	mid-upper-arm circumference
OTP	outpatient therapeutic programme
PLW	pregnant and lactating woman
SAM	severe acute malnutrition
SMART	Standardized Monitoring and Assessment of Relief and Transition
TFC	therapeutic feeding centre
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization
YER	Yemeni Riyal

Executive Summary

Yemen continued to be one of the worst places in the world to be a child in 2018. The conflict that began in March 2015 has rendered Yemen one of the world's largest and most complex humanitarian crises. By the end of 2018, 24.1 million people (almost 80 per cent of the country's population and up from 22.2 million from the beginning of the year) required some form of humanitarian or protection assistance, including 14.3 million who are in acute need.

The food security situation is alarming and continues to deteriorate. The latest Integrated Food Security Phase Classification (IPC) released in December 2018 showed that 53 per cent of the population (15.9 million people) is facing severe acute food insecurity in the presence of humanitarian food assistance. Besides the direct impact of the conflict, the main driver for the food insecurity is the conflict-driven economic crisis, with sharply deteriorating GDP and currency, significant diminishing employment opportunities in the private sector, and the worsening in the already very high incidence of poverty. Against this insecurity, the second wave of cholera outbreak continued, with 1,391,329 suspected cholera cases of, including 2,741 related deaths.

As a response to the expected deterioration in the nutrition situation for children, the nutrition programme for 2018 focused on further expansion of the Community Based Management of Acute Malnutrition (CMAM) programme. In 2018, UNICEF continued to expand essential malnutrition prevention and treatment interventions, making significant gains against planned targets. Of around 400,000 children estimated to be suffering from Severe Acute Malnutrition (SAM) in 2018, UNICEF planned to reach at least 70 per cent with required treatment. Working in partnership with 17 international and local NGOs, UNICEF supported the management of 345,604 children under the age of five with SAM, representing 125 per cent of the annual target. A total of 3,686,963 (120 per cent of the annual target) children under the age of five were screened for malnutrition. In addition, 4,144,744 children under the age of five were given micronutrient supplements (including both Vitamin A and micronutrient supplements). A total of 1,771,521 caregivers of children 0-23 months were provided with access to Infant and Young Child Feeding (IYCF) counselling for appropriate feeding (162 per cent of 2018 target), and 182 new IYCF corners were established, bringing the total number in the country to 1,081.

To further scale up CMAM coverage in the country, UNICEF in collaboration with the World Health Organization (WHO) and the Ministry of Health, established 277 new Outpatient Therapeutic Programmes (OTPs) and Stabilization Centres. Furthermore, 128 mobile teams were functional in 2018 versus 58 in 2017. A total of 1,221 health workers were trained on CMAM/IYCF, which contributed to the scale up of CMAM/IYCF services at health facilities. In total, 83 per cent of the health facilities in the country (3,595 facilities) are now delivering SAM treatment services. Expansion was not the only priority; focusing on programme quality also was: the cure rate for SAM treatment reached 83 per cent in 2018 versus 77 per cent in 2017, while the defaulter rate dropped to 15 per cent from 20 per cent in 2017.

UNICEF continued to provide leadership in the nutrition cluster and inter-agency coordination, as well as active participation in the integrated inter-cluster famine response framework with a range of other partners. UNICEF also strengthened assessment of the situation through Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys. A total of 17 SMART surveys were conducted at the governorate level. In the context of conflict and national survey data that dates to 2013, SMART surveys are a key source of up-to-date information on the nutrition status of women and children. This data generation will allow for more robust evidenced-based planning and programming.

UNICEF again supported the Scale Up Nutrition (SUN) initiative in 2018, reviving the secretariat at Ministry of Planning and International Cooperation (MoPIC), revising the Multi-Sectoral

Nutrition Action Plan and its cost and rallying partners around malnutrition in partnership with WFP and WHO and DFID through launching a Call to Action on Nutrition around the UNGA in September 2018.

Strategic Context of 2018

The current humanitarian crisis in Yemen is one of the worst in the world with 24.1 million people (almost 80 per cent of the country's population) requiring some form of humanitarian or protection assistance, including 14.3 million who are in acute need. The size of the population in need was already at 15.9 million in 2014 before the conflict began and at 21.1 million as the conflict broke out in 2015. Children are among the most vulnerable and are disproportionately affected by the conflict.

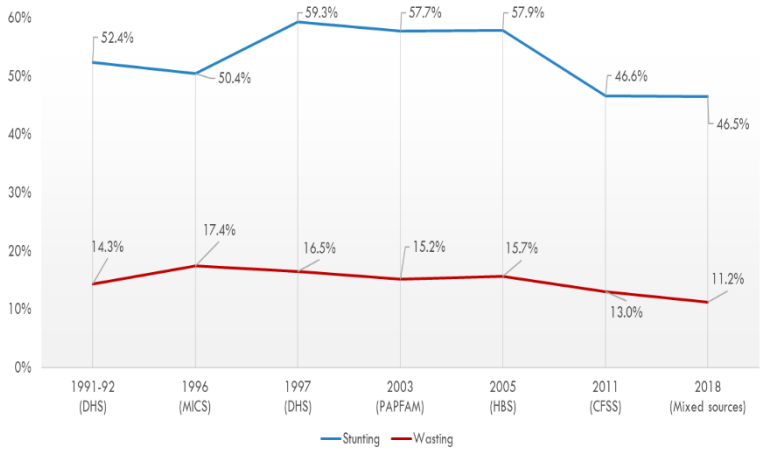
Food insecurity is at alarming high levels, with recent analysis from the Integrated Food Security Phase Classification (IPC) indicating that from December 2018 to January 2019, 17 per cent of the population analyzed (about 5 million people) will be in IPC Phase 4 (Emergency) and 36 per cent (about 10.8 million people) in IPC Phase 3 (Crisis). Of greatest concern are the 65,000 people in IPC Phase 5 (Catastrophe).[1] Overall, this constitutes 15.9 million or 53 per cent of the total population. It is estimated that in the absence of humanitarian food assistance, about 20 million people, or 67 per cent of the total population (including Internally Displaced People (IDPs)), would be in need of urgent action to save lives and livelihoods. The situation has deteriorated since 2017 as for the first time there are pockets of the population classified as IPC Phase 5.

An estimated 1.8 million children are acutely malnourished, including an approximate 400,000 suffering from Severe Acute Malnutrition (SAM) and 1.1 million pregnant or lactating women are malnourished. Despite the deterioration in food security, livelihoods and the family income generation opportunities, in 2018 the burden of severe acute malnutrition continue at the same levels as 2017, attributable to the critical scale up of interventions. Nevertheless, the risk of acute malnutrition for children under 5 years remains high, especially in active conflict or access-restricted communities such as Hudaydah, Hajjah and Taizz. At least one child dies every ten minutes in Yemen because of preventable diseases such as diarrhoea, malnutrition and respiratory tract infections. In Yemen, almost half of all children (46 per cent) under 5 are stunted and 1 out of 3 children is at risk of acute malnutrition. Additionally, 1 out of 5 Pregnant and Lactating Woman (1.1 million of PLWs) is at risk of acute malnutrition.

[1] http://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1151858/

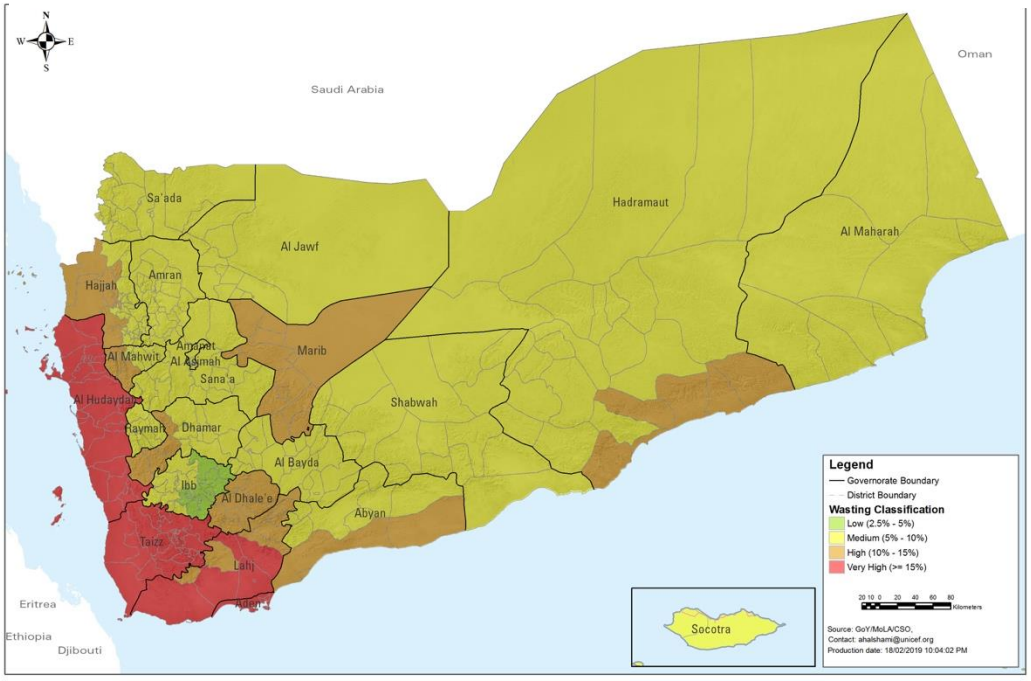
Acute malnutrition levels in Yemen at any given time during the past 40 years ranged between slightly above 10 per cent to slightly above 15 per cent. The trendline shows a decrease in wasting levels between 2011 and 2018, from 13% to 11.2%, despite the conflict since 2015 (see Graph 1: Stunting and wasting trends in Yemen over 27 years, 1991 to 2018). There is also an accompanying reduction in severe wasting from 3.7 per cent to 1.7 per cent. The trend can be attributed to the country-wide scale up of the CMAM programme, especially in the component that treats severe and moderate acute malnutrition and in the community component that promotes infant and young child feeding and caring practices.

Graph 1: Stunting and wasting trends in Yemen over 27 years, 1991 to 2018



The higher classifications of wasting are localized in coastal and lowland areas, especially in the western and south-western districts, where the levels exceed 20% (see Map 1: Wasting Classification Levels by Governorate/ Sub-governorate, Yemen).

Map 1: Wasting Classification Levels by Governorate/ Sub-governorate, Yemen



Food insecurity is exacerbated by the conflict-driven economic crisis. The average monthly cost of a minimum food basket rose by 55 per cent over the year. With a more than 50 per cent decrease in the country's GDP, the employment opportunities in the private sector have significantly diminished. For one million people working in the public sector, salaries have not been paid for over two years. The estimated poverty rate increased by nearly 30 per cent since 2014, to approximately 80 per cent. With the Yemeni Riyal having lost more than 200 per cent of its pre-crisis value by September 2018, the currency depreciation has further undermined the economy, which relies heavily on imports, driving up the cost of household goods. The number of IDPs increased from 2 million to 3.34 million over 2018, and with displacement, limiting their ability to contribute to the economy while generating specific needs. Local agricultural production has decreased by 20 per cent to 30 per cent between 2016 and 2018, challenged by rainfall shortages, highly priced farm inputs, and conflict, which limits access to fishing grounds, which have also been affected by cyclones and hurricanes. According to the Ministry of Agriculture and Irrigation's Assessment, all agricultural sectors have been affected, accounting for about 25 per cent of the national food basket.

As of 2015, almost half of Yemenis were iodine deficient, and no improvement is expected, as the lack in local markets means that the consumption of iodised salt is reduced to less than 5 per cent. As for anaemia, 86 per cent of children and 70 per cent of women are anaemic, according to Demographic and Health Survey of 2013.

The ruin of the infrastructure, including roads, bridges, land, sea and airports, imposes severe restrictions on the movements of people and internal and external trade, thus raising costs. In-country transportation of goods is restricted by checkpoints along roads.

The protracted armed conflict and the state fragmentation slowed the implementation of activities in some governorates; however, UNICEF has attempted to step up implementation by adopting a more decentralized approach, working with several parties to deliver services for children.

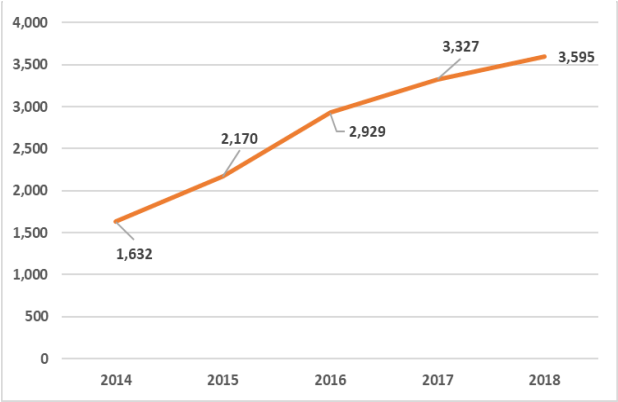
Despite the above challenges, UNICEF continues as the strongest and most trusted partner to deliver results for children in difficult situations, taking the most appropriate mitigating actions. UNICEF will continue to deliver lifesaving interventions, and side-by-side will support development-based interventions.

Results in the Outcome Area

To protect the nutritional status of children and women from effects of the conflict, UNICEF continued to provide leadership in the nutrition cluster inter-agency coordination, continued to monitor and assess the health and nutrition situation through SMART surveys and other health facility assessments, and scaled up health and nutrition interventions to ensure high-impact health and nutrition services were available. Interventions that were undertaken under the 2014-2017 Strategic Plan continued to show results through 2018, the first year of the 2018-2021 Strategic Plan; consequently, the results presented in this section cover the period 2014 to 2018.

Through nutrition interventions, UNICEF supported the introduction of outpatient therapeutic programme (OTP) services to 277 new sites in 2018. With the latest additions, the number of OTPs grew from 1,632 in 2014 to 3,318 in 2017 and 3,595 by the end of the 2018, meaning that 83% of all functioning health facilities countrywide now provide OTP services (see Graph 2: Cumulative number of outpatient therapeutic programmes established in Yemen, 2014 to 2018).

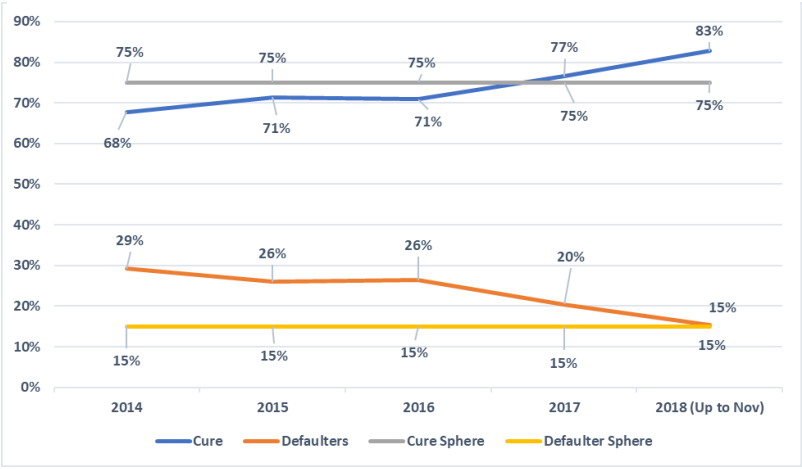
Graph 2: Cumulative number of outpatient therapeutic programmes established in Yemen, 2014 to 2018



UNICEF has also supported the operational costs for 15 therapeutic feeding centres (TFCs)/ stabilization centres, three of which were new in 2018, and provided supplies to all 82 functional TFCs/ stabilization centres in the country.

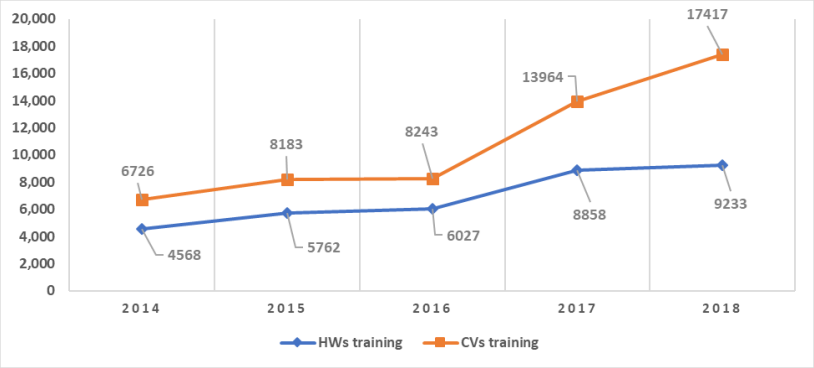
UNICEF support to the CMAM in 2018 resulted in the management of 345,604 under-5 children with SAM (151,543 boys and 194,061 girls), representing 125% of the 2018 target for UNICEF. Of those, 14,193 under-5 children with SAM and medical complications (7,462 boys and 6,731 girls) were admitted to the TFCs. Some 3,686,963 children (1,819,185 boys and 1,867,778 girls) were screened for acute malnutrition through fixed OTPs at health facilities, Mobile Teams, Integrated Outreach Teams, Community Health Volunteers (CHVs), and MUAC screening campaigns. Comparing 2014 to 2018, the performance indicators of the programme for treating children with SAM changed as follows: the cure rate increased from 68% to 83%, the defaulter rate decreased from 28.6% to 14.1% and the non-respondent rate decreased from 2.9% to 2.3%, while death remain remained the same at 0.3% (see Graph 3: SAM treatment programme performance indicators, Yemen, 2014 – 2018).

Graph 3: SAM treatment programme performance indicators, Yemen, 2014 - 2018



In 2018, 1,771,521 women received IYCF counselling through IYCF corners, outreach activities, mobile teams, and CHVs. Some 4,144,744 6-59 months children (2,093,311 girls and 2,051,433 boys) received micronutrient interventions, including 3,416,997 children (1,724,888 girls and 1,692,109 boys) who received vitamin A supplementation and 727,747 aged 6-23 months children (368,424 girls and 359,324 boys) who received micronutrient sprinkles. Furthermore, 801,274 under-5 children (407,735 girls and 393,539 boys) received deworming capsules and 1,003,827 pregnant and lactating women received iron-folate. With the objective of reducing stunting, UNICEF also substantially scaled up the implementation of community-based nutrition interventions from two districts in 2016 to 59 districts by the end of 2018 in priority governorates, reaching 353,929 children under two with growth monitoring and promotion services through trained CHVs.

Graph 4: Cumulative numbers of trained health workers and CHVs, Yemen, 2014 to 2018



During 2018, 494 new health workers (289 males and 205 females) and 31 TFC staff were trained to enrol and treat children with SAM (including those with medical complications), and 3,002 CHVs were trained on community mobilization, screening and referring children with acute malnutrition for treatment. These new numbers increased the cumulative numbers of trained CHVs to 16,791, up considerably from 6,726 in 2014 and 13,964 in 2017. Refresher trainings on CMAM continued in 2018, including for 727 health workers (347 males and 380 females) and 4,826 female CHVs (including 2,716 CHVs who were trained to undertake growth monitoring and promotion) (see Graph 4: Graph 4: Cumulative numbers of trained health workers and CHVs, Yemen, 2014 to 2018).

The decline in stunting level from 58% to 46.5% observed between 2005 and 2011 was mainly attributed to multi-sectoral improvements, especially improvements in the water, sanitation, and women education sectors. To sustain stunting reduction, UNICEF had developed a strategic document for the reduction and prevention of stunting in Yemen and participated actively with other partners in the Scaling Up Nutrition (SUN) Movement. Progress has been hindered since 2015 with the eruption of conflict; nevertheless, during 2017 and 2018, the datasets of surveys done during the crisis was shared with the Maximising the Quality of Scaling Up Nutrition Programme (MQSUN) to update the contextual causal analysis and the Multisector Nutrition Action Plan. The MQSUN analysis has since been completed and the process to update the multispectral plan is in progress.

In 2018, UNICEF supported the implementation of SMART surveys in 17 of the planned 18 governorates, a significant increase over the four surveys completed in 2017. Anational technical committee for SMART, led by the government, was established to replace the nutrition cluster-

led Assessment Working Group. The support and facilitation provided by the Ministry of Public Health and Population (MoPHP) and the Central Statistics Organization enabled the surveys to be implemented. Also helpful was the training on the field operations of surveys provided to government SMART Survey Managers and Supervisors in southern governorates.

As a result of training at District Health Offices (DHOs) in 4 governorates, the DHOs were able to report on a weekly basis on screening, supply stock situation and OTPs functionality status using their own smart phones through an Android-based application called Nutrition Mobile Based Reporting System. In addition, 318 DHOs were trained on nutrition information management and they were provided with a validation checklist that can help them to review monthly data when received.

Throughout 2018, UNICEF continued to support the revision of the national community-based training guidelines and package, including job aids for Community Health Volunteers. Furthermore, UNICEF supported the updating of monitoring tools for nutrition interventions at health facility and community levels.

As of December 2018, over 6,035 metric tons of nutrition supplies had been procured and 5,844 metric tons were distributed, to cover the needs of children with severe acute malnutrition in all 22 governorates (the remaining supplies which were procured will be distributed in 2019). Supplies included, but not restricted to, ready-to-use therapeutic food (RUTF), antibiotic amoxicillin, deworming tablets, micronutrients powders, Vitamin A capsules, folic acid tabs, iron-folic tabs, anthropometrical scales, height boards, MUAC tapes and consumable hygiene kits for children with SAM. UNICEF supported the provision of the needed registries and printing materials for CMAM, micronutrients supplementation and IYCF programmes operations, as well as for the community programme operated by CHVs.

UNICEF provided logistic support with transportation services for moving supplies from entry ports to central warehouses and then to governorates and MoPHP warehouses. A key result of this support was that no interruption in the nutrition supplies pipeline, including for ready-to-use therapeutic food, was reported in the year. UNICEF maintained an adequate quantity of contingency stock in the country.

Table 1: Summary of Nutrition Indicators in Yemen - 2014 to 2018

Indicator	Baseline	Target	Results
Percentage of under-5 girls and boys affected by SAM enrolled into CMAM services	2012: 30	2017: 80%	2014: 121% 2017: 81% 2018: 125%
Number of targeted children 6-59 months with SAM admitted to therapeutic care for a specified period of time	2015: 16,678	2017: 323,197	2014: 181,383 2017: 263,313 2018: 345,604
Number of targeted caregivers of children 0-23 months with access to IYCF counselling for appropriate feeding	2016: 572,852	2017: 948,696	2014: 164,805 2017: 869,853 2018: 1,771,521
Number of children under 5 given micronutrient interventions	2015: 202,883	2017: 4,543,121	2014: 83,912 2017: 4,814,694 2018: 4,144,744
Number/proportion of children under two receiving growth monitoring and promotion service	2012: 0	2018: 100,000	2017: 48,671 2018: 353,929

Case Study

Establishment of Nutrition Information System in an Emergency Context: Yemen

Top Level Results:

- Nutrition data is tracked at the health facility level and on a monthly basis from all outpatient therapeutic programme sites, mobile teams, community health volunteers, infant and young child feeding counselling corners, and outreach teams. By the end of 2018, there were 3,595 reporting sites, 83% of functioning health centres now report.
- Well-trained reporters act at all levels. By the end of 2018, there were 350 active reporters at the district level (327) and governorate level (23).
- Well-established mechanism of reporting tools including standardized hard-copy registers in health facilities and electronic reporting tools for higher levels.

- Improved data quality is continuously enforced through several types of reviews and measures.

Issue/Background:

Before this project began, the existing nutrition information system was limited in scope and usefulness; there was only district level data, with low reporting rates (less than 60 per cent). At that time, the programme covered only 161 districts, of which only some 96 districts were reporting. The quality of reporting, in terms of the plausibility of data, was poor in most districts and monitoring was hard to conduct, as the reported data did not include the lowest reporting level.

In 2012, UNICEF, with the Ministry of Public Health and Population (MoPHP) and other Nutrition Cluster partners, recognized there was a need to strengthen and expand the existing nutrition information system. They decided to widen the interventions, especially in high acute malnutrition prevalence areas.

Rationale:

Ahead of the beginning of this project, UNICEF had started supporting the implementation of nutrition surveys in 2011 in western Yemen. In 2012, the implementation continued and expanded into different regions, with the aim to establish a base for evaluation the nutritional situation in Yemen. The need to widely scale up nutrition interventions required a strong information system to support the scale up.

Strategy and Implementation:

In building the system, nutrition information management mechanisms were developed that included standardized reporting tools in both hard and electronic forms for all levels, depending on the level of reporting (for details, please see Diagram 1: Current reporting mechanism flow for Nutrition Information System, Yemen). Next, capacity building plans were developed to systemize the reporting procedure, so it would be able to work smoothly even in an emergency situation, coping with all challenges and providing good quality data in easy-to-use manner that is compatible with the available infrastructure across the country.

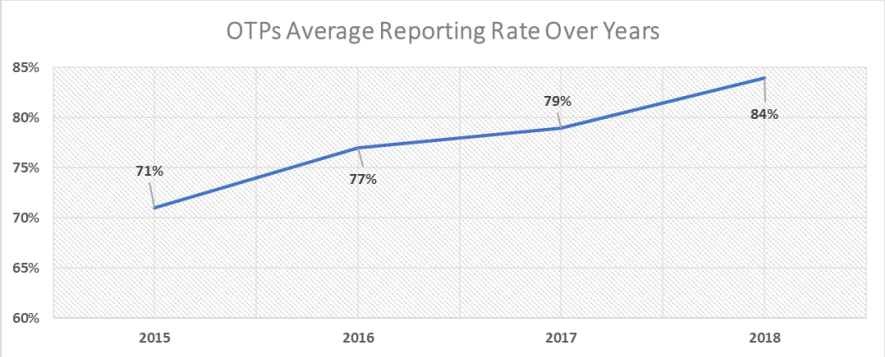
Resources Required/Allocated:

The establishment of the information system is not considered to be a standalone task; rather it is included in all other nutrition-related capacity building activities. While there was no independent budget allocated for the information system in the humanitarian Thematic Funds, an amount of US$215,000 (out of US$3.25 million utilised by the Nutrition Programme) contributed directly or indirectly to strengthening the system, in terms of review and supervision of the implementation. The resources are mainly used to improve the capacity of workers, rather than provide supplies.

Progress and Results:

Since developing the information management mechanism—and despite the challenges caused by the conflict situation and huge scale up in nutrition services—there has been a great

improvement in data quality, timely submissions, and reporting rates (the graph below shows the improvement in the reporting rate over the years since 2015).



Adherence to capacity building plans and yearly improvements to reporting tools were the main contributors the improved information. The reporting mechanism receives data from all nutrition interventions, from all locations, through to the health facilities level. As the reporting mechanism is well understood by the reporting actors, the data flows smoothly each month and requires less follow up all the time.

In recognition of the capacity available at the level of health facilities, mobile teams and outreach campaigns, the reporting mechanism is not fully electronic and does not use currently available data collection technologies (e.g., Online Data Collection System). Consequently, its present configuration provides better data quality than a fully electronic system would allow at this time. The data flow goes through multiple validations and review stations, where each station filters data before sending it to next station, so by its final destination, the data has been reviewed and revised by at least four people, ensuring high quality data upon completion. Implementing any electronic system in future would produce similar data quality, since the culture of reporting, data review, data validation, and best data collection practices have been developed by all reporting actors at all levels.

Lessons Learned:

The main challenge faced by the system is the late submission of monthly data in some governorates in conflict, due to the disconnection of internet services. For example, the Hodeidah Governorate has experienced internet interruptions since mid-2018 because of the escalation of the conflict. In addition, problems with the Internet connection is the main challenge that hampers the implementation of a fully electronic information system.

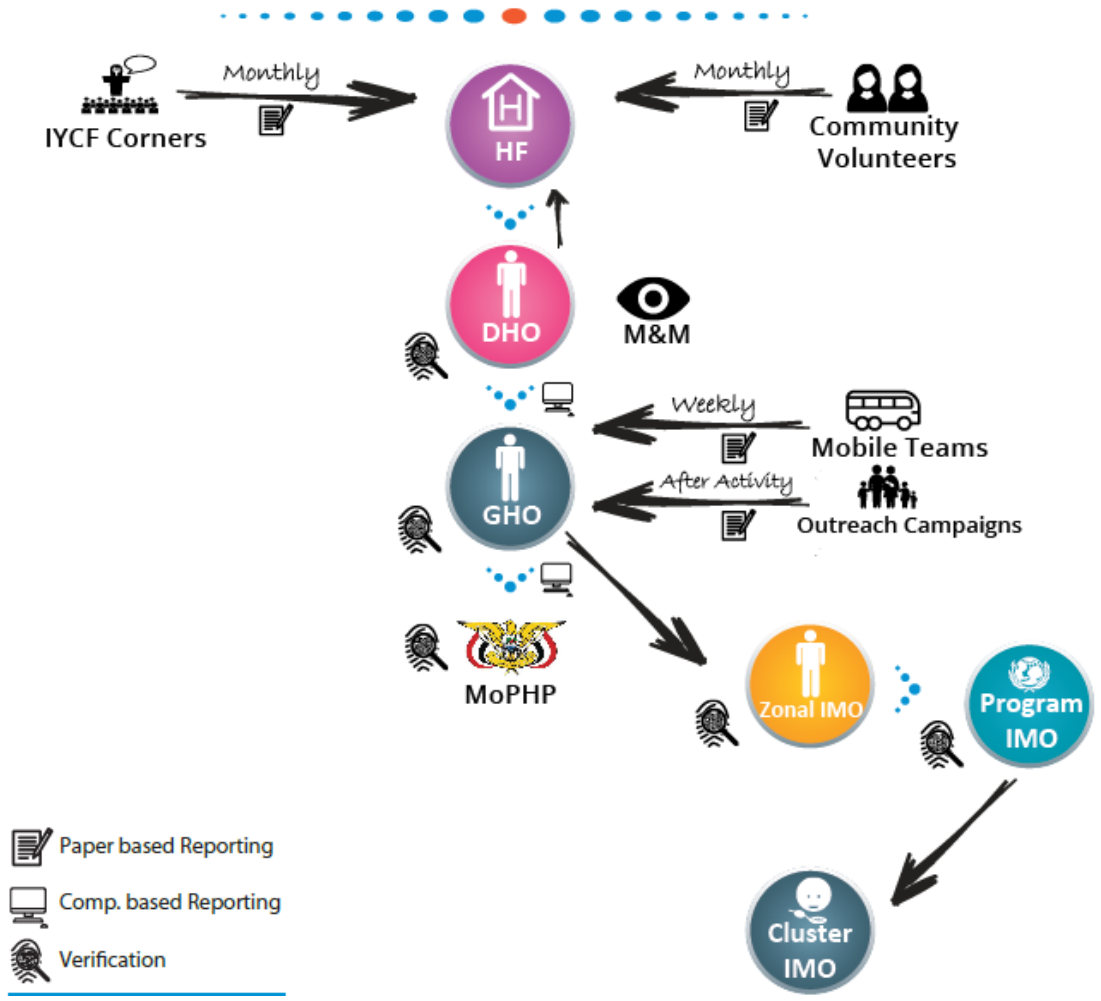
Another challenge occurs when local authorities interrupt training workshops for reporting actors, causing delays in the capacity building plan.

Moving Forward:

Building on the system developed, UNICEF plans to implement an online-based electronic information management system. It will be implemented in several phases, to guarantee its

success before final implementation and so as not to interrupt the existing reporting mechanism. Besides that, UNICEF has started the exercise of mapping community health volunteers to villages, in which CHVs' data management will contribute to the lowest reporting level, and there will be a database to monitor CHVs distribution at the village level, linked to GIS visualization. To enhance data quality, there are plans to establish a mini-call centre in MoPHP, from which staff will regularly call sampled health facilities to verify the data available on the health facilities' register is the same as was reported. They will also call beneficiaries to ensure services were delivered.

Diagram 1: Current reporting mechanism flow for Nutrition Information System, Yemen



Financial Analysis

The cross-sectoral needs of children have grown exponentially as the conflict wears on, and the nutrition programme has seen long-term development gaps compounded by the conflict, displacement and loss of coping mechanisms. Despite attempts to achieve and improve value for money in its programmes, needs continue to out-strip UNICEF's funding resources. Predictable and flexible funding will be vital to supporting a scaled-up response.

Table 1: 2018 Planned budget by Nutrition

Thematic Sector 3: Nutrition
Yemen
Planned and Funded for the Country Programme 2018 (in US Dollars)

Intermediate Results	Funding Type[1]	Planned Budget[2]
1.D: Nutrition Emergency	RR	-
	ORR	4,700,000
	ORE	90,130,000
1.E: Nutrition Development	RR	400,000
	ORR	18,200,000
	ORE	-
Total Budget		**113,430,000**

[1] RR: Regular Resources, ORR: Other Resources - Regular and ORE: Other Resources - Emergency
[2] Planned budget for ORR and ORE do not include estimated recovery cost (only programmable amounts).

Table 2: Country-level Thematic contributions to thematic pool received in 2018

Thematic Pool 3: Nutrition
Thematic Contributions Received for Thematic Pool 3 by UNICEF Yemen in 2018
(in US Dollars)

Donors	Grant Number*	Contribution Amount	Programmable Amount
Slovak Committee for UNICEF	SC1499040072	29,631.12	28,106.77
Slovak Committee for UNICEF	SC1899030006	28,703.70	27,250.70
Total		58,334.82	55,357.47

Table 3: Expenditures in the Thematic Sector

Thematic Sector 3: Nutrition
Yemen
2018 Expenditures by Key-Results Areas (in US Dollars)

Organizational Targets	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	All Programme Accounts
21-04 Prevention of stunting and other forms of malnutrition	77,182	1,842	139	79,163
21-05 Treatment of severe acute malnutrition	35,588,291	18,572,937	1,687,325	55,848,553
Total	35,665,473	18,574,779	1,687,464	55,927,716

Table 4: Thematic expenses by Results Area

The table below shows a breakdown of expenditures of Thematic contributions by results area (in US dollars).

Organizational Targets	Expense
Other Resources - Emergency	3,090,026
21-04 Prevention of stunting and other forms of malnutrition	50,764
21-05 Treatment of severe acute malnutrition	3,039,262
Other Resources - Regular	31,020
21-03 Child Health	1,389
21-05 Treatment of severe acute malnutrition	29,631
Grand Total	**3,121,046**

Table 5: Expenses by Specific Intervention Codes (in US Dollars)

Specific Intervention Code	Expense
21-02-12 Continuous social mobilization and communication	408,594
21-04-07 National multisectoral strategies and plans to prevent stunting (excludes intervention-specific strategies)	58,905
21-05-01 Care for children with severe acute malnutrition	6,198,442
21-05-02 Capacity building for nutrition preparedness and response	44,306,006
26-01-03 Humanitarian planning and review activities (HRP, RRP, UNICEF HAC)	188,271
26-02-02 MICS - General	35,322
26-02-05 Administrative data, registers and non-MICS household surveys and censuses	44,288
26-02-08 Programme monitoring	166
26-02-09 Field monitoring	1,431,695
26-03-02 Capacity and skills development for social behaviour change	342,568
26-03-04 Community engagement, participation and accountability	1,936,588
26-06-01 Parliamentary engagement for policy advocacy	576,535

26-06-08 Emergency preparedness (cross-sectoral)	2,610,134
26-06-13 Joint programmes/pooled funding/inter-agency agreements	169,532
26-07-01 Operations support to programme delivery	4,195,865
27-01-07 HQ and RO technical support on gender	808,738
28-03-05 Management of advocacy and communication at HQ	-874
28-07-04 Management and Operations support at CO	559,864
Unknown	357,307
Grand Total	**64,227,946**

Table 6: Planned budget for 2019

Thematic Pool Area 3: Nutrition
Yemen
Planned Budget and Available Resources for 2019 (in US Dollars)

Intermediate Result	Funding Type	Planned Budget [1]	Funded Budget [1]	Shortfall
1.D: Nutrition Emergency	RR	-	765,270	(765,270)
	ORR	20,878,000	28,441,620	(7,563,620)
	ORE	71,140,000	12,020,486	59,119,514
1.E: Nutrition Development	RR	400,000	-	400,000
	ORR	39,680,000	57,646	39,622,354
	ORE	-	586,221	(586,221)
Sub-total Regular Resources		400,000	765,270	(365,270)
Sub-total Other Resources - Regular		60,558,000	28,499,266	32,058,734
Sub-total Other Resources - Emergency		71,140,000	12,606,707	58,533,293
Total for 2019		132,098,000	41,871,243	90,226,757

[1] Planned and Funded budget for ORR and ORE exclude recovery cost. RR plan is based on total RR approved for the Country Programme duration.

Future Work Plan

UNICEF will continue to focus on both the treatment of children with severe acute malnutrition and the prevention of all forms of malnutrition among children and women; to work at the community and health facility levels; and to generate evidence through SMART surveys and other Nutrition assessments.

With growing levels of food insecurity, UNICEF will prioritize areas that are at increased risk of famine: districts classified as IPC phase 3, 4 or 5. The Nutrition programmes will continue scale up, including those for community-based and facility-based management of children with SAM, IYCF Counselling for mothers/caregivers, micronutrient supplementation, and growth monitoring

and promotion. The adolescent anaemia control program will be piloted in 8 districts before being scaled up.

UNICEF plans to cover a minimum of 80% of the 2019 SAM caseload during 2019 and to increase its geographical coverage from the present 83% to 90% of health facilities functioning as OTPs by the end of 2019. UNICEF, in collaboration with WHO, also plans to scale up the TFCs from the present numbers of 81 to 120 TFCs across the country by the end of 2019.

It is proposed that SMART surveys will undertaken in all Yemen's 22 governorates during 2019 to generate critical data in particular on children under 5 and, in addition, undertake rapid nutrition assessments in districts that have some population in Phase 5 (Catastrophe), as per the 2018 IPC report.

Expression of Thanks

UNICEF recognizes the contributions from resource partners and expresses sincere thanks. It is important to ensure critical support and commitments continue. The flexibility of thematic support (OR+) that have contributed to the results against the programme area targets is crucial and have helped the Nutrition programme reach children and women in Yemen.

Annex I: Human Interest Story

In Hajjah, children fight every day to survive
https://www.unicef.org/yemen/reallives_12747.html

Young Waseem is being treated for suspected cholera at the Diarrhoea Treatment Centre of Hajjah Hospital.

Story and photography by Marie Bracquemont

Hajjah, Yemen, 1 November 2018 – At first sight Hajjah seems a quiet place to live as a child. The city, located 127 kilometres northwest of Sana'a, the capital of Yemen, offers breathtaking views over the surrounding mountains and green valleys, which used to attract many visitors before the conflict escalated in 2015 and before Yemen became one of the worst places on Earth to be a child. More than three years after the beginning of the current war, the situation keeps worsening, with children being the primary victims of this conflict.

In Yemen, one out of three children and one out of five pregnant and lactating mothers are at risk of acute malnutrition. Currently, an estimated 1.8 million children are acutely malnourished, including nearly 400,000 children who are at risk of suffering from Severe Acute Malnutrition (SAM). A child with SAM is twelve times more at risk of death than a healthy child.

Eight-year-old Tahani arrived few days earlier at the UNICEF-supported Therapeutic Feeding Centre of Hajjah Hospital.

Even before the conflict, Hajjah was an area heavily affected by malnutrition. Now, it is estimated there are more than 28,000 children affected by SAM in the Governorate of Hajjah and 124,000 children affected by Moderate Acute Malnutrition (MAM). These children fight every day for their lives and they need immediate assistance to survive.

At the Therapeutic Feeding Centre (TFC) of Hajjah hospital, there are currently eight children being treated for SAM, including Tahani, Abduld Kader and Sahar. They all arrived in severe conditions, suffering from complications, such as severe pneumonia and diarrhoea with severe dehydration. Here at the hospital, the medical staff is working rotating shifts to make sure that children like them get the treatment they need for long-term recovery. In other, remote parts of the governorate, it is difficult to ensure a full-time medical presence and a quality treatment.

11-month old Abdul Khader also arrived few days ago at UNICEF-supported Therapeutic Feeding Centre of Hajjah Hospital, where there are currently 8 children being treated for complications of Severe Acute Malnutrition (SAM).

Earlier this month, a UNICEF Yemen team, led by the Chief of Nutrition, Dr. Karanveer Singh went to Hajjah to assess the situation on the ground, meet with the local health authorities and agree together on an action plan to quickly respond to the dire situation in the governorate. “We are facing a cross-sectoral issue in Hajjah and we cannot improve children’s health and nutrition without taking the whole picture into consideration,” explains Dr. Singh. “Without incomes and with inflation increasing, people cannot afford to buy food. Families are struggling to provide their children with education, and schools remain closed due to the lack of teachers. In fact, health workers and teachers have not received their salaries for over two years. The already fragile health centres are running slow because of the shortage of personnel, medical supplies and equipment. It is also a challenge to bring food and essential supplies to families in these hard-to-reach mountainous areas. Water facilities have been partially damaged and are poorly maintained, which contributed to a resurgence in early 2017 of water-borne diseases in the area, such as cholera/acute watery diarrhoea.” Dr. Singh continued, “Children are lacking everything and there is an urgent need for assistance and that’s why we are here today, to come up with a quick response plan to tackle malnutrition in Hajjah so that we can save more children’s lives.”

The UNICEF Nutrition team meeting with the health workers of the TFC, in Hajjah Hospital.

UNICEF already supports six health facilities in the area, with the contribution of the World Bank Emergency Health and Nutrition Project (EHNP). The support includes appropriate training to health workers on malnutrition screening and treatment, the provision of medical and nutrition supplies and equipment, and assistance to health workers with incentives to carry out specific health and nutrition activities.

UNICEF nutrition team assists a health worker of the TFC, in Hajjah Hospital, to measure 11-month old Abdul Khader.

The operational costs for health facilities is also an important element of the World Bank-supported project, as is the deployment of mobile teams to hard-to-reach areas. These interventions are supported by the World Bank group, the United Kingdom Department for International Development (DFID), the Kingdom of Saudi Arabia, the United Arab Emirates, the Office of U.S. Foreign Disaster Assistance (USAID/OFDA), the German Development Bank (KfW), ECHO, the Italian Ministry of Foreign Affairs and International Cooperation, the Government of Japan and many other donors.

"We have seen an increase in number of malnutrition cases in our governorate in the last year. Heath facilities are receiving more SAM and MAM case every day which means that we need additional medical supplies and health workers to address these increased needs. We are glad we are here today with UNICEF to see how we can strengthen our cooperation and respond rapidly to the urgent needs of the children in the area. UNICEF is always present when we need more support this is highly appreciated." says the director of the Primary Health Care Department of Hajjah's governorate.

Dr. Karanveer Singh visiting one of the UNICEF-supported warehouses in Hajjah where nutrition supplies are being stored.

With UNICEF's support, and thanks to the support of donors, more than 196,000 under-5 severely malnourished children were admitted to therapeutic care across the country, between January and September 2018. In addition, to improve infant and young child feeding and caring practices, over one million mothers and caregivers were counselled during the same period, and over 417,000 children under-5 were given micronutrient interventions among other basic health assistance.

Annex II: Donor Report Feedback Form

UNICEF is working to improve the quality of our reports and would highly appreciate your feedback. Kindly answer the questions, which can be found on the online form here, for the above-mentioned report. Thank you!