Yemen Nutrition Cluster

Lessons learned in Yemen Nutrition Cluster

Exercise conducted by the Global Nutrition Cluster

Synthesis report

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By GNC and Yemen Nutrition Cluster

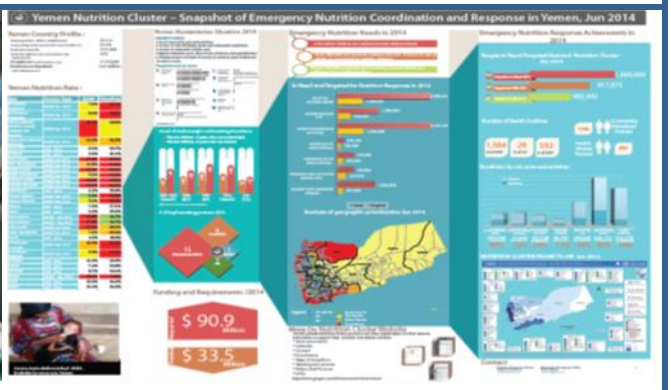


Table of Contents

1. Executive summary

In Yemen the cluster approach was initially activated by ERC in August 2009 mainly to respond to the conflict and displacements in the North of the country. The events following the 2011 Arab Spring uprising led Yemen to one of the world's major humanitarian crises, with more than half of the population affected and a third targeted for humanitarian aid. Malnutrition is a major problem in Yemen as the country experiences one of the highest rates of chronic malnutrition in the world, with close to 50 per cent of children found stunted in 2014, whilst rates of acute malnutrition is estimated at 12.7 per cent[1]. To effectively respond to the crisis, continued presence of a well-functioning cluster coordination is indispensable. In view of this nutrition and other eight clusters remained activated throughout over last years. Currently nutrition cluster is well established at national level, with four sub-National cluster groups in the Northern, Central, Western and Southern parts of the country, undertaking the key functional responsibilities to ensure that needs of vulnerable people is met effectively, strong partnership is created and maintained among nutrition actors, humanitarian nutrition response is timely, effective and coherent and a system of accountability is well in place.

This report concisely describes how cluster is undertaking its core functions. It presents overview of the humanitarian situation in the country, the best practices, lessons learned and challenges faced during the course of the years with particularly focus on the years following the 2011 uprising. Summary of key activities carried are outlined under each core functions of the national cluster. Engagement of cluster with development oriented sectorial coordination such as SUN (Scale up Nutrition Movement) is highlighted as notable best practice. The cluster experience in the adopting Humanitarian Programing Cycle (HPC) approach for strategic response planning this year is among the lesson learned included in this report.

Methodology

This report is based on the desk review of important documents on humanitarian response in Yemen. To gain insight of the overall situation, the Yemen Humanitarian Strategic response plans, Mid Year and Annual Humanitarian Response reports were reviewed. Nutrition cluster specific information was gathered from Nutrition Response plans, Nutrition Needs Analysis documents, Quarterly bulletins, Quarterly Response Snapshot, meeting minutes, and TOR for various technical working groups. Although cluster partners were not consulted during compilation of this report, utmost effort is made to minimise bias and to substantiate the views expressed in the report with documents endorsed by partners. The documents mentioned in this report and other relevant information on Yemen can be accessed on the Yemen Nutrition cluster Website https://sites.google.com/site/yemennutritioncluster/ and https://yemen.humanitarianresponse.info/.

[1] CFSS 2014 preliminary report.

Background

The events following the 2011 Arab Spring uprising led Yemen to one of the world's major humanitarian crises, with more than half of the population affected and a third targeted for humanitarian aid. The total population of Yemen is estimated to be 25 million and about 4.5 million are children under five. An estimated 14.7 million Yemenis – 58 per cent of the population – are affected by the decline in conditions following the 2011 political crisis. Long-standing underdevelopment, poor governance, environmental stress, demographic pressure and continued political instability have exacerbated this vulnerability. About 13 million Yemenis – over half of the population – have no access to improved water sources, with rural areas worst affected. Some 8.6 million people lack access to adequate health care. Over 500,000 IDPs, returnees and other marginalized people are struggling to re-establish their livelihoods. Human rights violations remain widespread, and fragmented or absent local government and insecurity undermine the rule of law in many areas. Women and girls bear a disproportionate share of this burden and face multiple barriers to justice.[2]

Food insecurity and malnutrition affect many Yemenis throughout their lives, with 10.5 million people unable to meet their basic food needs. Of these, 4.5 million people are severely food insecure. Yemen has one of the highest rates of chronic malnutrition in the world, with close to 50 per cent of children under five found stunted in 2014, whilst rates of acute malnutrition are estimated at 13.6 per cent.[3] In certain areas of the country acute malnutrition affects as much as 23 per cent of children under the age of 5, which is far beyond the emergency threshold. About 1.1 million Yemeni girls and boys under 5 are suffering from acute malnutrition, of whom 280,000 are suffering from severe acute malnutrition. [4]

The clusters were activated 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. Currently Nutrition, WASH, Food Security and Livelihood, Health, Logistics, Shelter/NFI/CCCM, Early recovery, Education and Protection (Child protection and GBV Sub clusters) clusters are active.

Despite significant humanitarian efforts over the last three years and limited improvements in stability, the humanitarian situation in Yemen continues to require significant external assistance. Nutrition cluster identified an estimated 1.8 million boys, girls and women in need of nutrition assistance in 2014. Given the capacity and prospect of funding availability about 917,000 children under five and Pregnant and lactating women who are suffering from acute malnutrition have been targeted for assistance. The 2014 nutrition Strategic Response Plan incorporated a range of life saving and preventive activities. A total of 24 nutrition partners (15 International NGOs, 6 National NGOs, 3 UN agencies) and the MOH are engaged in implementing nutrition interventions. A total of 94 Million USD was required to respond to immediate and high priority needs of nutritionally affected groups. By mid

[2] Yemen HNO 2014
[3] CFSS 2014 Preliminary Report
[4] Nutrition cluster Needs Overview – Yemen HNO 2014

of this year about 35 Million USD was received by Nutrition partners. To date there is a shortfall of about 60% funding requirement.

2. Cluster Management Arrangements

The nutrition cluster coordinates a network of 35 active partners of which just 25 % are National NGOs.The Nutrition cluster is currently well established at national level, with four stand –alone sub-National cluster groups in the Northern, Central, Western and Southern parts of the country. ,

At national level cluster is jointly led by UNICEF and the Ministry of Health. A full-time Cluster Coordinator is recruited by UNICEF and the Nutrition Director of the MOH is assigned as a Co-coordinator. At Sub-national level, in the four coordination areas UNICEF assigned Nutrition Officers (NOB) to perform cluster functions in a "double-hatting" arrangement with Governorate Health Office Directors co-leading the coordination. Cluster coordination team at the national and sub national levels composed of a Coordinator (P-3) and Information Management officer (NOA). In addition an Assessment Manager seconded by IMC coordinates nutrition assessment activities within the cluster. At the moment Nutrition Cluster is the only coordination mechanism in the nutrition sector in Yemen although under the SUN (Scale up Nutrition) movement there is ongoing initiative to establish development oriented food security and nutrition coordination coordination platform under the Ministry of Planning and International cooperation (MOPIC).

The Nutrition cluster gets guidance from the strategic plan steering committee which has an equivalent role as the Strategic Advisory Group. The group members include INGOs (IMC, ACF, SCI, Mercy Corps), National NGOs (CSSW, Soul Yemen), UN agencies (WFP, WHO, UNICEF) and IOM. The group identifies key strategic areas of coordination and contributed to work plan for coordination team. The group meeting is called based on need and usually on quarterly basis mainly to review progress of response and emerging priorities.

Depending on need Technical working groups have been established in the cluster such as Capacity Building Technical working Group, CMAM guideline Review Technical working group, Assessment Technical Working group (ATWG) and Taskforces (TFs) in conflict emergencies in North and South of the country? The ATWG is a permanent TWG while the TFs although active currently are usually activated based on need. The works of the TWGs are guided by Terms of Reference (TOR) developed in consultation with members. The TWGs are mostly effective in delivering expected outputs. However at times they didn't meet deadlines.

Clusters both at national and Sub national level holding regular scheduled monthly meetings and call extraordinary meetings when necessary. In 2013 90 % of planned monthly coordination meetings were conducted. The meetings are planned in such a way that there is sufficient time to communicate information from national to sub national and vice versa. To avoid overlap with other cluster meetings, NC submit meeting plan or changes if any to OCHA (ICCM.). All cluster meetings are strategic in purpose, planned with a clear agenda (contributed by partners), action-oriented, and propose reality-based decisions for follow-up. Strategic issues appear in the agenda of the general assembly of all members and decision making body is established (usually the strategic Planning committee takes

charge) as deemed important by the members. Action points from the meetings are assigned to specific responsible person(s) (organisations) and are follow up directly by the coordination team. Update on the progress made on action points is shared to partners on subsequent meetings and are included in the meeting minutes. Meeting presentations, endorsed meeting minutes and other relevant documents are posted regularly on the cluster website.

Given the political transitional the country is going through and protracted nature of the emergency, phasing out strategy for clusters hasn't been clearly laid down yet. However building the capacity of ministries in sectorial coordination has been one of the key areas of the Yemen Humanitarian Response Plan 2014-2015. In addition although the cluster mandate is more of coordinating nutrition in emergency response and early recovery, given the chronic nature of the nutrition problems in Yemen, engagement with SUN movement and any other long term nutrition coordination forum was set as a key objective by cluster partners in the 2014-15 Nutrition Response plan. Cluster Coordination Team and Interested NGO partners (IMC, and SCI) took part in SUN steering committee in Yemen as the context requires to do so. NCC has been participating in SUN steering committee meetings. Key partners such as UNICEF, WFP, WHO, IMC, and SCI are members in the committee chaired by Ministry of Planning and international Cooperation (MOPIC). ACF and Other national NGOs (CSSW) technically assisted in costing of national action/Investment plan. NC also provided technical support in situation analysis and development of national action/investment planning exercise. The support involved analysis of nutrition data from past and recent surveys, mapping of malnutrition situation in the past and current trend and nutrition program statistics. In addition, cluster coordinated the costing exercise of key direct nutrition interventions based on the recent experience of partners in the country.

The coordination platform created an opportunity to have consensus among the steering committee members and cluster over the nexus between Life Saving and Long Term preventive oriented approaches and the geographic focus for nutrition interventions in mid to long term. As a result the draft Action plan incorporated a mix of comprehensive nutrition interventions that range from immediate lifesaving to long term prevention focused interventions in priority geographic areas common to both chronic and acute malnutrition.

Best Practice and Lessons Learned:

- Taking part in sectorial coronations such as the SUN movement country steering committee gives an opportunity to cluster to ensure that lifesaving interventions often regarded by some decision makers as not so much contributing to prevention of chronic malnutrition be including in a SUN country Action/investment plan
- Lesson learned from emergency nutrition response programing over the years in protracted emergencies in Yemen, can contribute to long term planning of development oriented nutrition programs. Hence cluster should continue engaging in sectorial coordination forum.
- However guidance on the level of engagement of Nutrition cluster in development oriented coordination platforms such as SUN movement is required from GNC and CLA.

3. Core function 1: Supporting service delivery

Nutrition cluster strategic response plan which as part of the HCT approved Yemen Humanitarian Strategic Response Plan (YHRP) 2014-2015 gives guidance on priority intervention packages, targets per each activity, and geographic areas of critical need. The response plan comprises a compressive service packages such as Screening and treatment of SAM, Targeted SFP, BSFP, Multiple Micronutrient supplementation, hygiene promotion and provision of Hygiene kits to families of CMAM admitted children and IYCF promotion. Out of 333 districts in Yemen 152 were identified as serious or critical emergency nutrition areas. Hence all new emergency nutrition response activities are expected to give priority to these districts. About 70% of SAM and MAM management facilities in Yemen are located in this priority districts. The remaining are either ongoing interventions from previous year or run by MOH as part of CMAM scale up plan.

Capacity mapping was carried out during the response planning exercise. Partners in consultation with cluster coordination team identify gaps in Capacity of governorates (MOH) to provide nutrition services and decided where to intervene by taking into count severity and magnitude of nutrition problem. Based on the decision by HCT, during the HPC process this year project peer reviewing and prioritisation was not carried out during planning phase. Instead nutrition partners indicated their respected intended districts of response. A 3W map with Planned Interventions was produced and was annexed in the published YHRP2014-2015 document for use by partners on ongoing basis. As result gaps in coverage were identified and duplication was avoided.

During the course of the year using the most up to date data collected from partners and MOH cluster periodically generates prioritisation maps, estimated caseloads (by Village, district and governorate), estimate of unmet nutrition needs, geographic coverage of nutrition services (3W maps) , and Situation Reports and Nutrition Response snapshots .etc. Partners made use of these products to make programing decisions. Before embarking on nutrition response activity partners routinely consult the Sub national cluster and Governorate Health offices. So this approach has effectively eliminated duplication. The Nutrition cluster also started using Google Earth Maps to locate health facilities with CMAM services which can serve as a sort of special 3/4W.Partners and others interested can access online a health facility on google earth map and get information on the type of service provided, expected caseload of acute malnutrition, planed target for the year, the partner supporting/running the facility, the focal person of the facility and the contact phone number.

Mostly NGOs deliver nutrition services through mobile team in hard to reach communities where MOH facilities are non-existent and where there is significant need. In some cases NGOs support or independently run fixed health facilities even though MOH CMAM trained staff are available in the same facilities. Cluster realised this potentially may create difficulty in handing over the nutrition program to MOH health workers once the caseload (admission rate) reaches manageable level. Lack of Clarity on what kind of support NGOs are /should be providing to MOH has been identified by Hodeida (Western Yemen) sub national cluster as main challenge in service delivery. Subsequently national nutrition cluster coordination team in collaboration with partners organised CMAM implementation modality assessment mission in Hodeida governorate. MOH and all partners currently implementing CMAM participated in the exercise. The Assessment team identified four

CMAM implementation (NGO support) modalities which potentially suit to specific context of district or health facilities. Currently A decision making tool to adopt the Modalities has been developed and awaiting feedback from cluster partners. However partners agreed during meeting in August that the roll out of the Modalities requires a comprehensive guidance. Based on the recommendation currently a technical team started working on rolling out guidelines.

Best Practice and Lessons Learned:

- Examining how NGOs are supporting nutrition service delivery in MOH facilities is an important exercise to ensure smooth handover of services once emergency is gone and also to avoid compromising the commitment of MOH staff to run nutrition service by themselves with minimal support NGO support.
- Developing guidance on NGO CMAM implementation modality during and post emergency is vital to ensure smooth handover of services once the emergency subsides

4. Core function 2: Informing HC/HCT decision making

The cluster identifies gaps in needs information and does consult with partners on how to go about assessment during the course of the year. Areas with lesser information and where access can be negotiated are including in the assessment plan (reviewed every quarter). The ATWG develops and reviews the assessment plan. Assessment Map is produced and shared by cluster on quarterly basis. Wherever possible and resources are available a more robust assessment is carried out through household surveys. At times when there is limited resources to do a full scale assessment rapid method is used which may include Nutrition Rapid assessment tools or a MIRA approach if during first weeks of emergency. During times of sudden onset emergencies (sporadic conflicts) cluster consolidates already available information and ATWG decides whether there is need to embark on assessment preferably rapid and joint one. Assessments are carried out jointly by multiple agencies and main MOH takes the lead with technical support from Cluster. Preliminary Survey Findings are shared within 2-3 weeks of completion of data collection, the data quality and findings are validated by the ATWG .Dissemination of findings is followed by governorate level development /revision of response plan. Where the findings are significant and major gaps need to be filled immediately, the issue is brought up through the ICCM so that it is communicated to the HCT. In some situations where there is need to relay the information directly to HCT ,the cluster coordinator informs head of cluster lead agency (UNICEF) and Emergency focal person about the gaps, obstacles and any other issues that need the attention of HCT. In Yemen UNICEF led –clusters (Nutrition, WASH, Education and Child protection sub cluster) in Yemen conduct a monthly in-house meeting with the Head of agency and emergency focal person. There is TOR for the meeting which usually takes place on monthly basis and at times more frequently depending on need. The main objective is to ensure that clusters are getting the necessary support from CLA to effectively undertake their coordination responsibility. The in house consultation has served as an important means to convey through the head of agency key gaps, obstacles and any other issues that need the attention of HCT.

Best Practice and Lessons Learned:

- Through CLA in-house consultation among clusters and CLA Head or Agency emergency focal person on common challenges and obstacles faced can be used as means of conveying issues to HCT for prompt decision.
- Inter cluster communication and coordination need to happen within agency to reinforce the conventional ICCM level coordination.

5. Core function 3: Planning and development of the strategy

The Humanitarian Programing Cycle (HPC) has been adopted in Yemen in 2014 – 2015 humanitarian response planning. It has got Need Analysis, Overarching Humanitarian country Strategy, Costed Cluster Response Plan, Resources mobilisation and Response Monitoring components that make the whole cycle. It is a bit different from the CHAP/CAP process, which had been used in in Yemen in Humanitarian Response planning exercises in in 2011 – 2013, in that the Need Analysis component is separate from response plan and appear in two documents. In addition the overall funding requirement for the response is estimated using cost per beneficiary per activity instead of total sum of budget requirement for priority projects submitted by appealing agencies .In Yemen the process began by conducting a national level familiarisation workshop in which cluster coordinators and key partners came to understand the approach and what is expected from them. Subsequently, Needs Analysis consultative workshops were conducted at Sub national and national level. Each cluster did consultation with partners and desk review of available information and came up with identified causal factors for humanitarian situation, perceived sectorial needs, and indicators of severity and magnitude of a humanitarian need. With these input OCHA generated a prioritisation map called 'Heat MaP' per sector. The Heat maps mainly used composite indicators to categorise severity levels of needs. In addition a map on accessibility to humanitarian actors was produced by OCHA. With input from clusters a Humanitarian Needs overview (HNO) documents was developed and finally endorsed by HCT.The HNO was followed by development of Country Response strategy was developed by incorporating inputs complied from through sub national and national level consolations of humanitarian partners.

Nutrition cluster adopted the approach as prescribed by the HCT. Initially need analysis was carried out by consulting partners at governorate and national level. The consultation sessions were organised in such a way that multiple clusters work together to come up with common drivers (underlying causes) of the humanitarian situation and followed by individual cluster partners group discussions to identify needs. Following the initial consultation, the nutrition cluster established a steering committee at the national level tasked with consolidating the nutrition needs information, prioritising geographic locations and population groups, formulating objectives of the nutrition response, identifying priority interventions, setting targets and indicators of success and costing of key interventions. The group identified comprehensive service package which comprises of Screening and treatment of SAM, Targeted SFP, BSFP, Multiple Micronutrient supplementation, hygiene promotion and provision of Hygiene kits to families of CMAM admitted children and IYCF promotion.

Prioritisation was done using the most recent SMART nutrition survey findings and CFSS (Comprehensive Food security Survey) nutrition data. Geographic areas were categorised into normal, poor, serious, and critical based on levels of Acute Malnutrition. Those which fall under serious and critical categories based on WHO standard were selected as high priority. A total of 146 districts out of 333 were in high priority category. Additional six districts with high concentration of acute malnourished cases but with poor level of acute malnutrition were later included among high priority districts.

The objectives of the cluster response plan were formulated in such a way that they contribute to the achievement of overarching Yemen Humanitarian Response Plan strategic Objectives. Priority interventions were identified based on internationally recognised norm (SPHERE standard) and taking into account MOH recommended nutrition service package by giving precedence to life saving services and incorporating activities that mitigate and prevent sufferings. Total funding requirement was determined through costing of each priority intervention. Cost per beneficiary/activity was estimated considering the local context and international best practices (Afghanistan and DRC Costing tools were used).

Best Practice and Lessons Learned:

- Adoption of HPC process gives an opportunity for phase by phase consultation on humanitarian needs and response at lower administrative levels. Hence enhances engagement with local authorities, line ministries at lower administrative level.
- Estimating funding requirement for nutrition response using a thoroughly developed costing tools is relatively rapid and reasonably dependable approach that should be replicated
- The following were some of the concerns, and challenges faced during the HPC process
    - Need analysis was simply consultation and desk review and could have been proceeded by joint assessment
    - Some of Need Anaysis tools (Heat Map) prescribed by OCHA to be used by clusters to prioritize needs had lots of flaws and to some extent generated confusing and misleading information. The errors in rating of severity arise mainly from inappropriate use of composite indictors (were used by OCHA) for prioritisation within a specific sector and among multiple sectors.
    - Some activities don't have precise cost per beneficiary figures to refer to and that made it difficult to precisely estimate funding requirements for some activities.
    - As projects were not submitted during the SRP development, monitoring response of funded projects was difficult during the first half of the year.
    - There wasn't guidance document on HPC and almost no one was trained specifically trained on HPC process in OCHA.

6. Core function 4: Monitoring and evaluation

During the development of response plan cluster coordinator ensures active engagement and full participation of all cluster partners and subnational cluster coordination teams. Their active involvement in the planning process makes them be familiar and commit to the targets set in response plan. Partner reporting officers are given orientation on the standard Reporting system right at the

beginning of the year. They are informed about the indicators to report, the frequency, deadlines, format to use, data sharing mechanism and reporting procedure etc. Subnational clusters send monthly reports by collecting from partners in their respective governorates. Using nutrition program national database, the cluster does analyses of data and produces various products such as Nutrition Response Snapshot and Bulletins which show the progress against the target and key recommendations for corrective actions. During national and sub national cluster meetings presentations on progress of the emergency nutrition response are done on quarterly basis. Major gaps are discussed and recommended actions are agreed up on. At times joint field visits are conducted to monitor whether beficiary targeting is done properly and response activities are as per acceptable national and international standards (SPHERE).

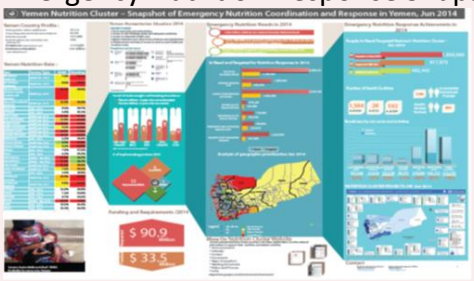
Coverage Assessment surveys using the SQUEAC methodology have been conducted in selected districts which were thought to be relatively representative of a governorate.

Cluster also organised a national level CMAM program consultative workshop at the beginning of 2014 to disseminate coverage survey findings, review the performance and quality of delivery of services and come up an improvement plan. By the end of the workshop partners and MOH under each Sub national cluster developed action plan aimed at improving the CMAM service uptake and effectiveness. The information from analysis of National CMAM database and recommendations from Coverage surveys were used as input in developing the action plan.

Best Practice and Lessons Learned:

- Quarterly Snapshot of Emergency Nutrition Response produced by cluster to periodically monitor response against SRP targets as well as funding status was found a useful comprehensive and informative IM product that need to be replicated.

- Emergency Nutrition Response Snapshot- Screen copy



7. Core function 5: Preparedness and contingency planning

The preparedness and contingency plan exercises were coordinated by OCHA. Initially the scenarios are drafted with input from clusters. Once likely scenario is agreed up on, the ICCM decides the estimated population that can be affected. Based on expected affected population figures, each cluster comes up with their sector needs and response activities during the initial phase of emergency. At the same time mapping of available resources, coordination mechanisms, and capacity to respond is

carried out. Nutrition cluster does consultation with partners, complies the information and contributes to the overall county contingency and preparedness plan.

Apart from involving national NGOs and MOH in preparedness and contingency planning exercise, there hasn't been a well-planned capacity building activity. Cluster will advocate for inclusion of capacity building activities on preparedness and contingency planning in 2015 SRP

Core function 6: Advocacy

On behalf of partners the NC undertook various advocacy activities during the course of last two to three years. Some of the major issues that needed advocacy include:

- Bringing nutrition problem to the attention of local and national level authorities and decision makers so that they regard it as one of priorities that needs urgent action
- Using quarterly NC and OCHA bulletins highlight areas with deteriorating nutrition situation and appeal for resource mobilisation
- In collaboration with CLA communication team organise media briefs that highlight the nutrition situation and the need for immediate response
- Among cluster partners there is a tendency to confine nutrition response activities to just CMAM and to give little attention to preventive interventions such as IYCF promotion and Micronutrient supplementation. Cluster in several occasions made utmost effort to influence partners to incorporate preventive interventions alongside CMAM services.

The advocacy efforts to some extent has yielded tangible results. Cluster managed to influence Pooled funding (ERF) allocation where new nutrition needs emerged. In addition a donor at times revised its priority governorates for funding due to insistence of the cluster.