The humanitarian crisis in Yemen is widely acknowledged as the worst in the world. Sixty percent of the country’s population is hungry, including 8.5 million acutely food insecure people who do not know where their next meal will come from and an additional ten million people who will slip into pre-famine conditions by the end of the year unless the conflict ends. A staggering 7.5 million Yemenis, 25% of the entire population, are in need of nutrition interventions. At least 1.8 million children and 1.1 million pregnant or breastfeeding women are acutely malnourished, including over 400,000 children under the age of five who are suffering from severe acute malnutrition (SAM).

SMART surveys conducted during the first half of 2018 confirm alarming rates of global acute malnutrition; rates have soared above 20% in two governorates, are between 15% and 20% in two others and between 10% and 15% in four governorates. Half of all children in Yemen are stunted and surveys confirm that stunting has been increasing by as much as 1.7% annually since the escalation of the conflict in 2015. The prevalence of anaemia among children 6-59 months of age is 68.3% and that of severe anaemia is 15.5%.

Iodine deficiency, the leading preventable cause of brain damage worldwide, is a concern; the national survey of 2015 indicated that the median urinary iodine had dropped to 101µg/l from 173 µg/l in 1998.

The high levels of maternal undernutrition across the country are no doubt contributing to the high levels of child stunting. Since 1997, there has been no improvement: almost 25% of women are malnourished (body mass index (BMI) below 18.5 kgm⁻²). Anaemia, a major cause of maternal mortality, is also at alarming levels, affecting 70.6% of women of reproductive age, reaching to 78.2% of pregnant women, 8.5% of whom have severe anaemia.

Exclusive breastfeeding rates went down from an already low rate of 18% in 1997 to around 10% in 2013, and 2 out of 5 children under 2 years are fed with a bottle. The 2013 Demographic and Health Survey (DHS) indicated that only 17.3% of breastfed children aged 6-23 months were fed with the minimum acceptable diet, an indicator of poor complementary feeding practice.

Key drivers of undernutrition in Yemen
The root causes of malnutrition and the factors leading to it are complex and multidimensional. Conflict, poverty, underdevelopment, and low socioeconomic status are major contributors, along with other social circumstances. Women and young girls and boys suffer disproportionately. Annex 2 provides further detail on these factors.

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1 See Addressing Malnutrition in Yemen, coming together to save Yemeni lives and help future generations thrive, Global Nutrition Cluster, WFP, WHO, UNICEF, 2018 (including Annex 1. Situation background)
2 DHS 2013
3 DHS 2013

In November 2012, before the current conflict engulfed Yemen, the Government of Yemen joined the Scaling Up Nutrition (SUN) movement and elaborated a multi-sectoral approach to fighting the root causes of malnutrition. This involved multiple ministries implementing integrated health, agricultural, education, water and sanitation, fisheries and social programmes, with support from the Ministry of Planning and International Cooperation and the Ministry of Finance. Under the SUN initiative a USD 1 billion five-year Multi-Sectoral Nutrition Action Plan for 2015-2019 was developed. However due to lack of funding it was never implemented and in 2015, as the humanitarian crisis worsened, partners were forced to shift their focus to saving the lives of the millions of people at risk.

In April 2017, new data from national surveys conducted in 2013 and 2014 were analysed and incorporated with recommendations on key interventions and ways forward in light of the current conflict and emergency situation into a USD 1.2 billion three-year Multi-Sectoral Nutrition Action Plan for 2019-2021. This updated document includes a greater focus on maternal health and nutrition, water treatment, ante- and postnatal care, community health and nutrition workforce development and community level participation. The plan also includes a number of new activities to enhance inter-sector collaboration and coordination, strengthening multi-sector monitoring and evaluation mechanisms to track progress towards meeting agreed objectives and targets. It specifies geographic prioritisation and describes the efforts to achieve improved nutrition by the Government of Yemen.

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 the Nutrition Cluster has been constantly active as Yemen has continued to face complex emergencies that are largely conflict-generated and in part aggravated by civil unrest and political instability. 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 Nutrition cluster is currently established at national level, with five subnational clusters at the zonal level in Hodeidah, Ibb, Aden, Sa’ada and Sanaa. The Cluster is co-led by the Ministry of Public Health and Population (MOPHP) and UNICEF and consists of 37 partners. A Strategic Advisory Group provides strategic directions to the Cluster, while several technical groups and ad-hoc taskforces have been established to support partners in different technical areas.

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4 The 2013 Yemen National Demographic and Health Survey (DHS) and the 2014 Yemen Comprehensive Food Security Survey (CFSS).
Nutrition interventions scale up in Yemen

A comprehensive package of nutrition specific interventions was developed by the Nutrition Cluster in 2015, however, due to limited in-country capacity, the focus of nutrition interventions has been mainly on the treatment of acute malnutrition, with preventive activities (such as infant and young child feeding, blanket supplementary feeding and micronutrient supplementation programmes) only being scaled up more recently.

Despite working under some of the most difficult field conditions in the world, there has been a massive scale-up of services to address malnutrition in Yemen in the past three years. Community-based management of acute malnutrition (CMAM) programmes are now available in 325 of 333 districts, with SAM treatment available in 79% and moderate acute malnutrition (MAM) treatment in 56% of health facilities. MAM services have increased from 607 to 2590 Targeted Supplementary Feeding Programme sites in the 2.5 years and SAM services from 2364 to 3501 during the same period, with treatment to address SAM with complications from 38 to 62 Therapeutic Feeding Centres. Major efforts have also been made to reduce defaulter rates and increase cure rates; for example, 77% of children under-five years with SAM and 78% with MAM were cured in 2017, which is a 6 and 11% increase respectively since 2015.

Infant and young child feeding (IYCF) interventions are being scaled up, however are significantly lagging behind the CMAM scale up, with programmes available in 901 health facilities, focusing on providing skilled counselling to mothers and children. The number of women receiving IYCF counselling services almost doubled between 2015 and 2017, from 445,351 to 867,853 and has increased further to 1,046,604 in the first eight months of 2018.

A number of programmes to prevent malnutrition are also in place, for example Blanket Supplementary Feeding programmes for children and pregnant and lactating women were launched in 2017 (205,000 children under the age of two were admitted in 107 priority districts in the first eight months of 2018), Vitamin A and multiple micronutrient supplementation, deworming and iron-folic acid supplementation of pregnant and lactating women.

The Nutrition Cluster has established multi-cluster coordination with the Water, Sanitation and Hygiene (WASH), Food Security and Agriculture (FSAC) and Health Clusters, with all four clusters prioritising 107 (of 333) districts at risk of famine for their response in 2017. Guidance for the integrated famine risk reduction was developed by the four clusters and is now being piloted. Partners of the four clusters have agreed that this is a comprehensive approach to address both immediate and underlying causes of malnutrition.

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5 The package includes all components of CMAM treatment, Infant and Young child feeding counselling and micronutrient supplementation (through Blanket Supplementary Feeding or Multiple Micronutrient Powders).
6 This is based on the IPC Guidelines on key parameters for IPC famine classification (IPC, 2016), according to which famine is declared based on the three following indicators:
   • At least one piece of direct reliable evidence on Mortality
   • At least one piece of direct reliable evidence on the prevalence of Global Acute Malnutrition
   • At least one piece of direct reliable evidence on Food Consumption or Livelihood Change OR Documented inference analysis based on at least 4 pieces of somewhat reliable evidence (direct or indirect) on food security contributing factors or outcomes.
   • As there is no recent mortality data in Yemen, only two indicators (district level estimated GAM rate levels of 15% above and percentage of severely food insecure population of 20% and above) based on the conducted surveys were used for the prioritisation of districts in need of IFRR.
Barriers to scale up of nutrition programming

Further scale up is complicated by the consequences of economic collapse and ongoing conflict in the country. Most ministries are currently working without any budget for programming, thus functioning at a minimal level, with government staff (including health workers) working without payment. Added to this, a fragile political situation and the escalation of the war to encompass new areas creates a high-risk situation with challenges of access to locations, as well as the resultant focus by the international community on humanitarian response with little or no support for developmental activities.

While there is agreement on the composition of a comprehensive package of nutrition services, implementation is fragmented, in part due to different approaches employed by different agencies, and funding sources that focus only on limited components of the response (due to differing internal mandates of agencies and funding streams for MAM and SAM services). Other reasons include limited in-country capacity, limited scale up of community-based interventions (including early detection of malnourished women and children and referral as appropriate), difficulties with access and lack of salaries to the health workers.

Several initiatives are already ongoing in Yemen to address these barriers, such as:

- Health and Nutrition Clusters’ ongoing discussion with the MOPHP on harmonisation of incentives
- Joint advocacy by the Health, FSAC, WASH and Nutrition Clusters to donors for multi-cluster funding
- Creation of a working group on Access under the Humanitarian Country Team to advocate for increased access
- Development of a scale up plan for the Nutrition Cluster response, including preventive interventions
- Joint prioritisation of the districts at increased risk of famine and development and piloting of the Integrated Famine Risk Reduction Operational Guidance
- An agreement between the UN agencies to utilise as much as possible the same implementing partners for their interventions in the same locations

**A call to action to end malnutrition in Yemen**

Much more can and should be done. Partners agree that major efforts are needed to increase the number of health facilities providing treatment and prevention activities. Referral systems and screening for children suffering from MAM and SAM need to be strengthened through better community engagement. The barriers that prevent care-givers from seeking care, including financial obstacles, need to be addressed urgently. Multi-sectoral action is needed to prevent all forms of malnutrition.

A Call to Action to end malnutrition in Yemen was developed by the Yemen partners and endorsed at the United Nations General Assembly (UNGA) on 25th September 2018\(^8\). Its vision is to reduce all forms of malnutrition, saving the lives of Yemeni children, helping them to thrive, grow to their full potential and contribute to their communities and country.

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The international community is offering a series of commitments to support the authorities in Yemen over the next three years to achieve two key targets:

1. Reduce global acute malnutrition to pre-crisis levels in all governorates, and in the long-term aim for rates below the serious threshold of 10% in each of the 22 governorates.
2. Reverse chronic malnutrition prevalence to pre-crisis levels and in the long-term aim for a national 1% annual rate of reduction.

Achievement of these targets hinges on three conditions:

1. Increased coverage and quality of nutrition programmes
2. Improved access to both preventive and curative services
3. Adequate capacity and commitment among national counterparts.

Specific commitments are made by UN agencies, donors and NGOs to achieve these (see summary in Box 1).

**Box 1: Core commitments by UN agencies, donors and NGOs in the Call to Action**

The international community has agreed to establish a joint, inter-agency approach to preventing and treating undernutrition in Yemen, focusing on the core commitments in the Call to Action, summarised here:

- Support the update of the Multi-Sectoral Nutrition Action Plan in the first half of 2019 to address all forms of malnutrition in Yemen and establish a common monitoring, evaluation and learning framework.
- Build the Ministry’s capacity to develop policies, implement programmes, map resources, collect up-to-date information and inform decision-making.
- Support the implementation of nutrition programmes in hard-to-reach areas.
- Develop a common advocacy and fundraising strategy for nutrition programming in Yemen, in collaboration with the relevant stakeholders, which includes mechanisms to:
  * Allocate multi-year funding.
  * Increase the flexibility and adaptability of the funding.
  * Advocate for global commitment to address all forms of malnutrition in Yemen.
  * Advocate for the importance of compliance with International Humanitarian Law.
  * Advocate for increased access by UN and partners in hard-to-reach and marginalised areas to increase operations/programmes addressing malnutrition across the country.

**Global Nutrition Cluster side-event on Yemen**

The Nutrition Cluster, UNICEF EMOPS and Programme Division have taken the opportunity of the annual Global Nutrition Cluster meeting to convene a special side event meeting to capitalise on the Call for Action and drive it forward.

**Objectives of the Side Event**

This side event will bring together a focused group to develop clear parameters for action in support of addressing malnutrition in Yemen. Representation is expected from the Yemen Nutrition Cluster and SUN Movement, Ministry of Public Health and Population from Sana’a and Aden, UN, NGO and World Bank partners from Yemen, alongside key donors and Global Nutrition Cluster partners with operational presence or interest to engage in Yemen. Collectively, we will consider the current nutrition situation in Yemen, examine the Call to Action commitments and challenges to date in addressing them, and agree next steps to operationalise a three-year plan of action.
Objectives of the event are:
- to identify the operational implications of the Call to Action to end malnutrition in Yemen
- to develop an immediate plan of action, defining the support needed from national and international partners to address key challenges.

**Proceedings of the Side Event**

Priority and feasible areas for action to move forward on will be examined in working groups, informed by presentations on the prevailing nutrition situation and operational context, the Call for Action commitments, and challenges to date in addressing them.

Practical questions will address funding mechanisms, health system strengthening, harmonised UN ways of working, local capacity development, scale up of SAM and MAM treatment with limited functional health facilities, and securing continuum of care.

Linking humanitarian and development programming and planning and supporting government will be implicit across all actions.

**Outcome of the Side Event**

Agreed priority actions specifying UN, NGO and donor support at global and country level to operationalise the commitments made in the Call to Action to end malnutrition in Yemen.
Annex 1
Situation analysis: What Is the Scale of Undernutrition in Yemen?

SMART surveys conducted during the first half of 2018 confirm alarming rates of Global Acute Malnutrition (GAM); rates have soared above 20% in two governorates, are between 15 and 20% in two others and between 10 and 15% in four governorates. Half of all children in Yemen are stunted: 13 governorates have stunting levels of 40%; of these, five have levels above 60%. Surveys confirm that stunting is increasing by as much as 1.7% annually.

The nutrition crisis in Yemen has alarming implications. There are about 1.4 million children with moderate acute malnutrition, who are about 4 times more likely to die than their well-nourished peers. An estimated 400,000 children are severely malnourished who are 12 times more likely to die. Children who are stunted suffer physical and often irreversible long-term cognitive effects. Children who survive do less well at school, have 10 percent lower lifetime earnings, and are more likely to have undernourished children. Countries with high levels of malnutrition lose as much as 10% national Gross Domestic Product (GDP) year-on-year.

Since 1997, there has been no improvement in the nutritional status of women; one quarter (25%) of women are malnourished (BMI<18.5 kgm-2). The high levels of maternal undernutrition across the country are no doubt contributing to the high levels of child stunting.

Anaemia in children is associated with reduced cognitive development (as much as 9 IQ points may be lost), lack of concentration and listlessness. In women of reproductive age, anaemia is a major cause of maternal mortality. The level of anaemia among children and women is high in Yemen. The DHS of 2013 indicated that among children 6-59 months of age, the prevalence of anaemia is 68.3% and that of severe anaemia is 15.5%. Anaemia prevalence among women is 70.6% and severe anaemia is 3.2%; the levels of anaemia and severe anaemia among pregnant women are 78.2% and 8.5% respectively.

Iodine deficiency is the leading preventable cause of brain damage worldwide and it can significantly lower the IQ of whole populations by 10 to 15 points. The most severe effects of iodine deficiency occur during foetal development and in the first few years of life. National surveys in Yemen reveal that the median urinary iodine decreased from 173 µg/l in 1998 to 101µg/l in 2015.

Improving infant and young child feeding (IYCF) practices, especially exclusive breastfeeding and complementary feeding, has been identified as the single most important intervention in a package of essential child survival interventions recommended for low-income countries with high levels of child undernutrition and mortality rates. Promoting breastfeeding and complementary feeding are, therefore, integral interventions for child survival; they have the potential to substantially reduce child mortality. In Yemen, half of mothers are not initiating breastfeeding within the first hour after delivery, while exclusive breastfeeding rates have reduced from an already low rate of just under 18% in 1997 to around 10% in 2003. Bottle feeding is a practice experienced by 2 out of 5 children under 2 years of age.

The DHS of 2014 indicated that 58.5% of children aged 6 to 23 months are fed with the minimum meal frequency, 26.6% with minimum dietary diversity, and collectively, those with minimum acceptable diet make up just 17.3% (among breastfed children), which is an indicator of poor complementary feeding practice.
Annex 2
Key drivers of undernutrition in Yemen

In Yemen, the main causes of malnutrition mirror the UNICEF conceptual framework with the three main underlying causes being (i) inadequate access to food and or/poor use of available food ((ii) inadequate child care practices (with exclusive breastfeeding rates as low as 10% nationwide) and (iii) inadequate health services (only 50% of health facilities are fully operational and only 79% provide any nutrition services whatsoever (only 46% provide treatment for both severe and moderate acute malnutrition)).

The protracted conflict in the country has led to increased rates of acute malnutrition by further exacerbating these existing underlying conditions. In the 107 districts at risk of famine, heightened vulnerability levels have resulted in millions of food insecure households facing severe food consumption deficits that are life threatening. Out of a total of 7.3 million individuals requiring immediate food assistance, 4.1 million individuals do not know where their next meal will come from and face the grim risk of starvation and hunger. In tandem with this is the fact that most households’ livelihood assets are at near collapse and coping strategies are almost exhausted leading to spiralling extreme coping behaviours such as sale of houses, land, productive assets, and livestock which is severely compromising their future household food security status. To access food, the households purchase on credit, borrow, or receive food as gifts leading to high levels of household debt accumulation. The precarious situation has been further exacerbated by the huge caseloads of internally displaced persons (IDPs) that have stretched the coping mechanisms of both IDP households and host families to the brink of exhaustion, bringing their lives to a virtual standstill.

A large number of water systems that depend on electricity or fuel are no longer functional or depend heavily on humanitarian support within the high-risk districts. Access to improved water has significantly decreased and most people resort to an unimproved water source, since they are not able to afford trucked or bottled water. Drinking water from an unimproved water source puts them at high risk of diarrhoeal disease which then leads to deteriorating nutritional status and in some cases to risk of mortality. The fact that people also rely heavily on trucked or bottled water as the only relatively ‘safe’ water source puts additional pressure on household expenditure, especially for those that have lost their livelihood due to the crisis. The large-scale displacement continues to put additional pressure on already scarce water sources and sanitation services.

With regard to health, only an estimated 50% of health facilities are fully functional in the high-risk districts. The decline in the public health sector is attributable to the lack of salaries for health personnel and difficulties in importing medicines and other critical supplies. Private sector health services (where they exist) are out of reach for millions of vulnerable and needy individuals due to high prices and unaffordability, especially considering their disrupted livelihoods. This unjustifiable situation has led to mortality in some areas, concentrated mainly among children, mothers, and those suffering from communicable disease, malnutrition, non-communicable diseases, or those who cannot access healthcare because of the conflict.

In Yemen, the food and nutrition crisis has escalated due to the conflict as well as the subsequent collapse of the economy. The disruption of formal markets, fluctuation in the currency, escalation of prices of basic goods and diminished purchasing power mean that Yemenis can buy less with the money they have. Around 80% of Yemenis are estimated to be in debt. The interruption of the payment of salaries for 1.25 million public sector workers is ongoing and has been prolonged over the past two years in the northern governorates, undermining public systems. Half of all health facilities in the country are closed or not fully functional. A quarter of all children are not attending school.

11This figure varies considerably from one district to another. HERAMS 2017
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