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Operational Guidance on Yemen Integrated Famine Risk Reduction Programming

Final guidance for pilot July 2018

Yemen Nutrition Cluster

WASH Cluster
Water Sanitation Hygiene

HEALTH CLUSTER YEMEN

YEMEN
FOOD SECURITY AND AGRICULTURE CLUSTER
Strengthening Humanitarian Response

Operational Guidance

on Yemen Integrated Famine Risk Reduction Programming

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Yemen Nutrition Cluster

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For more information visit the IFRR website

https://www.humanitarianresponse.info/en/operations/yemen/integrated-programming-famine-risk-reduction-ifrr

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Acknowledgement

The guidelines were prepared though extensive consultations with the stakeholders of the Yemen WASH, Health, Nutrition and FSAC Clusters. More than 250 people directly contributed to guidance development.

The initial workshop for the Integrated Famine Risk Reduction (IFRR) package development was held in October 2017 with the Strategic Advisory Groups (SAGs) and technical line ministries of the 4 clusters, preceding and followed by the SAG consultations within the four clusters.

This was followed by the workshops in Hodeidah (January 2018), Aden (March 2018) and Ibb (June 2018) for the hub cluster partners to further develop the approach and refine the package based on the field perspective.

At the hub workshops a wide variety of local and international NGOs, UN agencies, local authorities and technical ministries were consulted and contributed to the guidance development[1].

Additionally, the draft operational guidance was circulated to all partners of the four clusters at national and sub-national levels for their inputs, before finalising the guidance for initial piloting in 2018.

It will be further updated in 2019 based on the feedback from the pilot in 2018.

More than **250** people directly contributed to guidance development.

1 For more information, consult workshop reports available from the IFRR website

Introduction

The Nutrition, FSAC, Health and WASH clusters have agreed to support Integrated Programming for Famine Risk Reduction (IFRR) in Yemen.

107 priority districts were identified as those most in need of IFRR in 2018. 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[2]. Furthermore, 30 pilot districts have been selected out of the 107 priority districts for IFRR (districts at risk of famine) where the four clusters will monitor and evaluate the pilot in 2018. However, the partners are encouraged to follow this operational guidance in all 107 priority IFRR districts in 2018 and beyond. The list of 30 pilot and 107 priority districts is attached as annex 1 and the selection criteria for pilot are presented below:

The partners are encouraged to follow this operational guidance in all 107 priority IFRR districts and beyond

- The district is a priority for all the four clusters based on needs and priorities and
- All four clusters have capacity to implement in the district (i.e. have submitted targets for the 2018 Yemen Humanitarian Response Plan), and
- There are no access constraints (security related, physical, and administrative, etc.).

The IFRR includes interventions from the four clusters (WASH, Nutrition, Health and FSAC) due to interdependent nature of causes related to health, WASH, nutrition and food security and agriculture, that together lead to malnutrition, disease, starvation and preventable mortality if not addressed in a coherent manner.

The guideline aims to provide operational guidance to the four cluster partners to jointly assess, plan, implement and monitor Integrated Famine Risk Reduction (IFRR) Programmes. Clear steps and instructions are provided for each phase in the programme cycle.

The guideline is still a draft and is for field testing, reviewing and updating by the clusters and partners.

The following indicators were used for prioritisation:
- GAM prevalence - based on SMART surveys 2016-2017, emergency food security and nutrition assessment (EFSNA) 2016, and the 2014 comprehensive food security survey (CFSS). There was a need to prioritise districts for nutrition interventions within governorates, however, there was a lack of representative district level data to base this on. Therefore, districts were clustered by livelihood zone, agro-ecological zone and elevation and the proportion of GAM cases within the new clusters were re-calculated. The resulting percentages used for prioritisation do not provide GAM prevalence rates for the clustered districts, but present the proportion of children with GAM from the total number of children measured. This provides an indication of the severity of the situation in that area. Cut-off points for each category were assigned based on the international thresholds where possible, taking into account the local context.
- Percentage of severely food insecure population - based on district level FSAC Famine Risk Monitoring data).

Understanding integration

There are many forms of integrated programming. For the pilot phase of IFRR, the convergence model was selected as the most suitable, because of its focus on the geographical co-location of response and services targeting the same beneficiaries with a standard IFRR minimum package. The package was developed by the four clusters and identifies services and activities at the household (HH), health facility (HF), and community levels.

Selected HFs and their catchment areas are the "centres of integration", around which the IFFR is implemented, i.e. a HF with catchment areas serving the most vulnerable population is selected to implement IFRR approach and all partners from the four clusters committed to work together in those areas to implement full IFRR package as per figure 1 below.

Selected HFs and their catchment areas are the "centres of integration", around which the IFFR is implemented

To help understand linkages between different activities and to guide targeting of beneficiaries, as well as to guide how to mainstream protection in the IFRR response, a matrix with the minimum package, beneficiary selection criteria, linkages among the four clusters and protection considerations is attached as annex 2.

While this operational guideline focuses on convergence, it is possible that varying levels of integration will be ongoing simultaneously in different locations depending on the context and partner capacity.

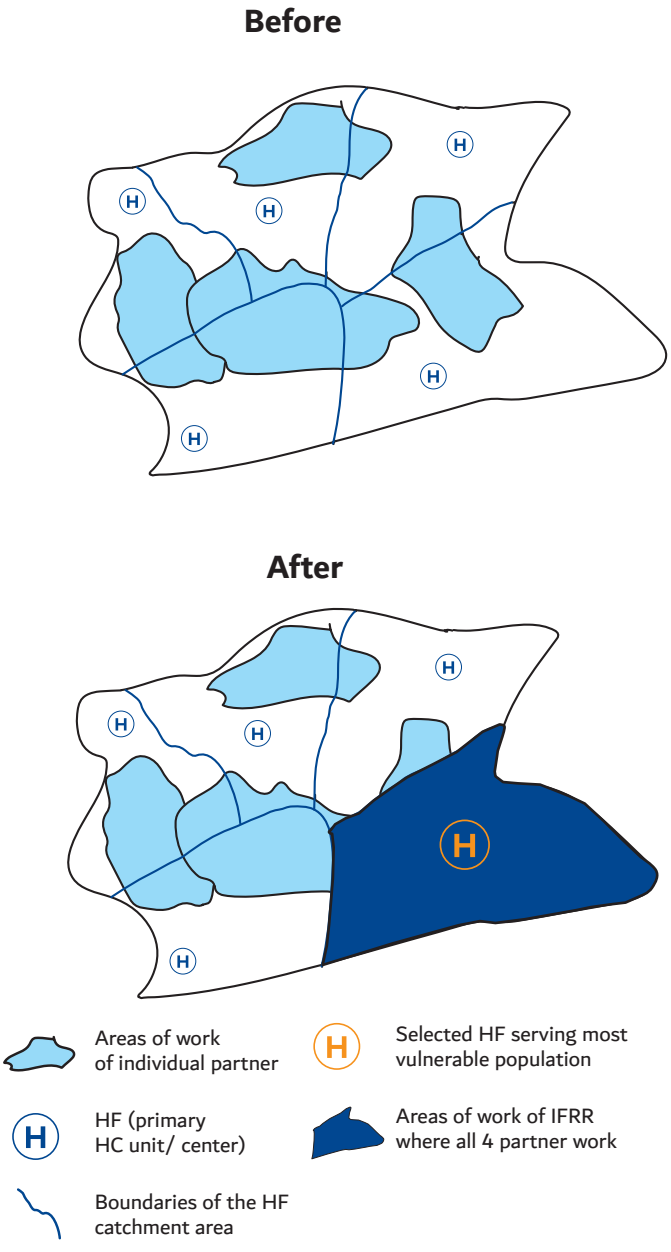

Figure 1. IFRR approach explained

IFRR implementation process:

Part 1

Selection of HFs as a centre of integration

The operational guideline focusses on integrated programming at the health facility and its catchment area. The selection process should start from identifying the most vulnerable locations in a district and them looking into what HFs are serving them.

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Selection criteria for most vulnerable villages

The first step is to select the most vulnerable locations (villages) in the districts. This should be decided based on the available data, such as areas with increased morbidity and mortality, high rates of severe food insecurity, highest malnutrition rates/caseloads, and experts' opinions through discussion and reaching consensus among all stakeholders working in the district.

Selection of the HFs

After the villages are selected, the next step is to find what HF/HFs is/are serving them providing primary health care.

It is most likely that it will be primary health care centre (catchment population ranging between 5,000 and 20,000 people) or primary health care unit (catchment population ranging between 1,000 and 5,000 people)[3].

It is recommended to further focus strengthening the response in the whole primary health care catchment area of this HF, and not only on the selected in the previous step most vulnerable villages, as in most cases while strengthening Health and Nutrition component of the IFRR, the affect would be seeing for the whole catchment areas, plus the selection of only come villages would introduce disparities among similar population.

It is recommended to further focus strengthening the response in the whole primary health care catchment area of this HF, and not only on the selected in the previous step most vulnerable villages,

HF selection should be done through a **meeting** of all relevant stakeholders at sub-cluster, governorate (recommended) or district level. Note that this step can be skipped if the HFs are already selected (in consultation with authorities), or if a partner took a decision to implement IFRR in its catchment area of the HF (in any of the 107 districts at risk of famine and beyond), which is encouraged even if the district was not prioritised for 2018 IFRR pilot – in such case the partner should have capacity to implement IFRR in at least several sectors. Any partner not implementing all interventions in all four sectors should be encouraged to coordinate with the four clusters in identifying the gap and lobbying for another partner to intervene to ensure comprehensive IFRR.

[3] In an unlikely situation that the most vulnerable population lives in the proximity of a district hospital, its catchment area for the primary health care can be selected.

The objectives of this meeting should be:

- To familiarize all stakeholders (including local authorities, technical line ministries, cluster partners, and UN/NGO representatives) with IFRR approach in Yemen
- To agree on the HFs (and their catchment areas) for the implementation of IFRR
- To agree what partners will co-lead on the IFRR in each selected HF (one NGO and one government representative, such as District Health Officer or Health Facility manager)
- To agree on next steps to prepare for the follow up planning and coordination meeting in selected HFs
- Identify if any of the four sectors is not covered by partners in a district and inform relevant sub-national coordinator for follow up

The proposed participants for the meeting (to be adjusted as relevant based on context):

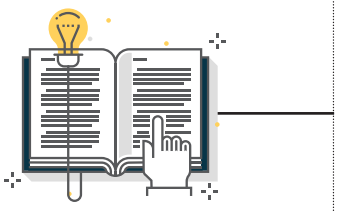
- Sub-national cluster coordinators of the four clusters (should jointly organize a meeting and co-chair it)
- UN agencies and NGOs from Health, WASH, FSAC and Nutrition Clusters that are operational in the districts that are selected for IFRR programming
- OCHA representative at sub-national level
- GHOs and DHOs of the districts for the IFRR programming (ensure that a person represents both Health and Nutrition departments, or invite two per district as relevant)
- Local water and sanitation authorities: Local water and sanitation Corporation (LWSC), General authority for Rural water supply projects (GARWSP) and Cleaning Fund (CF) from the relevant governorates and districts
- Ministry of Agriculture and Irrigation (MAI) and Ministry of Planning and International Cooperation (MoPIC) Directorate Generals (DGs)
- It is recommended to invite a protection focal point (contact protection cluster for this)
- Other local authorities, such as a head of the local council, can also be also invited based on the need

The proposed agenda for the meeting is below:

The meeting should be chaired if possible by the sub-national cluster coordinator(s) with DHO/GHO or MoPIC representative. The proposed duration is at least two hours.

hours

Time	Title	Purpose	Facilitator(s)	Comments
60 min	Welcome and introduction	Explain the purpose of the workshop and the IFRR package	Representatives of the technical ministries (i..e GHO, MoPIC, etc.)[4] Sub-national CCs	The proposed PPT is a part of this operational guidance
60 min	Selection of the HFs and lead agencies/organizations	Group work per district: selection of locations (villages and corresponding HFs catchment areas) and selection of the partner most suitable to coordinate/lead IFRR in each location (NGO/UN plus an authorities technical representative)	Each group should select one. It is recommended that one CC is co-facilitating each group is possible	Prior to the meeting prepare a matrix with list of HFs, their catchment areas (i.e. villages) and partners operating in each of them – per district. If possible provide a map of each district
30 min	Presentations and discussion of group work	Agreement on the way forward	Sub-national CC and representatives of the technical ministries (i.e GHO, MoPIC, etc.)	Way forward should include tentative dates for a HF level meetings



Note on the **selection leading partners** for each HF catchment area.

Both NGO and government focal points should be selected for the HF and they are the leading partners who will work together on leading IFRR implementation. The technical government ministries should select who will be the government focal point (usually GHO or HF manager) and cluster partners from the four clusters working in the HF catchment area should select who would be the NGO leading partner.

After the HFs are identified, the **next step** is to prepare and conduct the HF-level coordination meetings of all relevant stakeholders. A leading partner per HF identified at the first meeting should lead the IFRR planning and coordination meeting at HF level. A detailed explanation for this meeting is given in the next section of the guidelines.

[4] Governorate level; authorities should be oriented on the IFRR approach by sub-national CC before the meeting

IFRR implementation process:

Part 2

Planning and coordination meeting at HF level

The central integration point of the IFRR is a health facility and its catchment area. The aim of the IFRR is to implement a minimum package of IFRR interventions at HF, community and HH levels targeting the same beneficiaries, including IDPs, whenever needed and possible.

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All stakeholders that work in the catchment area of the selected HF should be invited to a planning meeting

All stakeholders (HF manager, members of local council, community leaders, technical line ministries, UN agencies, NGOs) that work in the catchment area of the selected HF should be invited to a planning meeting. This will be a coordination forum for IFRR implementation in this HF. It should be inclusive and new agencies should be involved as soon as they are planning to start interventions in the catchment area of the HF.

The objectives of the meeting are to:

- Familiarize all stakeholders with IFRR approach (as there will be some people who were not part of the previous IFRR meeting)
- Prove update to all partners on the current need and response in the HF and its catchment area to ensure all stakeholders are on the same page
- Identify gaps in the response as per the suggested IFRR package and how to address them
- Select partners for each of the activities in the IFRR package (one partner can do multiple activities from one or more sectors) if not done previously
- Prepare a joint IFRR workplan and agree on the next steps, including how to address the gaps
- To clarify and agree on the roles of all stakeholders in facilitating implementation of IFRR

The proposed agenda for the meeting is below:

The meeting should be at least 4 hours long to allow sufficient time for agreements.

hours

Time	Title	Purpose	Comments
60 min	Welcome and introduction	Explain the summary of the IFRR (by selected leading partner and a line ministry focal point)	The proposed PPT is a part of this operational guidance
60 min	Situation update	Overview of current health, nutrition, WASH and Food Security situation and ongoing / planned interventions in the HF catchment area by the partners	A leading partner to prepare an overview of the needs situation, each partner to update on their current response
15 min Coffee			
60 min	Planning the response	Plenary: Mapping of current activities and gaps at HF, community and HH levels	A list of the villages/communities (and relevant population data) to be obtained from the GHO/MoPIC prior to the meeting Use the developed template (annex 3)
60 min	Workplan and next steps	Joint drafting of the workplan and identification of next steps, including regular coordination meetings	A draft template for the work plan is a part of this guidance (annex 4)
30- 60 min Lunch and prayer			

- It is a role of the leading partner with the support of the respective subnational cluster coordinators to ensure that everyone is implementing their activities as per the work plan and to follow up with other partners.
- A list of participants with the contact details should be prepared during the meeting and should be in possession of the leading partner to be able to follow up with relevant agencies and people.

IFRR work plan at HF catchment area level

To facilitate implementation of the IFRR it is advised to develop a work plan during the first meeting and to review progress at subsequent meetings. A template for the workplan is presented in annex 4.

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IFRR implementation process:

Part 3

Monitoring and implementation at HF level

Regular coordination meetings

The group should hold regular coordination meetings to discuss progress against the workplan, opportunities for joint programming and any challenges and opportunities that are part of the IFRR.

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Objectives of the monthly/bimonthly coordination meetings:

- Monitor progress towards the workplan developed at the first meeting;
- Follow-up on action points

The proposed agenda of the regular coordination meetings is presented below.

Time	Title	Purpose	Comments
10 min	Welcome and introduction	To familiarise everyone with the purpose of the meeting, agenda, introduce new partners	
20 min	Welcome and introduction	Follow-up on the action points from the previous meeting	Based on the meeting minutes prepared at the previous meeting
30 min	Work plan progress	Discuss progress towards the workplan. Include discussion/documentation on • key issues and challenges in implementation with mitigative measures to address those. • lessons learnt and common touch points for integration.	Based on the workplan developed
60 min	Situation update	Overview of progress on health, nutrition, WASH and FSAC ongoing/ planned interventions in the HF catchment area by the partners	Based on the mapping template filled in the previous meeting (annex 3)

IFRR monitoring and evaluation

There are different levels of monitoring and evaluation throughout the IFRR implementation that are necessary to ensure that the IFRR is implemented according to the plan and that corrective actions are taken when needed.

Pre- and post-programme assessment

due to small sample size of the HFs catchment area (on average about 10,000-15,000 people) a survey that would provide malnutrition estimation, health, WASH and food security situation would be very resource consuming and would not bring sufficient additional value to justify spending additional time, financial and human resources, therefore it is not recommended, including for pre- and post- programme assessment.

The locations selected are recognised by all stakeholders as the most vulnerable, and therefore it is a good enough justification to implement the IFRR on those locations. However, if there is a need to have the baseline and end line assessment, a tool for such assessment is recommended in the annex 3.

Added value of IFRR approach.

To monitor added value of the IFRR approach, it is recommended to use annex 4 (template for IFRR planning matrix) and annex 4 (template IFRR workplan that includes indicators and targets), regularly updated throughout the IFRR implementation and to compare the first ones with the current ones to see the progress made.

Monitoring IFRR workplan

The IFRR workplan, to be developed at the first meeting and to be updated regularly at the follow up meeting, is the main monitoring mechanism to evaluate if IFRR implementation is on track and what corrective actions should be taken. A proposed draft template for the workplan is available in the annex 4.

The workplan should also include indicators to monitor its implementation and thus, would be a monitoring plan as well.

The workplan plan is in annex 5 should be regularly updated and shared with sub-national cluster coordinators, DHOs/GHOs, MoPIC and other stakeholders at district, governorate and hub levels.

Joint field visits

If possible, joint field visits to the HF and nearby villages should be conducted to monitor the progress of the IFRR, to identify gaps and opportunities.

The field visits should feed into the regular coordination meetings, and should be a part of the workplan.

Additional reporting

It is NOT recommended to add any additional reporting to the current reports submitted to the four clusters, in order not to overburden partners and not to take attention from implementation to the reporting.

ANNEXES

Annex 1 – Priority districts for the IFRR in 2018

30 district were identified as for the pilot of IFRR in 2018, however all partners are encouraged to implement the IFRR approach in all 107 priority districts at risk of famine, and beyond throughout the country's 333 districts

Hub	Governorate	Code	District	In need of IFRR in 2018 (107 districts)	IFRR pilot 2018 (30 districts)	Population
Aden	Abyan / أبين	1209	Ahwar	Yes		33,534
Aden	Abyan / أبين	1211	Khanfir	Yes	Yes	148,463
Aden	Abyan / أبين	1206	Rasad	Yes		73,235
Aden	Abyan / أبين	1207	Sarar	Yes		20,358
Aden	Abyan / أبين	1205	Sibah	Yes		22,187
Aden	Abyan / أبين	1210	Zingibar	Yes	Yes	35,564
Aden	Aden / عدن	2406	Al Mualla	Yes		78,260
Aden	Aden / عدن	2402	Ash Shaikh Outhman	Yes		168,267
Aden	Aden / عدن	2401	Dar Sad	Yes	Yes	137,258
Aden	Aden / عدن	2408	Khur Maksar	Yes		72,553
Aden	Al Dhale'e / الضالع	3008	Al Azariq	Yes	Yes	62,966
Aden	Al Dhale'e / الضالع	3009	Al Husha	Yes		99,087
Aden	Al Dhale'e / الضالع	3007	Jahaf	Yes	Yes	39,146
Aden	Hadramaut / حضرموت	1922	Adh Dhlia'ah	Yes		27,276
Aden	Hadramaut / حضرموت	1906	Al Abr	Yes		9,324
Aden	Hadramaut / حضرموت	1926	Al Mukalla	Yes		22,464
Aden	Hadramaut / حضرموت	1903	Al Qaf	Yes		3,186
Aden	Hadramaut / حضرموت	1921	Amd	Yes		29,547
Aden	Hadramaut / حضرموت	1917	Ghayl Ba Wazir	Yes		73,319
Aden	Hadramaut / حضرموت	1905	Hagr As Sai'ar	Yes		3,707
Aden	Hadramaut / حضرموت	1924	Hajr	Yes		38,396
Aden	Hadramaut / حضرموت	1928	Huraidhah	Yes		27,803
Aden	Hadramaut / حضرموت	1920	Rakhyah	Yes		12,734
Aden	Hadramaut / حضرموت	1910	Sayun	Yes		152,613
Aden	Hadramaut / حضرموت	1923	Yabuth	Yes		14,699

Hub	Governorate	Code	District	In need of IFRR in 2018 (107 districts)	IFRR pilot 2018 (30 districts)	Population
Aden	Hadramaut / حضرموت	1904	Zamakh wa Manwakh	Yes		2,214
Aden	Lahj / لحج	2514	Al Hawtah	Yes	Yes	32,905
Aden	Lahj / لحج	2512	Al Maqatirah	Yes		83,500
Aden	Lahj / لحج	2508	Al Milah	Yes	Yes	39,216
Aden	Lahj / لحج	2509	Al Musaymir	Yes	Yes	36,672
Aden	Lahj / لحج	2510	Al Qabbaytah	Yes	Yes	124,894
Aden	Lahj / لحج	2507	Radfan	Yes		60,597
Aden	Lahj / لحج	2515	Tuban	Yes	Yes	126,710
Aden	Shabwah / شبوة	2115	Ar Rawdah	Yes		38,028
Aden	Shabwah / شبوة	2113	Ataq	Yes		51,572
Aden	Shabwah / شبوة	2114	Habban	Yes		41,244
Al Hudaydah	Al Hudaydah / الحديدة	1809	Ad Dahi	Yes		84,543
Al Hudaydah	Al Hudaydah / الحديدة	1825	Al Garrahi	Yes		137,942
Al Hudaydah	Al Hudaydah / الحديدة	1811	Al Hajjaylah	Yes	Yes	15,072
Al Hudaydah	Al Hudaydah / الحديدة	1820	Al Khawkhah	Yes		46,146
Al Hudaydah	Al Hudaydah / الحديدة	1816	Al Mansuriyah	Yes		68,810
Al Hudaydah	Al Hudaydah / الحديدة	1813	Al Marawi'ah	Yes	Yes	199,378
Al Hudaydah	Al Hudaydah / الحديدة	1808	Al Mighlaf	Yes	Yes	62,181
Al Hudaydah	Al Hudaydah / الحديدة	1815	As Sukhnah	Yes		91,057
Al Hudaydah	Al Hudaydah / الحديدة	1826	At Tuhayat	Yes		102,144
Al Hudaydah	Al Hudaydah / الحديدة	1807	Az Zaydiyah	Yes	Yes	148,705
Al Hudaydah	Al Hudaydah / الحديدة	1810	Bajil	Yes	Yes	245,532
Al Hudaydah	Al Hudaydah / الحديدة	1817	Bayt Al Faqiah	Yes	Yes	367,948
Al Hudaydah	Al Hudaydah / الحديدة	1812	Bura	Yes		69,602
Al Hudaydah	Al Hudaydah / الحديدة	1824	Zabid	Yes		243,083
Al Hudaydah	Al Mahwit / المحويت	2703	Ar Rujum	Yes		114,243
Al Hudaydah	Al Mahwit / المحويت	2707	Bani Sa'd	Yes		94,176
Al Hudaydah	Hajjah / حجة	1704	Abs	Yes	Yes	271,200
Al Hudaydah	Hajjah / حجة	1714	Aflah Al Yaman	Yes	Yes	61,701

Hub	Governorate	Code	District	In need of IFRR in 2018 (107 districts)	IFRR pilot 2018 (30 districts)	Population
Al Hudaydah	Hajjah / حجة	1725	Ash Shaghadirah	Yes	Yes	76,352
Al Hudaydah	Hajjah / حجة	1712	Aslem	Yes	Yes	100,560
Al Hudaydah	Hajjah / حجة	1727	Bani Al Awam	Yes		80,339
Al Hudaydah	Hajjah / حجة	1724	Bani Qa'is	Yes	Yes	85,951
Al Hudaydah	Hajjah / حجة	1729	Hajjah	Yes	Yes	42,496
Al Hudaydah	Hajjah / حجة	1705	Hayran	Yes		25,179
Al Hudaydah	Hajjah / حجة	1711	Khayran Al Muharraq	Yes		114,869
Al Hudaydah	Hajjah / حجة	1722	Ku'aydinah	Yes	Yes	110,124
Al Hudaydah	Hajjah / حجة	1706	Mustaba	Yes		84,462
Al Hudaydah	Hajjah / حجة	1713	Qafl Shamer	Yes	Yes	78,262
Al Hudaydah	Hajjah / حجة	1723	Wadhrah	Yes		17,003
Al Hudaydah	Raymah / ريمة	3101	Bilad At Ta'am	Yes		49,854
Ibb	Ibb / إب	1111	Al Udayn	Yes		197,280
Ibb	Ibb / إب	1110	Far Al Udayn	Yes	Yes	127,125
Ibb	Ibb / إب	1109	Hazm Al Udayn	Yes	Yes	114,659
Ibb	Ibb / إب	1117	Mudhaykhirah	Yes		115,102
Ibb	Taizz / تعز	1517	Al Mudhaffar	Yes	Yes	163,721
Ibb	Taizz / تعز	1521	Al Ma'afer	Yes	Yes	149,179
Ibb	Taizz / تعز	1518	Al Qahirah	Yes	Yes	120,150
Ibb	Taizz / تعز	1515	Al Wazi'iyah	Yes		36,885
Ibb	Taizz / تعز	1514	Ash Shamayatayn	Yes		237,234
Ibb	Taizz / تعز	1520	At Ta'iziyah	Yes		256,775
Ibb	Taizz / تعز	1512	Dimnat Khadir	Yes	Yes	181,672
Ibb	Taizz / تعز	1504	Maqbanah	Yes	Yes	260,370
Ibb	Taizz /	1501	Mawiyah	Yes	Yes	179,116
Ibb	Taizz / تعز	1519	Salh	Yes		105,991
Ibb	Taizz / تعز	1503	Shara'b Ar Rawnah	Yes	Yes	207,781
Ibb	Taizz / تعز	1502	Shara'b As Salam	Yes	Yes	157,459
Sa'ada	Al Jawf / الجوف	1610	Bart Al Anan	Yes		86,559
Sa'ada	Sa'ada / صعدة	2207	Al Dhaher	Yes		34,835
Sa'ada	Sa'ada / صعدة	2213	Al Hashwah	Yes		27,601
Sa'ada	Sa'ada / صعدة	2201	Baqim	Yes		16,630
Sa'ada	Sa'ada / صعدة	2204	Ghamr	Yes		29,326
Sa'ada	Sa'ada / صعدة	2214	Kitaf wa Al Boqe'e	Yes		47,074
Sa'ada	Sa'ada / صعدة	2210	Majz	Yes		110,054
Sa'ada	Sa'ada / صعدة	2203	Monabbih	Yes		79,287
Sa'ada	Sa'ada / صعدة	2202	Qatabir	Yes		35,799
Sa'ada	Sa'ada / صعدة	2205	Razih	Yes		46,996
Sa'ada	Sa'ada / صعدة	2209	Saqayn	Yes		96,119
Sa'ada	Sa'ada / صعدة	2206	Shada'a	Yes		5,225
Sana'a	Amran / عمران	2920	Bani Suraim	Yes		43,686

Hub	Governorate	Code	District	In need of IFRR in 2018 (107 districts)	IFRR pilot 2018 (30 districts)	Population
Sana'a	Amran / عمران	2909	Dhi Bin	Yes		42,205
Sana'a	Amran / عمران	2919	Khamir	Yes		101,914
Sana'a	Dhamar / ذمار	2012	Al manar	Yes		76,201
Sana'a	Dhamar / ذمار	2011	Dawran Aness	Yes		187,231
Sana'a	Dhamar / ذمار	2003	Jabal Ash sharq	Yes		97,416
Sana'a	Dhamar / ذمار	2002	Jahran	Yes		132,153
Sana'a	Dhamar / ذمار	2005	Utmah	Yes		235,978
Sana'a	Dhamar / ذمار	2006	Wusab Al Ali	Yes		263,387
Sana'a	Dhamar / ذمار	2007	Wusab As Safil	Yes		242,612
Sana'a	Sana'a / صنعاء	2314	Bani Dhabyan	Yes		31,492
Sana'a	Sana'a / صنعاء	2310	Manakhah	Yes		116,168
Sana'a	Sana'a / صنعاء	2311	Sa'fan	Yes		45,043
						10,173,899

Annex 2
Minimum IFRR package with cross-sectoral linkages and beneficiary selection criteria

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
Household level								
FSAC	HH1	Emergency food assistance (through in-kind, n, cash transfers, or voucher transfers)	FSAC criteria (see note below the table), including HHs with children under 5 with SAM or MAM, vulnerable HHs with children under five years old and/ or pregnant women and/ or lactating women		MUAC screening and referral of malnourished children aged 6-59 months and PLW Distribution of micronutrients of BSFP to children 6-23 months old	Information education and communication (IEC), awareness creation, home visits screening and referral, iCCM (integrated community case management for treatment of minor ailments),	Distribution of CHKs & WMKs if appropriate; Hygiene awareness (including cholera prevention when needed), chlorination of water tanks and jerry bans	Distribution points should be implemented in safe and accessible area with enough space for women, elderly and disabled persons. The distribution should take place in daylight to minimize safety risks Issue ration cards to female-headed households, child-headed households and unaccompanied children in their own name Distribution process should prioritise pregnant and lactating mothers, the elderly, people living with disabilities, chronically ill and unaccompanied and separated children Provision of information to the beneficiaries on selection criteria, targeted assistance and related procedures
FSAC	HH2	Provision of agricultural inputs (e.g. seeds, tools), livestock support (e.g. vaccination, feed/ concentrate) and fishery inputs support (e.g. fishing nets, cooler boxes etc.)	Vulnerable farming, pastoralist, or agro-pastoralist households (for vulnerable farming households they should have access to productive resources/ assets e.g. land and labour Vulnerable fishermen		N/A	N/A	Provision of water should consider agricultural needs (if possible based on the context)	Ensure both male headed, female headed and all categories of households have equal and fair access to agriculture and livestock support Involve and consult all categories of the affected population in identifying and responding to FSAC needs. (Special needs of all vulnerable segments of the population e.g Youth must be put into account

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
FSAC	HH3	Agricultural related Income generating activities	Vulnerable IDPs and Host communities (as per FSAC vulnerability and targeting criteria))		N/A	N/A	Cash for work should prioritize water and sanitation interventions	Ensure attention to the special role of women and youth in income generating activities and plan according. Promote active participation of women, and other at risk groups in all IGA. Ensure IGA design minimises the risk of GBV Offer livelihood opportunities that are suitable for persons with disabilities and older persons – these groups are often excluded from such projects and find it difficult to source funds or other inputs. Ensure that marginalised and disenfranchised groups have equal and fair access to income generating activities
NC	HH4	Screening and referral of children with severe or moderate acute malnutrition and PLW with acute malnutrition	All children aged 6-59 months and all PLW	Emergency Food Assistance (in-kind, cash transfers or voucher transfers)		Information education and communication (IEC), awareness creation, , iCCM (integrated community case management for treatment of minor ailments),	Distribution of CHKs &WMKs for referred children and PLW with MAM/SAM; Hygiene awareness during screening (including cholera prevention when needed)	Ensure child-headed households, unaccompanied and separated children as well as older persons receive special distribution of nutrition items as necessary Ensure children have access to nutrition services such as children living or working on the streets, children with disabilities, children living in collective centres, Ensure referral mechanisms between child protection and nutritional programmes are in place

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
NC	HH5 (see also HH8 and HH13)	Infant and young child feeding messaging (and IEC distribution)	PLW and caregivers of children 0-24 months	Include information on hygienic food handling and proper food preparation methods		Information education and communication (IEC), awareness creation, iCCM (integrated community case management for treatment of minor ailments)	Hygiene awareness (including cholera prevention when needed)	Communicate information through various means to reach the broader community and to account for different literacy levels and age groups, (eg. door-to-door, poster, radio, social media, use of pictograms).
HC	HH6	Immunisation	Children aged 0-59 months Women of reproductive age	N/A	MUAC screening and referral of children aged 6-59 months and PLW Distribution of micronutrients IYCF messaging		Hygiene awareness (including cholera prevention when needed)	Communicate information through various means to reach the broader community and to account for different literacy levels gender and age groups (eg. door-to-door, poster, radio, social media, use of pictograms, use of child friendly messages). Ensure all children have access to vaccination such as children disabilities, children living in collective centres
HC	HH7	Outbreaks management	All Population	Include information on hygienic food handling and proper food preparation methods	Ensure identification and referral of children with SAM/ MAM and PLW with acute malnutrition		If waterborne, include hygiene awareness (including cholera prevention when needed), hygiene kits distribution, chlorination of water tanks and jerry cans	Communicate information through various means to reach the broader community and to account for different literacy levels gender and age groups (eg. door-to-door, poster, radio, social media, use of pictograms). Ensure all children have access to vaccination such as children disabilities, children living in collective centres
HC	HH8 (See also HH5 and HH13)	Health education	All population	Include information on hygienic food handling and proper food preparation methods	Nutrition education, IYCF messaging		Include hygiene awareness (including cholera prevention when needed) and environmental health messaging	Communicate information through various means to reach the broader community and to account for different literacy levels gender and age groups (eg. door-to-door, poster, radio, social media, use of pictograms). Involve and consult all categories and layers of the affected population in identifying and responding to health needs.

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
HC	HH9	Reproductive health services (distribution of safe delivery kits)	Women (15-49) Males	N/A	Nutrition Education, including infant and young child feeding Screening and referral of malnourished children and pregnant and lactating women		Hygiene awareness (including cholera prevention when needed)	Ensure that the health services are respectful and inclusive of cultural and religious practice. Have a proportionate number of female health staff. Introduce special arrangements for persons unable to access health facilities e.g mobile health services and etc. Involve and consult all categories and layers of the affected population in identifying and responding to health needs. Put into consideration the needs of children and adults living with disabilities.
WC	HH10	Provide sustainable access to safe drinking water	Same beneficiaries as FSAC and NC are targeting; households without access to safe drinking water	Work with farmer house-holds to address irrigation and water conser-vation issues aligned with ag-ricultural support provided by FSAC	N/A	N/A		Locate water sources in visible, central locations and not more than 500 metres from settlement. If overcrowding at water points is reported, consider scheduling time shifts for water collection in consultation with the beneficiaries and in recognising that different people have different work schedules – women and girls who are most often the water collectors have specific times when they are busy making meals.

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
WC	HH11	Latrine construction through community mobilization approaches (which can include a subsidy component or cash for work approaches)	Same beneficiaries as FSAC and NC are targeting; households without access to improved latrine	Conditional Cash for Assets (CFA)/ Conditional Food for Assets (FFA)	N/A	N/A		Build separate toilet and bathing facilities for males and females. Make sure they are clearly marked in pictorial form for illiterate users and work with community to ensure they are used by the indicated sex. For privacy, provide secondary enclosures around facilities or put locks on the doors to latrines and bathing houses. Discuss this with beneficiaries to consider their preferences. Consider lighting systems around latrines to minimise risk of GBV Build latrines that put into consideration the needs of those with physical disabilities
WC	HH12	Provide consumable hygiene kits (CHKs) and water management kits (WMKs) (water storage containers and household water treatment options)	Children and PLW with MAM/SAM	Can be coordinated and included as a part of the emergency food assistance and emergency livelihoods assistance kits	Awareness campaign (C4D)	Information education and communication (IEC), awareness creation, home visits screening and referral, iCCM (integrated community case management for treatment of minor ailment)		Consider safety risks to children e.g. size of drop hole; provide smaller jerry cans for children to collect water to avoid potential injury and consider their physical capacity in designing water pumps. Involve and consult all categories and layers of the affected population in identifying and responding to WASH needs. Different criteria may affect the power dynamics
WC	HH13 (see also HH5 and HH8)	Inter personal communication on hygiene and environmental health	Same beneficiaries as FSAC and NC are targeting	Include information on hygienic food handling and proper food preparation methods	Awareness campaign (C4D)	Information education and communication (IEC), awareness creation, home visits screening and referral, iCCM (integrated community case management for treatment of minor ailments)		Provide information through various communication means to reach the broader community and to account for different literacy levels, age and gender differences eg. door-to-door, poster, radio, social media, use of pictograms). Promote simple hygiene messages for children using child-friendly information (ie. Cartoons).

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
Community level								
FSAC	C1-2	Basic agro-processing (e.g. sesame oil extraction), rehabilitation and resilience building through cash for work, food for work, cash for assets, food for assets schemes	As per FSAC's vulnerability and targeting criteria		N/A	N/A	N/A	Ensure both men and women, youth and all groups have equal and fair participation and access to agriculture and livestock support Involve and consult all categories of the affected population in identifying and responding to FSAC needs Ensure that assistance and services are reaching the most vulnerable - Identify and prioritise the most vulnerable groups in the community and prevent discrimination or exclusion of marginalised groups
FSAC	C3	Demonstration plots	As per FSAC's vulnerability and targeting criteria		N/A	N/A	Consider this when providing sustainable community water source	
FSAC	C4	Mass livestock vaccinations	As per FSAC's vulnerability and targeting criteria and Livestock Emergency Guidelines and Standards (LEGS)		N/A	Reporting of suspected disease outbreaks, follow up of cases and contact tracing.	Hygiene awareness (including cholera prevention when needed), waste/ cadaver disposal	Involve and consult all categories of the affected population in identifying and responding to FSAC needs
NC	C5	Blanket Supplementary Feeding programme (BSFP)	Children aged 6-23 months without SAM or MAM, PLW without acute malnutrition	BSFP to be implemented through General Food Distribution points		IEC, immunization Distribution of clean delivery kits, dignity kits etc. Education and issuance of basic family planning methods, referral linkages, treatment of minor ailments and referral of complicated cases	Hygiene awareness (including cholera prevention when needed)	Ensure that assistance and services are reaching the most vulnerable children such as children living or working on the streets, children with disabilities, children living in collective centres, unaccompanied and separated children
NC	C6	Mother to mother support groups (infant and young child feeding)	Mothers with children aged 0-23 months	Education on home based income generation , food handling and proper food preparation methods		IEC, immunization Distribution of clean delivery kits, dignity kits etc. Education and issuance of basic family planning methods, referral linkages, treatment of minor ailments and referral of complicated cases	Hygiene awareness (including cholera prevention when needed)	Ensure that services are respectful and inclusive of cultural and religious. Give special attention to adolescent mothers due to their age and specific needs

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
HC	C7	Health education and issuance of basic family planning methods	Women of child bearing age	Include information on hygienic food handling and proper food preparation methods	Include IYCF education		Hygiene awareness (including cholera prevention when needed)	Communicate information through various means to reach the broader community and to account for different literacy levels and age groups (eg. door-to-door, poster, radio, social media, use of pictograms). Involve and consult all categories (i.e. adolescent boys and girls, pregnant and lactating adolescents, people living with disabilities) and layers of the affected population in identifying and responding to health needs.
HC	C8	Limited curative care	All population	N/A	Include screening and referral of children with SAM/MAM and PLW with acute malnutrition		Hygiene awareness (including cholera prevention when needed)	Consult women, men, boys, girls, youth, persons with disabilities, chronically ill, older persons, pregnant and lactating women and marginalised persons to collect accurate information about their specific needs and preferences for health centre location, design and services. Engage the community and committee representative to play an active role in identifying solutions and in the decision-making processes that affect them, so as to promote a sense of ownership, build their self-esteem and improve the relevance and sustainability of the response Create health committees to help maintain health structures and encourage representatives to be involved in the design of facilities and services

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
WC	C9	Provide sustainable access to safe drinking water	Whole community, HH without access to safe drinking water	Work with farmer house-holds to address irrigation and water conser-vation issues aligned with ag-ricultural support provided by FSAC	N/A	Outbreaks disease reporting system – follow up and contact tracing		Locate water sources in visible, accessible and safe location. If overcrowding at water points is reported, consider scheduling time shifts for water collection in con-sultation with the beneficiaries and in recognising that different people have different work schedules – women and girls who are most often the water collectors have specific times when they are busy making meals. Involve and consult all categories and layers of the affect-ed population in identifying and re-sponding to WASH needs.
WC	C10	Latrine construction through community mobilization approaches (which can include a subsidy component or cash for work approaches)	Whole community, HH without access to improved latrine	Cash for Work, Food for Work, Food for Assets	N/A	Outbreaks disease reporting system – follow up and contact tracing		Build separate toilet and bathing facilities for males and females. Make sure they are clearly marked in pictorial form for people living with disabilities and young children, those that cannot read and/or write users and work with community to ensure they are used by the indicated sex. Engage the commu-nity and committee representatives to play an active role in identifying solutions and the decision-making processes that affect them, so as to promote a sense of ownership, build their self-esteem and im-prove the relevance and sustainability of the response. Build community ca-pacities to maintain WASH structures and ensure sus-tainable provision of WASH services eg. establish WASH committees, provide tools for minor repairs to infrastruc-ture

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
WC	C11	Health and hygiene awareness	Whole community	Include information on hygienic food handling and proper food preparation methods	Including nutrition messaging	Outbreaks disease reporting system – follow up and contact tracing		Communicate information through various means to reach the broader community and to account for different, gender, age groups and literacy levels (eg. door-to-door, poster, radio, social media, use of pictograms).
Health facility level								
NC	HF1	Referral of children with SAM and complications to the nearest TFC	Children aged 0-59 months with SAM with complications	Inclusion of households with children admitted in TFCs in the emergency food assistance programmes		Limited curative care including IMCI (intergrated management of childhood illnesses, ANC(Antenatal care/ PNC(postnatal care, EPI(Expanded programme on immunisations, FP(family planning (short-acting methods), IEC. Refill of NCD (non-communicable diseases) prescriptions, provide incentives for HCWs, formal trainings and on job trainings, referral of complicated cases to next level of care	Distribution of CHKs &WMKs for referrals (if not provided in the TFCs – need to check before)	Ensure referral mechanisms between child protection and nutrition programmes are in place Ensure all nutrition staff, implementing partners and volunteers working with affected populations understand, sign and adhere to a Code of Conduct stating their commitment to respect and foster humanitarian standards and the rights of beneficiaries, including the confidentiality of patients.
NC	HF2	Treatment of children with SAM (Outpatient treatment centres)	Children aged 0-59 months with SAM without complications	Inclusion of households with a child admitted in a SAM programme in the emergency food assistance programmes Inclusion of HHs with a child admitted in the SAM programme in the emergency livelihoods assistance (in case they have productive assets)		Limited curative care including IMCI (integrated management of childhood illnesses, ANC (Antenatal care/PNC (postnatal care, EPI (Expanded programme on immunisations, FP(family planning (short-acting methods), IEC. Refill of NCD (non-communicable diseases) prescriptions, provide incentives for HCWs, formal trainings and on job trainings, referral of complicated cases to next level of care	Distribution of CHKs & WMKs for children with SAM	Ensure referral mechanisms between child protection and nutrition programmes are in place Include a PSS component in the treatment of children with SAMs. Ensure all nutrition staff, implementing partners and volunteers working with affected populations understand, sign and adhere to a Code of Conduct stating their commitment to respect and foster humanitarian standards and the rights of beneficiaries, including the confidentiality of patients. Ensure that assistance and services are reaching the most vulnerable children

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
NC	HF3	Treatment of children with MAM and PLW with acute malnutrition (targeted supplementary feeding programme)	Children aged 6-59 months with MAM PLW with acute malnutrition	Inclusion of households with a child admitted in a MAM programme in the emergency food assistance programmes Inclusion of HHs with a child admitted in the MAM programme in the emergency livelihoods assistance (in case they have productive assets)		Limited curative care including IMCI (intergrated management of childhood illnesses, ANC(Antenatal care/ PNC(postnatal care, EPI(Expanded programme on immunisations, FP(family planning (short-acting methods), IEC. Refill of NCD (non-communicable diseases) prescriptions, provide incentives for HCWs, formal trainings and on job trainings, referral of complicated cases to next level of care	Distribution of CHKs &WMKs for children with MAM and PLW with acute malnutrition	Ensure all nutrition staff, implementing partners and volunteers working with affected populations understand, sign and adhere to a Code of Conduct stating their commitment to respect and foster humanitarian standards and the rights of beneficiaries, including the confidentiality of patients. Ensure child-headed households, unaccompanied and separated children receive special distribution of nutrition items as necessary, and children with MAM have access to PSS through liaison with child protection actors
NC	HF4	Health education (including IYCF counselling) for pregnant and lactating women and caregivers of children 0-24 months	PLW and caregivers of children 0-24 months	Include information on hygienic food handling and proper food preparation methods		Limited curative care including IMCI (integrated management of childhood illnesses, ANC (Antenatal care/ PNC(postnatal care, EPI(Expanded programme on immunisations, FP(family planning (short-acting methods), IEC. Refill of NCD (non-communicable diseases) prescriptions, provide incentives for HCWs, formal trainings and on job trainings, referral of complicated cases to next level of care	Hygiene awareness (including cholera prevention when needed)	Communicate information through various means to reach the broader community and to account for different literacy levels, age and gender (eg. door-to-door, poster, radio, social media, use of pictograms). Consult women, men, boys, girls, persons with disabilities, chronically ill, older persons, pregnant and lactating women and marginalised persons to collect accurate information about their specific needs and preferences for health services.

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
HC	HF5	Integrated management of childhood illnesses	Children 0-59 months old	N/A	Referral of children 6-23 months (without acute malnutrition) and PLW to BSFP or distribution of the multiple micronutrients, screening and referral of children 6-23 months (with acute malnutrition) to OTP/TSFP		Hygiene awareness (including cholera prevention when needed)	Reinforce the capacity of the community to provide sustainable health care (eg. engage and support health community workers/ volunteers in vaccination campaigns; hire and train local midwives) Coordinate with civil society specialising in working with persons with impaired mobility or disabilities to help identify such individuals and use them as a resource to improve service delivery, train staff and for the referral of cases.
HC	HF6	Ante-natal care and post-natal care (ANC/PNC)	Pregnant and lactating women	Inclusion of households with PLWs in the emergency food assistance programmes	Screening of mothers for acute malnutrition and referral to TSFPs IYCF consultations		Hygiene awareness (including cholera prevention when needed)	Reinforce the capacity of the community to provide sustainable health care (eg. engage and support health community workers/volunteers, hire and train local midwives) Involve and consult all categories and layers of the affected population in identifying and responding to health needs. Different criteria may affect the power dynamics.
HC	HF7	Family planning services (short acting methods)	women of child bearing age	Include information on hygienic food handling and proper food preparation methods	IYCF education		Hygiene awareness (including cholera prevention when needed)	Ensure that the health services are respectful and inclusive of cultural and religious practice. Have a proportionate number of female health staff. Introduce special arrangements for persons unable to access health facilities e.g mobile health services and etc. Involve and consult all categories (most especially people living with disabilities, adolescent boys and girls, youth) and layers of the affected population in identifying and responding to health needs

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
HC	HF8	Expanded programme on immunization (EPI)	Children 0-59 months old, women of reproductive age	N/A	Referral of children 6-23 months (without acute malnutrition) and PLW to BSFP or multiple micronutrient programme, screening and referral of children 6-23 months (with acute malnutrition) to OTP/TSFP		Hygiene awareness (including cholera prevention when needed)	Reinforce the capacity of the community to provide sustainable health care (eg. engage and support health community workers/volunteers in vaccination campaigns; hire and train local midwives
HC	HF9	Communicable and non-communicable diseases management	All	Include information on hygienic food handling and proper food preparation methods	Nutrition education		Hygiene awareness (including cholera prevention when needed)	Have a proportionate number of female health staff. Ensure that beneficiaries know of available health services and assistance where/how to obtain it. Ensure all health staff, implementing partners and volunteers working with affected populations understand, sign and adhere to a Code of Conduct stating their commitment to respect and foster humanitarian standards and the rights of beneficiaries, including the confidentiality of patients.
HC	HF10	Provide access to a sustainable and safe water source and functional and appropriate sanitation services (latrines, solid waste management, sewage) in the HF and ensure operation and maintenance (O&M)	Targeted health facility	Inclusion of HFs rehabilitation as Cash for ork, Food for Work or Food for Assets programmes	N/A		Provide technical support when relevant	Make infrastructure adaptions to WASH structures to make them accessible to persons with reduced mobility (eg. persons with physical disability, older persons). Ensure the mode and frequency of distribution minimises exposure to safety threats – be aware that beneficiaries may face theft, intimidation, sexual assault and extortion whilst taking their hygiene kits home. Ensure the location and access routes to WASH facilities and distribution points are safe.

Leading cluster	#	Activity	Beneficiary selection	Linkage with FSAC	Linkage with Nutrition	Linkage with Health	Linkage with WASH	Protection considerations
WC	HF11	Providing consumable hygiene kits (CHKs) and water management kits (WMKs) (water storage containers and household water treatment options)	Children aged 0-59 months with SAM or MAM	Can be coordinated and included as a part of the emergency food assistance and emergency livelihoods assistance	Kits provided to children with SAM or MAM	Limited curative care including IMCI (integrated management of childhood illnesses, ANC (Antenatal care/ PNC (postnatal care, EPI(Expanded programme on immunisations, FP(family planning (short-acting methods), IEC. Refill of NCD (non-communicable diseases) prescriptions, provide incentives for HCWs, formal trainings and on job trainings, referral of complicated cases to next level of care		Involve and consult all categories and layers of the affected population in identifying and responding to WASH and hygiene needs. Build separate toilet and bathing facilities for males and females putting into consideration the needs of people living with physical disabilities Make sure they are clearly marked in pictorial form for illiterate users?? and work with community to ensure they are used by the indicated sex. Engage the community and committee representatives to play an active role in identifying solutions and the decision-making processes that affect them, so as to promote a sense of ownership, build their self-esteem and improve the relevance and sustainability of the response. Ensure equal representation and participation in the WASH structures. Build community capacities to maintain WASH structures and ensure sustainable provision of WASH services eg. establish WASH committees, provide tools for minor repairs to infrastructure

Note

Beneficiaries' selection criteria

Nutrition Cluster vulnerability and targeting criteria:

- All children under age of 5, including those with severe and moderate acute malnutrition
- All PLW, including those with acute malnutrition

FSAC Household vulnerability and targeting criteria:

- Severely food insecure households;
- Vulnerable IDP households (presently IDPs have some of the worst food security indicators in the country);
- Vulnerable Host households hosting IDPs;
- Households with children under 5 with Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM);
- Vulnerable Households with children under five years old and/or pregnant women and/or lactating women;
- Vulnerable Female headed households;
- Child headed households;
- Vulnerable Households with no productive assets, or functional means of income/ reliable source of income;
- Vulnerable Elderly headed households;
- Vulnerable Households headed by chronically ill members;
- Vulnerable Households headed by physically challenged heads;
- Vulnerable marginalized communities e.g. Muhamasheen;
- Vulnerable Households not receiving adequate assistance from other sources;
- Households meeting other vulnerability criteria as identified by the communities

Health Cluster vulnerability and targeting criteria:

This will be the whole population of the catchment area depending on the level of the facility chosen.

WASH Cluster vulnerability and targeting criteria:

as per FSAC and Nutrition Clusters criteria.

Annex 3 - Recommended tool for the IFRR pre- and post-assessment

Yemen IFRR assessment Methodological Notes

Sample design and sampling technique and procedures

Sample design and sample size determination

The survey is to cover the selected Health Facility catchment area, where the IFRR is being implemented. The results of the IFRR survey is planned to be statistically representative at this catchment area only and cannot be extrapolated to different areas.

A two-stage cluster sampling method will be used to calculate the sample size for each HF catchment area (the survey area/ stratum). The two-stage stratified cluster sampling techniques uses the following formula to calculate the sample size for surveys with key indicators expressed as percentages:

$$n = (D)(Z^2 * p * q)/d^2$$

where:

n = the required minimum sample size

D = design effect (varies by type of sampling – 1.2 for two stage cluster sampling)

Z = the Z-score corresponding to the degree of confidence (90% is taken for the FRM)

p = estimated proportion of key indicator expressed as a decimal (e.g. 67% = 0.67) – this estimate is generated from the national average of the recently conducted FRM surveys where about 67% of the population is estimated to be food insecure.

q = **1 – p** (33% = 0.33 based on the above estimate)

d = minimum desired precision or maximum tolerable error expressed in decimal form (for this IFRR survey purpose 90% precision is desired considering costs and speed, in other words, a 10 percentage points is taken as maximum tolerable error = 0.10).

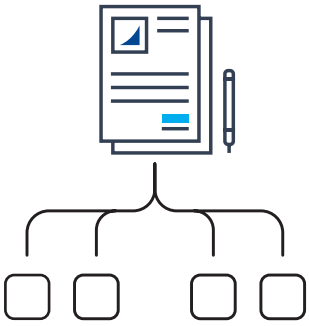
The results of the IFRR survey is planned to be statistically representative at this catchment area only and cannot be extrapolated to different areas.

The following table shows the parameters and corresponding estimates used to calculate the sample size for the planned survey for each catchment area.

Table 1:

Sample size calculation procedure – parameters and estimates used for the IFRR survey

Parameter	Estimate
Design effect for two stage cluster sampling (D)	1.2
Z-score value for 90% degree of confidence	1.645
Percentage of food insecure households – national level – key indicator (p)	67%
Percentage of food secure households – national level – key indicator (q=1-p)	33%
Minimum desired precision (90%) – maximum tolerable error (d=10%)	0.1
Non-response ratio	5%
The required minimum sample size (n) – using the above formula (average sample size for each HF catchment area where the IFRR to be conducted)	76 HH



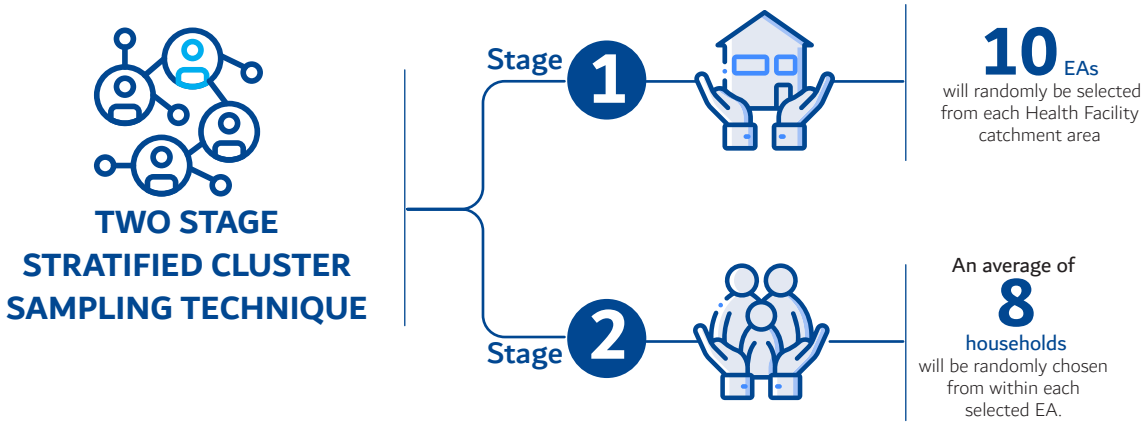
The following two stage stratified cluster sampling technique will be employed in order to select 76 households per HF catchment area.

- **1st Stage:**

10 EAs will randomly be selected from each Health Facility catchment area to be covered by the IFRR Survey using proportional to population size and considering agro-ecological zones and urban/rural areas of the HF catchment area;

- **2nd Stage:**

An average of 8 households will be randomly chosen from within each selected EA.



Yemen IFRR assessment

Questionnaire

Enumerator Name: ..... **Date:** .....

Section 1: Household ID and location information

1.1	Governorate Name		1.4	Village\neighbourhood	
1.2	District Name		1.5	Household Location	1 = Urban 2 = Rural ☐
1.3	Sub-district\ City		1.6	Household ID	
1.7	Relationship of respondent with head of household		1. Head of HH 2. Male Adult 3. Spouse of Head of HH 4. Female Adult		☐

Section 2: Household information

2.1	Are you an IDP or not?	0 = No 1 = Yes	☐ Skip to 2.4 if the answer to 2.1 is No
2.2	Do you live in a collective centre/camp or with a host?	1 = Collective Centre/Camp 2 = Host 3= Separated house	☐
2.3	For how long have you been displaced?	1 = newly displaced (June 2018 to date) 2 = displaced for 6 months - 1 year 3= displaced for over 1 year	☐
2.4	How many members are there in your household?		☐ ☐

Section 3: Coping strategies (consumption related)

3.0:	In the past 7 days, were there times when you did not have enough food or money to buy food?	0 = No 1 = Yes	☐
If "Yes" to the above question, how many days during the past week did your household use any coping mechanisms listed below? (put the codes of the choice from the right into the box provided)			**0** = Never **1** = 1 day **2** = 2 days **3** = 3 days **4** = 4 days **5** = 5 days **6** = 6 days **7** = 7 days
3.1	Rely on less preferred and less expensive food		☐
3.2	Borrow food or rely on help from a relative or friend		☐
3.3	Purchase/ Buy food on credit		☐
3.4	Gather wild food from forest, hunt or harvest immature crops		☐
3.5	Consume seed stock held for next season		☐
3.6	Send household members to eat elsewhere		☐
3.7	Send household members to beg		☐
3.8	Limit portion size at meal times		☐
3.9	Restrict consumption by adults for small children to eat		☐
3.10	Feed working members of the household at the expense of non-working members		☐
3.11	Reduce number of meals eaten in a day		☐
3.12	Skip entire days without eating food		☐

Section 4: Food Consumption Score (FCS) and Household Dietary Diversity Score (HDDS)

How many members are there in your household and were home in the last 7 days? ☐

	Focus on food eaten INSIDE the house	Did your household eat the following item in the last 24 hours 0 = No 1 = Yes	Number of days eaten in previous 7 days? 0 =Not eaten 1 = 1 day 2 = 2 days 3 = 3 days 4 = 4 days 5 = 5 days 6 = 6 days 7 = 7 days	What was the main source of the food in the last 7 days? 1 =Produced by the household 2 =Hunting/gathering/fishing 3 =Bought using cash 4 =Bought on credit 5 =Borrowed/gifts (friends/ relatives) 6 =Begging 7 =Swap 8 =Food assistance 9 =Received as payment 99=Not applicable
4.1	 Cereals (Bread, Pasta..)	☐	☐	☐
4.2	 Roots and tubers	☐	☐	☐
4.3	 Vegetables	☐	☐	☐
4.4	 Fruits/fruit juices	☐	☐	☐
4.5	 Meat, offal	☐	☐	☐
4.6	 Poultry	☐	☐	☐
4.7	 Eggs	☐	☐	☐
4.8	 Fish and other seafood	☐	☐	☐
4.9	 Pulses, legumes and nuts	☐	☐	☐
4.10	 Milk and milk products	☐	☐	☐
4.11	 Oils and fats	☐	☐	☐
4.12	 Sweets (Sugar/honey)	☐	☐	☐
4.13	 Spices, coffee, tea	☐	☐	☐
4.14	 Condiments (small quantities to add flavour)	☐	☐	☐

Section 5: Livelihood Coping strategies (livelihood/asset depletion measures)

During the past 30 days, did anyone in your household have to engage in any of the following activities because there was not enough food or money to buy food?		**0**= Never (had enough food) **1**=No; that option is no longer available (exhausted) **2**= Seldom or very rare (1-2 times in the past 30 days) **3**= sometimes (between 3 -10 times in past 30 days) **4**= Always (more than 10 times in past 30 days)
5.1	Sold household assets/goods (radio, furniture, refrigerator, television, jewellery, clothes etc.)	☐
5.2	Purchased food on credit	☐
5.3	Spent savings	☐
5.4	Borrowed money	☐
5.5	Sold productive assets or means of transport (sewing machine, wheelbarrow, bicycle, car, etc.)	☐
5.6	Consumed seed stocks that were to be held/saved for the next season	☐
5.7	Withdrew children from school	☐
5.8	Sold house or land	☐
5.9	Begged	☐
5.10	Sold last female animals	☐
5.11	Reduced health (including drugs) and education expenditures	☐

Section 6: Water sources

	Improved	Unimproved	
6. What water source did your household use the most in the last 30 days? (select one) *Water for drinking, cooking, and bathing	**1.** Piped water into compound **2.** Piped water connected to public tap **3.** Borehole **4.** Protected well **5.** Protected rainwater tank **6.** Protected spring **7.** Bottled water	**8.** Water Trucking **9.** Illegal connection to piped network **10.** Unprotected rainwater tank **11.** Unprotected well **12.** Unprotected spring	☐
	13. Surface water (river, dam, lake, pond, stream, canal)		
	14. Other (specify):		

Section 7: Fetching water problems

7. Did you have enough water in the last 30 days to meet your household needs?	1=Yes 2=No		☐
If respondent answered "no" to Q#7, ask this: **7.1 How did you adjust for the lack of water?** (select all that apply but don't read choices)	**1.** Reduce drinking water consumption **2.** Reduce water for hygiene practices (bathe less, etc) **3.** Spend money usually spent on other things to buy water	**4.** Go fetch water to a further water point than the usual one **5.** Get water on credit/Borrow water **6.** Drink water usually used for cleaning or other purposes than drinking **7.** Other (explain)	☐

Section 8: Latrines access

8. Do your household members have access to and use a functioning latrine? Select one	**1.** All members have access and use it **2.** All members have access but only some use it **3.** Only some members have access to a latrine **4.** No members have access **5.** I don't want to answer	☐
If respondent picked choice 2 or 3 to Q#8, ask **8.1 What is/are the problem(s) related to the latrine?** (select all that apply but do not read options)	**1.** There is not enough facilities/too crowded **2.** Absence/insufficiency of water **3.** Latrines are unclean/unhygienic **4.** Lack of privacy/no separation between men and women **5.** It is not safe (no door, no lock, etc) **6.** Cess pit is full **7.** Pipes are blocked **8.** Connection to sewage blocked **9.** The structure is damaged **10.** Other	☐
If respondent picked choice 1,2 or 3 to Q#8, ask: **8.1 What type of latrine do your household members have access to?** Select one	**1.** Flush latrine to the open (unimproved) **2.** Flush latrine to a tank/sewer system/pit (improved) **3.** Pit latrine-covered/with slab (improved) **4.** Pit latrine-open/without slab (unimproved) **5.** Other	☐

Section 9: Hygiene practices

9. Do you have soap in your household? Ask to see soap	**1.** Yes (saw soap) **2.** Yes (but did not see soap) **3.** No		☐
If respondent answered "no" to #9, ask: 9.1 **If no, why don't you have soap?** Select one	**1.** It is unavailable at the local market **2.** We prefer a substitute (ex: ash) **3.** We are waiting for the next distribution	**4.** We ran out of soap **5.** The market is too far **6.** We cannot afford it **7.** Soap is not necessary	☐
	8. Other (specify):		

Section 10: Disease prevalence and health seeking behaviour

10. Have you or a member of your households had any of the below diseases in the past two weeks? 1.Yes 2.No		If respondent answered "yes" to #10, ask: 10.1 If yes, have you or they sought treatment in the Health Facility? 1.Yes 2.No
Acute respiratory infections	☐	☐
Diarrheal diseases	☐	☐
Cholera	☐	☐
Malnutrition	☐	☐
Malaria	☐	☐
Measles	☐	☐
Skin diseases	☐	☐
Physical injuries	☐	☐
Toilet infection (Vaginal Infection)	☐	☐
Psychological illness	☐	☐
Illness related to women's reproductive and sexual health	☐	☐
None	☐	☐
Other	☐	☐
Do not know	☐	☐

Section 11: Problems associated with the Health Facility

What are the most serious problems associated with health facilities and access to them within the location? (max. 3 options)	1. No Problem 2. Price (too expensive) 3. Price (regular price but community unable to pay) 4. Quality (bad service, unqualified/unfriendly staff) 5. No female medical staff available 6. Quantity (Type of facility not according to the population size / overcrowded/lack of staff in the facility) 7. Closest health facilities were damaged/destroyed by the fighting 8. Lack of type of services (irregular supply of medicines) 9. Location 10. Other 11. Do not know	☐

Annex 4 – IFRR planning matrix

The matrix should be filled in for the population that are leaving in the specified areas that are catchment areas of the HF that is serving the most vulnerable population. The IDPS are not included separately, but can be included as an "IDP hosting site" under the catchment area and the gaps should be analysed for both IDPs and host population.

Cluster	#	Activity	Name of partners working in catchment area of (HF1), (add all villages included)			Name of partners working in catchment area of (HF2), (add all villages included)		
			Ongoing projects	Planned projects	Gap (yes/no)	Ongoing projects	Planned projects	Gap (yes/no)
Household level								
FSAC	HH1	Emergency food assistance (through either general food distribution, cash or voucher transfers)						
FSAC	HH2	Provision of agricultural inputs, livestock support and fishery inputs support						
FSAC	HH3	Income generating activities						
NC	HH4	Screening and referral of children with severe or moderate acute malnutrition and PLW with acute malnutrition						
NC	HH5 (see also HH8 and HH13)	Infant and young child feeding messaging						
HC	HH6	Immunisation						
HC	HH7	Outbreaks management						
HC	HH8 (See also HH5 and HH13)	Health education						
HC	HH9	Reproductive health services (distribution of safe delivery kits)						
WC	HH10	Provide sustainable access to safe drinking water						
WC	HH11	Latrine construction through community mobilization approaches (which can include a subsidy component or cash for work approaches)						

Cluster	#	Activity	Name of partners working in catchment area of (HF1), (add all villages included)			Name of partners working in catchment area of (HF2), (add all villages included)		
			Ongoing projects	Planned projects	Gap (yes/no)	Ongoing projects	Planned projects	Gap (yes/no)
WC	HH12	Provide consumable hygiene kits (CHKs) and water management kits (WMKs) (water storage containers and household water treatment options)						
WC	HH13 (see also HH5 and HH8)	Inter personal communication on hygiene and environmental health						
Community level								
FSAC	C1	Basic agro-processing (e.g. sesame oil extraction),						
FSAC	C2	Rehabilitation and resilience building through cash for work, food for work, cash for assets, food for assets schemes						
FSAC	C3	Demonstration plots						
FSAC	C4	Mass livestock vaccinations						
NC	C5	Blanket Supplementary Feeding programme (BSFP)						
NC	C6	Mother to mother support groups (infant and young child feeding)						
HC	C7	Health education and issuance of basic family planning methods						
HC	C8	Limited curative care						
WC	C9	Provide sustainable access to safe drinking water						
WC	C10	Latrine construction through community mobilization approaches (which can include a subsidy component or cash for work approaches)						
WC	C11	Health and hygiene awareness						
Health facility level								
NC	HF1	Referral of children with SAM and complications to the nearest TFC						

Cluster	#	Activity	Name of partners working in catchment area of (HF1), (add all villages included)			Name of partners working in catchment area of (HF2), (add all villages included)		
			Ongoing projects	Planned projects	Gap (yes/no)	Ongoing projects	Planned projects	Gap (yes/no)
NC	HF2	Treatment of children with SAM (Outpatient treatment centres)						
NC	HF3	Treatment of children with MAM and PLW with acute malnutrition (targeted supplementary feeding programme)						
NC	HF4	Health education (including IYCF counselling) for pregnant and lactating women and caregivers of children 0-24 months						
HC	HF5	Integrated management of childhood illnesses						
HC	HF6	Ante-natal care and post-natal care (ANC/PNC)						
HC	HF7	Family planning services (short acting methods)						
HC	HF8	Expanded programme on immunization (EPI)						
HC	HF9	Communicable and non-communicable diseases management						
HC	HF10	Provide access to a sustainable and safe water source and functional and appropriate sanitation services (latrines, solid waste management, sewage) in the HF and ensure operation and maintenance (O&M)						
WC	HF11	Providing consumable hygiene kits (CHKs) and water management kits (WMKs) (water storage containers and household water treatment options)						

Annex 5 – Template for a work plan at HF catchment area level for IFRR implementation

The workplan should include the IFRR activities and the month of implementation. It can also include other activities that should be done jointly, such as regular coordination meetings and joint monitoring visits. The group should identify all relevant activities that should be included in the workplan.

Activity	Responsible & Lead ((agency and person	Indicator	Target	Actions to be taken (include by who and by (when	Progress (completed, on track, delayed, postponed, (cancelled
Leading partner (NGO AND from local technical ministry) for IFRR in the HF catchment area identified		Leading partner identified	Yes		
		Leading local authority representative identifies	Yes		
Conduct monthly coordination meetings at HFs with all partners working in the HF catchment area conducted		Number of coordination meetings conducted in a year	12		
		Number of meeting minutes with clear action points prepared and shared	12		
Identify and fill in all gaps in activities as per IFRR planning matrix		Percentage of identified gaps filled	75%		
Conduct joint monitoring field visits		Number of visits conducted per year	2		

For more information visit the IFRR website

https://www.humanitarianresponse.info/en/operations/yemen/integrated-programming-famine-risk-reduction-ifrr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