

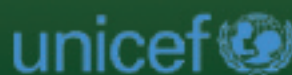


Case Study



Scaling up nutrition services and maintaining service during conflict in Yemen:

Lessons from the Hodeidah sub-national Nutrition Cluster



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Yemen

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This case study is one of six case studies produced through a year-long collaboration in 2015 between ENN and the Global Nutrition Cluster (GNC) to capture and disseminate knowledge about the Nutrition Cluster experiences of responding to Level 2 and Level 3 emergencies. They each provide very rich insights into the achievements of the cluster approach and the challenges of working in complex environments.

The findings and recommendations documented in this case study are those of the authors. They do not necessarily represent the views of UNICEF, its Executive Directors or the countries that they represent and should not be attributed to them.

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Summary

Yemen is one of the poorest Arab nations. It is characterised by high chronic and acute malnutrition and since March 2015 has been embroiled in a violent civil war. The Nutrition Cluster was established in 2009 and continues to coordinate the large-scale nutrition response in five governorates of Yemen. This case study documents the history of the nutrition response, focusing on two governorates, Hodeidah and Hajjah, which are characterised by high malnutrition and continuing conflict over 2012-2014. The case study highlights the challenges and lessons after an intense period of scale-up due to increased conflict in 2015.

Country overview

Yemen is the poorest Arab nation, characterised by high unemployment (40%, geopoliticalmonitor.com), rapid population growth (45% of the population are below the age of 15) and diminishing water resources.

The economy, heavily dependent on dwindling oil supplies (expected to end by 2017), has been severely disrupted by a lengthy political crisis and conflicts on several fronts spanning a number of years. Fighting escalated in March 2015 when clashes between supporters of Yemen's President and the Houthis (a Zaidi Shia group from northern Yemen) pushed the country into civil war.

The escalation of fighting has worsened an already severe humanitarian crisis. Attacks on oil and gas pipelines have caused fuel shortages, resulting in a dramatic decrease in export earnings. Water is scarce and many sources need fuel to extract the water, resulting in extremely limited access to water in many areas. Large-scale population displacement (around 150,000 according to the Yemen Flash Appeal launched in April 2015) is occurring due to the intensity of the fighting. Civilian infrastructure (including schools, hospitals, bridges, factories, power stations, etc.) has been destroyed or damaged in the fighting. Basic services are on the verge of collapse and the government is unable to pay civil servant salaries.



Health, nutrition and food security

Access to basic health services in Yemen is challenging. An estimated 8.4 million people lack access to basic healthcare, and mothers are 57% more likely to die in childbirth than elsewhere in the Arabian Peninsula. 13.4 million people lack access to safe drinking water and 12 million people have no proper sanitation facilities (Humanitarian Needs Overview, 2015).

Malnutrition is a major and chronic problem in Yemen. The country has one of the highest rates of stunting in the world (47% in 2011¹). Acute malnutrition is estimated nationally at 16% (DHS 2014), although there are areas where this is significantly higher. Yemen suffers from the double burden of malnutrition, with a combined male and female adult overweight population of 46% and a combined male and female obesity rate of 17% (WHO, 2008). Micronutrient malnutrition is high, with anemia affecting 38% of women of reproductive age and vitamin A deficiency affecting 27% of school-

aged children (Global Nutrition Report 2014). While breastfeeding is predominant in Yemen (97% of all women reportedly breastfed for some time after birth), the exclusive breastfeeding rate of infants under six months is 12% (UNICEF 2003). Timely initiation of breastfeeding is 40% (MICS 2006); however, the use of additional liquid and food to complement breastmilk in infants aged 0-6 months is common. A bottle with a nipple was used in the first three months of life in 42% of respondents from one survey (Yemen Family Health Survey, 2003).

Food security remains a challenge in Yemen; 46% of the population (12 million people) are food insecure (WFP Sit Rep #8, 28 May 2015). Almost all food (90%) is imported and since the escalation in conflict in March 2015 prices have increased due to disruption in food supply routes and sporadic transportation. Meanwhile, household incomes have decreased due to the devaluation of the local currency.

The Nutrition Cluster

The Nutrition Cluster was established in August 2009 following a large-scale Yemeni military response to the Houthi rebels in Sa'ada, northern Yemen. The aim of the Nutrition Cluster is to ensure that the needs of vulnerable people are effectively met; that strong partnership is created and maintained among nutrition actors; and that humanitarian nutrition response is timely, effective and accountable.

The Nutrition Cluster is co-led by the Ministry of Public Health and Population (MoPHP) and UNICEF at both national and sub-national levels. A steering committee comprised of both international and local NGOs² identifies key strategic areas of focus for the work plan and reviews progress of response and emerging priorities. At national level there are 35 active partners, approximately 25% of which are local NGOs (LNGOs). At sub-national level local NGOs often make up a higher



Magid Farid / 2015

¹ Global Nutrition Report 2014

² International NGOs: International Medical Corps, Action Contra La Faim, Save the Children International, Mercy Corps. Local NGOs: Charitable Society for Social Welfare (CSSW), Soul Yemen. UN agencies (WFP, WHO, UNICEF) and the International Organisation on Migration.

percentage of partners. An Information Management officer (IMO) supports both national and sub-national clusters. An Assessment Officer coordinates nutrition assessments for the cluster. There are five sub-national nutrition clusters at governorate (state) level across the country. These are led by the UNICEF programme officer and supported by UNICEF IMOs (who support UNICEF

programmes and all the UNICEF-supported clusters simultaneously). The Nutrition Cluster is the only coordination mechanism for nutrition response in emergencies in Yemen, although under the Scaling Up Nutrition (SUN) movement there is an ongoing initiative to establish a development-orientated food security and nutrition coordination platform.

Hodeidah and Hajjah Sub-Cluster Response 2012-2014

UNICEF has been involved in supporting health and nutrition activities in Hodeidah and Hajjah governorates since the 1990s, with specific support to vaccinations and Integrated Management of Childhood Illness (IMCI). In 2000 UNICEF began supporting community-based nutrition activities and a community-based, maternal, neonatal care programme was started in 2007. In 2008 UNICEF started community management of severe acute malnutrition (SAM) programming in Yemen in an effort to scale-up treatment of SAM services (the programme began in 2009 in Hodeidah). In 2011, the SAM caseload increased and, on anecdotal evidence of deteriorating nutrition, UNICEF conducted SMART surveys in November 2011 in Hodeidah and in May 2012 in Hajjah. The surveys revealed that acute malnutrition was high in both Hodeidah (global acute malnutrition (GAM) 31.7% and SAM 9.1%)

and Hajjah (GAM 19.8% and SAM 3.7%). High levels of GAM and SAM were most likely due to a long-term, gradual increase in a number of risk factors (long-term food insecurity, sporadic conflict, poor infant and young feeding practices, and limited access to quality health care).

Survey results were presented by UNICEF and the governorate Health Office (HO) to partners and agencies interested in working in these governorates in workshops in February 2012 (Hodeidah) and July 2012 (Hajjah). High-priority districts, potential partners and capacity gaps for LINGOs were identified collaboratively with the cluster partners and the government. Partners responded quickly to the needs in Hodeidah; however there was less partner interest in Hajjah, largely due to their limited capacity to expand operations. Sub-national clusters were established for each governorate.



Julien Hameis / 2015

Response – national level

In 2012 the National Nutrition Cluster developed a costed, integrated, strategic response plan for nutrition to massively scale up services to treat acute malnutrition and prevent undernutrition in Hodeidah and Hajjah and other governorates of Yemen. This plan was used at a national and

international level to advocate for funding for nutrition and for a multi-sectoral response to the nutrition situation.

The National Nutrition Cluster also actively engaged in the Scaling Up Nutrition (SUN) Movement.

The SUN movement in Yemen and links with the Nutrition Cluster

The Government of Yemen joined the SUN movement in November 2012 and appointed the Minister of MoPIC as the SUN focal point. In April 2013 the MoPHP presented the nutrition situation of women and children in Yemen to the cabinet. Following this the Prime Minister advised key ministries to develop an integrated, multi-sectoral response plan to address the nutrition situation and establish a technical consultation platform to support it. The MoPIC was assigned responsibility for convening and coordinating the movement and its steering committee by a government decree.

The SUN steering committee convenes a regular monthly meeting, chaired by the SUN focal point. The committee is comprised of key ministries (including MoPHP, Education, Agriculture, Fisheries, Water & Environment and Communication), UN organisations (UNICEF, WFP, WHO, UNDP and FAO), donors (UK AID, USAID, WB, EU), academia (University of

Sana`a), the private sector (chamber of commerce representative) and civil society organisations. A SUN technical committee also meets regularly; the national-level NCC actively participates in this forum.

Under the SUN framework, finalisation and costing (USD \$1.2 billion) of the five-year, national, multi-sectoral nutrition plan (MSNAP) together with the Ministries of Health, Water, Agriculture, Fisheries and Education has been concluded. The Nutrition Cluster was heavily engaged in this process and as a result the MSNAP includes costed interventions for emergency preparedness and response in addition to longer-term, developmental nutrition actions.

The aim was to introduce the plan into the 2015 government planning and budget cycle, but due to intensified conflict and the shifting political context it is currently 'on hold'.



Response – Hodeidah and Hajjah governorates

The following interventions were implemented in Hodeidah and Hajjah:

- **Therapeutic Feeding Centres (TFC) or Stabilisation Centres (SC)** – at district level to provide inpatient care (as per WHO protocols) for severely acutely malnourished children (under five years) with complications. Training on inpatient care was provided to Health Facility (HF) staff.
- **Outpatient Therapeutic Care (OTP)** – at HF level (fixed and mobile teams) to treat children (under five years) with uncomplicated SAM. Children were provided with ready-to-use therapeutic food (as per the Yemen National CMAM Guidelines). Training on outpatient care was provided to HF and mobile team staff.
- **Treatment of Moderate Acute Malnutrition (MAM)** – at HF level and within mobile teams, alongside outpatient therapeutic care. Ready-to-use Supplementary Food (RUSF) was provided to moderately acutely malnourished children (under five years).
- **Integration of IYCF activities** – including IYCF corners in HF and training of community health volunteers (CHVs) on IYCF best practice. IYCF messages were also integrated into UNICEF-supported Community Development activities.
- **Micronutrient supplementation** – including vitamin A supplementation and de-worming (for children under five), iron/folic acid supplementation for pregnant and lactating women, and multiple micronutrient powders for internally displaced persons.

- **Community mobilisation** – activities included training community health volunteers on screening for acute malnutrition through the measurement of mid-upper-arm circumference (MUAC). Additionally CHVs were trained on communication and counseling around infant and young child feeding.

Approximately 20% of this programming was taken on by NGOs and 80% by government. The government Health Office (HO) took on the responsibility for increasing and scaling up treatment of SAM and MAM in fixed HF (with UNICEF support for supplies), while local and international NGO partners agreed to fill capacity and training gaps in temporary HFs and establish mobile teams to access areas without services and support community mobilisation. WFP provided supplies to NGOs and the HO for treatment of MAM.

Capacity development of HF staff was required to implement the expansion of CMAM activities. The capacity development strategy included training all HW in fixed or temporary HF on CMAM protocols by the HO (with UNICEF support); technical support from international NGOs to HW working in temporary sites; and mobile teams established by international NGOs to access areas with no HF. Given its extreme levels of SAM, treatment was prioritised in Hodeidah, while there was a stronger push for prevention activities in Hajjah.

Local NGOs LNGOs have been an integral part of the provision of health and nutrition service delivery since 2011. LNGOs provide different services based on their mandate and experience. As of mid-2015, eight LNGOs were working in Hodeidah and Hajjah. One, the Charitable Society for Social Welfare (CSSW), trained by UNICEF and MoH in CMAM, is implementing four mobile teams providing CMAM services (two in Hodeidah and two in Hajjah). Another LNGO, Taypa Foundation for Development, has conducted medical campaigns and supports operations and management of some HCs and two SCs. The Yemen Family Care Association (YFCA) is providing CMAM services along-

side the free PHC services it offers in conjunction with the MoH. An additional five LNGOs (Me for My Country, Yemen Women Union, ABU MIOSA, WES and TAWASOUL) are involved in promoting behaviour change through messaging on health and nutrition practices, including IYCF, vaccination, antenatal care and hand-washing. CSSW and YFCA are national and sub-national Nutrition Cluster partners; others are partners only at the sub-cluster level. Local NGOs receive funding for nutrition-related activities from UNICEF, WFP, USAID and other donors, depending on the project, and have been integral in the response post-2015 due to the evacuation of international NGOs.

Experience with mobile teams

In 2012 the HO alongside the nutrition sub-cluster identified several areas of Hodeida and Hajjah with no health and nutrition services. Partners agreed to establish mobile teams to provide outpatient treatment for SAM and treatment for MAM (where possible with WFP supplies/support), Integrated Management of Childhood Illness (IMCI) services, vaccinations, reproductive health services, vitamin A supplementation and IYCF counseling. Mobile teams aimed to continue in a location until there are no new cases of SAM. When this point is reached all current cases are referred to the nearest HF to complete treatment. NGOs supported the development of 23 mobile teams (from 2012 to end 2014) to cover vulnerable districts of Hodeidah. In Hajjah, six NGOs (both local and international³) implemented mobile teams, but gaps in coverage remained. In response, the Hajjah HO developed mobile teams to fill the gaps and to build the capacity of district-level health workers on the mobile team approach. The HO rented vehicles for the mobile teams and trained local health workers from targeted districts to implement the following health services:

- Treatment of SAM
- IYCF counseling
- Antenatal care
- Reproductive health services, including family planning
- Vaccination (measles and pentavalent, a vaccine covering five illnesses: diphtheria, tetanus, whooping cough, hepatitis B, and haemophilus influenza type B)

Coverage of health services dramatically increased in mobile team catchment areas. In 2011, 1,345 children under five with SAM were enrolled from 32 districts (all

of Hajjah). However, the cure rate was only 12%. Hajjah HO MTs were launched in 2012 in three districts. By the end of the year 1,690 children under five with SAM were enrolled; the cure rate was 67% and default was 28.7%. In 2013 the MTs improved their performance and 1,925 children under five with SAM were enrolled. The cure rate for the year was 92% and default was 7%. The HO mobile team had the highest performance indicators of all implementing partners.

Vaccination coverage of children under one year dramatically increased in the six districts with mobile teams from 13% in 2014 to 100% in the targeted districts.

The cost for an HO-implemented mobile team is much less than that of an NGO team. HO monthly costs can reach up to \$3,000 USD, while the cost of an NGO team is estimated to be between \$5,000 and \$7,000 USD per month. The HO realized that this was an opportunity to build capacity within the government health services.

Advocacy efforts by the HO and nutrition sub-cluster during this time resulted in agreement by WFP to provide supplies to treat MAM for all mobile teams from 2015. By the end of 2014, the HO (with UNICEF support⁴) was supporting nine mobile teams with plans for expansion, but increased insecurity in 2015 has prevented expansion. These nine teams have continued to respond to the needs of the target populations during the current conflict. For example, when security deteriorated in Harad district and internally displaced persons (IDP) moved to Hayran district, the Harad mobile team moved to Hayran to ensure health coverage for the IDPs.

³ WHO, ADRA, RI, VHI, ACF & CSSW

⁴ UNICEF support included vehicle rental, HW daily fees.



Results

- In Hodeidah OTP was expanded from 52 sites (end 2011) to 353 (early 2014), covering 94% of all fixed and temporary health facilities. In Hajjah OTP sites increased from 82 sites (early 2012) to 177 (in 2014), representing 72% of all HF in Hajjah (fixed and temporary).
- Coverage surveys (SQUEAC⁵) were conducted in two districts in Hodeidah and two districts in Hajjah from 2013 to 2014, reporting point coverage prevalence of 49-64%. On average, this is above SPHERE standard for rural areas and has caused other governorates to adopt the CMAM model.
- Integration of inpatient TFCs and SCs into district-level HF increased from one (2011) to 10 (2014) in Hodeidah, while in Hajjah the number increased from two in 2012 to three in 2014.
- Supplementary feeding for children with MAM and pregnant and lactating mothers was increased in Hodeidah from four (early 2012) to 274 (end 2014) HF. In Hajjah it increased from 11 (2012) to 121 (2014) HF providing services for MAM.
- Mobile teams implementing integrated health and nutrition services increased from zero (2011) to 23 (2014) in Hodeidah and from three to 12 in Hajjah in the same time period.
- Community mobilisation efforts resulted in an increase in CHVs trained in nutrition from zero (2012) to 2297 (2014), increasing further to 1551 (2014) for Hajjah. Additionally, a total of 1,645

Monitoring

From 2010 to 2012 routine monitoring highlighted that only 25% of OTPs delivered monthly reports on time to the nutrition department at the HO in Hodeidah and Hajjah, many of which were incomplete. Additionally, 10% of OTPs had stock-outs (gaps in supplies) due to the irregular monitoring and unclear mechanism for supplies delivery from governorate to district and HF level.

To address this, in 2013 UNICEF funded training and support for 26 district and six zonal monitors in Hodeidah and 31 district and six zonal monitors in Hajjah to

monitor nutrition services in HF and in mobile teams. Individual monitors are district and zonal health office staff who are given transport money and a daily allowance to conduct nutrition monitoring. All district monitors have to visit each HF every month. All zonal monitors have to visit each district under their jurisdiction every month.

By early 2013, after activating the monitors, 90% of HF monthly reports were received on time and there was significant improvement in stock-outs as observed by the HO and UNICEF.

Table 1 Prevalence of nutrition in Hodeidah and Hajjah since 2011⁶

	Hodeidah		Hajjah lowlands		Hajjah highlands	
	2011 SMART survey (November)	2014 SMART survey (March)	2012 SMART survey (May)	2014 SMART survey (May)	2011 SMART survey (December)	2014 SMART survey (March)
Global Acute Malnutrition	31.7%	18%	19.8%	18%	9.3%	9.2%
Severe Acute Malnutrition	9.9%	3%	3.7%	2.9%	0.9%	1%
Underweight	59.6%	50%	46.2%*	40.4%*		
Stunting	55%	63.5% (53.8% lowlands)	55%**	44.1%**	66%**	53.2%**

* These surveys included both lowlands and highlands as data were not disaggregated.

** The difference in the prevalence of stunting from 2011/2012 to 2014 decreased but not statistically (P<0.005).

⁵ Semi Quantitative Evaluation of Access and Coverage

⁶ All survey results are available at <https://sites.google.com/site/yemennutritioncluster/documents/nutrition-survey-reports>

community leaders were sensitised in both Hodeidah and Hajjah.

- In Hodeidah SAM enrollment increased from 8,878 (2012) to 21,026 (2014). Cure rates, initially 41% (2012), increased to 70% by 2014, while default rates decreased from 54% (2012) to 26% (2014). In Hajjah, SAM enrollment increased from 3,748 (2012) to 10,216 (2014). Cure rates increased from 61% (2012) to 81% (2014) and default rates decreased from 35% (2012) to 15% (2014).
- IYCF: The number of breastfeeding corners in health facilities increased from zero (2012) to 60 (2014) in Hodeidah and from one to 34 in Hajjah during the same period.

During the response the number of cluster partners increased from three to 21 partners from 2012 to

2014 (both international and local NGOs) in Hodeidah and Hajjah.

SMART surveys were conducted again in both Hodeida (March 2014) and Hajjah (May 2014).

The improvement in the nutrition situation in Hodeidah from 2011 to 2014 is believed to be largely due to the high coverage of nutrition interventions (64% in Jabal Ras district, May 2014), complemented by a range of multi-sectoral interventions being implemented in the same area. In Hajjah the limited change in the nutrition situation is thought to be due to the absence of multi-sector interventions (because of the lack of partners with capacity in multi-sectoral interventions) and the lower coverage of nutrition interventions (49% in Aslem district, May 2014).

Challenges from the 2012-2014 response

Integrated treatment and reporting of SAM and MAM

With different UN agencies providing support for each component of treatment of acute malnutrition, there was not always geographic overlap in the two

services as UNICEF and WFP prioritise districts differently. WFP has expanded its target area based on advocacy from the nutrition sub-cluster, and the sub-cluster coordinator continues to advocate with WFP for further expansion into areas where UNICEF is supporting treatment of SAM. Additionally, different reporting structures for treatment of MAM and SAM are used, with UNICEF providing support to district and zonal monitors and WFP providing support only at the governorate level. District-level monitoring has supported the development of a strong reporting system for SAM, yet reporting for MAM is less timely, specific and reliable.

Addressing stunting and prevention as part of emergency response

It was recognised that stunting was a problem in the situational analysis prior to 2012. The 2012-2014 SRP, while primarily focused on rolling out CMAM at district and community level, included a community component (IYCF and PHC interventions) to address the underlying causes of undernutrition. More emphasis was gradually being given over this time period to the community component, but increased insecurity limited roll-out.



Funding

Lack of funds for the nutrition response in general has been and remains a challenge. The reasons for such a funding gap are unclear, although some donors seem to be increasing interest. Funding gaps have resulted in areas with limited or no nutrition services (through HF, mobile teams or temporary HFs).

2015 conflict

Conflict increased significantly in Yemen in March 2015. Since then, basic infrastructure has been destroyed, populations have been displaced, fuel is in short supply, electricity is intermittent and unreliable, and transport of nutrition supplies is limited and sporadic. In response to the increased insecurity, international NGOs pulled international staff out of Yemen in April 2015.

The current crisis has affected all governorates more directly than in 2011-2014, when the conflict was centered in San'aa. Currently three districts in Hajjah are experiencing intense fighting and all HF in these districts have closed down indefinitely. HFs in Hodeidah generally remain open, although access is security-dependent.

In response to the escalation of conflict, the nutrition sub-cluster has had to revise its focus, shifting from the move to development-oriented health and nutrition programming back to a focus on emergency response. Essentially the response is comprised of the same interventions as in 2012-2014 across 23 sub-governorates, with an increased use of mobile teams and no community sensitisation activities due to increased insecurity.

On-going operational challenges

- **Lack of clear figures of IDPs (and continual movement).** Even though there are designated units to monitor population flux, continued insecurity has resulted in frequent movements, making it difficult to assess numbers of affected effectively.
- **Fuel.** Shortage of fuel has negatively impacted transport, delivery of supplies and implementation of mobile teams. In collaboration with other clusters, the Nutrition Cluster has advocated for and accessed alternative sources of fuel, including stock from private companies, government authorities, existing partners, the black market and renting vehicles already fuelled.
- **Supplies.** Insecurity has disrupted supply pipelines for Ready-to-Use Therapeutic Food. To overcome this, UNICEF procured additional supplies from Djibouti, delivered directly to Hodeidah by boat as all main airports were destroyed in early 2015. In-country transportation costs have increased due to limited fuel supplies and increased conflict.
- **Conflict.** Ongoing conflict has constrained access to affected and vulnerable communities. HFs within the three districts in Hajjah are under fire and have closed as most families have moved to other districts. The conflict situation and supplies are monitored daily by HF staff, communicated to the HO by mobile phone and reports are hand-carried to the HO.
- **Communications.** Communications are largely conducted by mobile phone and while all telephone companies are still working, coverage is limited in some areas. Electricity to charge mobile phones is also often scarce. Internet services are still available in Hodeidah and Hajjah, but provision is sporadic and generators are often used to ensure reliable internet connections, although these require fuel.
- **Partner capacity and staffing.** International staffs were evacuated out of the country in April and while most agencies involved in the Nutrition Cluster had strong local staff to take over activities and engage directly with the nutrition sub-cluster, decision-making is still conducted by international staff, remotely. This has resulted in delayed decision-making and reporting. LNGOs (30% of nutrition cluster partners in Hodeidah and Hajjah) have been involved in the response since 2012 and continue to play their role in service delivery, based on their expertise and capacity.

Learning

Yemen is a complex and challenging country that has achieved significant scale-up of nutrition services, particularly in treating acute malnutrition, despite increasing conflict and limited access. The following points of learning from this experience have been identified:

- Importance of local NGOs in service delivery. A nutrition response should seek to identify, build capacity and utilise local NGOs from the outset for implementation and to support the eventual transition of cluster activities. The default position tends to be on mapping capacity of international NGOs only on the basis that they may have more capacity to respond to a crisis and have global support. However, as has been shown in Yemen, international NGOs often have limited access in a crisis, with local NGOs able to provide more continuity of response. It is therefore important to focus explicitly on local NGOs in capacity-mapping exercises. Where international NGOs are involved in supporting the response, provision should be made and responsibility taken to build capacity of local NGOs where needed, with the aim of ensuring handover of services at some future point.
- Importance of building local government capacity. While it can be challenging to build local government capacity, long-term impact can be significant. The development of local government-run mobile teams to implement nutrition service delivery has allowed for high coverage and development of governorate health staff for significantly less cost than an international NGO-run mobile team. Additionally, training local health officials in monitoring and providing them with daily allowances to conduct monitoring has greatly improved reporting. Building capacity of local government in logistics and transport can facilitate future transition of services (and implementation in insecure areas).
- Integration of treatment and reporting for SAM and MAM. Geographic integration of MAM and SAM services remains low (25%), presenting a huge challenge for service delivery. While joint planning was conducted, shortage of funding



Julien Harnois / 2015

(WFP) and different geographic areas of priority between UNICEF and WFP limit actual overlap of services. Advocacy is required at all levels to ensure integration of service delivery, even if this means a 'one agency/one programme approach'. Standardised reporting of both SAM and MAM programmes is useful and has been achieved through open discussion and flexibility of partners.

- Addressing stunting through prevention initiatives as part of emergency response. In the high-stunting context of Yemen, it was recognised that emergency response had to address stunting in some way. Initial response in Hodeidah and Hajjah therefore included prevention activities like IYCF and capacity-building for health facilities. Community outreach activities were planned, but increased conflict and insecurity halted these efforts from March 2015 onwards. If the conflict had not escalated, the nutrition response would probably have transitioned more effectively into development-type programming. The high level of stunting in spite of decreased wasting in Hodeidah raises the issue of how to treat and prevent stunting in this kind of complex emergency.
- Multi-sectoral programming. The multi-sectoral response in Hodeidah resulted in a more significant improvement in the nutrition situation than that of the vertical nutrition response in

Hajjah. The multi-sectoral response was possible due to a strong National Nutrition Cluster Coordinator, continued advocacy across sectors at national and governorate level, and the capacity of partners to carry out nutrition-sensitive interventions.

- Engagement in the SUN Movement. Nutrition Cluster engagement in the SUN movement is critical to ensure that emergency preparedness and response is part of the national multi-

sectoral plan. While motivated individuals within the Nutrition Cluster can support this process on an ad-hoc basis and achieve good results, engagement with SUN should be institutionalised within the Nutrition Cluster at national level. Additionally, it is apparent that intense conflict and political unrest can slow down progression of SUN processes, as evidenced by the lack of movement in endorsing SUN budget lines within the national budget.

Conclusion

Nutrition coordination in Yemen remains challenging, given the continued violence and insecurity that are restricting movement and programming. However, local government and agency staff are committed and working hard to implement nutrition services where security permits.

When and if a political solution is found and security improves, there is hope that the SUN multi-sector plan that covers both emergency preparedness and development initiatives will receive renewed attention and serve as a guide for improving nutrition outcomes for the people of Yemen.



Brekke Truls