**GLOBAL ACTION PLAN ON CHILD WASTING**

**Country Operational Roadmap**

**Yemen**

## CHILD WASTING: GLOBAL TARGETS AND NATIONAL PREVALENCE

**SUN Yemen**

| | |
|---|---|
| Global Target (2030) | 7% |
| Global Target (2025) | 11.50% |
| Current National Prevalence (Yemen National Health and Demographic Survey (YNHDS) 2013 | 16.30% |

## CHILD WASTING: A NATIONAL AND SUB-NATIONAL SNAPSHOT

| National | Sub-National (Second Tier Administrative Boundaries) | | Current (%) | 2025 Target (%) |
|---|---|---|---|---|
| Yemen | Al-Hodeida | | 31.00% | 21% |
| | Abyan | | 27.00% | 19% |
| | Lahj | | 24.00% | 17% |
| | Taiz | | 23.00% | 16% |
| | Haja | | 21.00% | 15% |
| | Dhamar | | 20.00% | 14% |
| | Al-Mahwait | | 19.00% | 13.30% |
| | Al-Dhale | | 18.00% | 12.6 |
| | Sadaa | | 18.00% | 12.6 |

**BACKGROUND**

**Background:**

**Acute malnutrition**: is a major public health problem in Yemen associated with very high rates of morbidity and mortality. Even before the 2015 outbreak of widespread conflict, Yemen was experiencing extreme and protracted poverty and humanitarian needs. The economy has shrunk massively, resulting in decreased public service delivery capacity across sectors. As a consequence, Yemen is experiencing the largest humanitarian crisis in the world. In 2019, the United Nations (UN) estimated that 24.1 million people—80 percent of the population—were in need of humanitarian assistance, of which 10 million were one step away from starvation.

In 2013 the Yemen National Health and Demographic Survey (YNHDS) found that 16.3 percent of children under 5 years of age in Yemen were wasted and 5.2 percent were severely wasted. Boys showed higher wasting rates than girls (17.8 percent and 14.4 percent, respectively), and children from rural areas showed higher rates than their peers from urban areas (GOY MOPHP and CSO and PAPFAM, 2013). According to the recent mix of 2016/2017/2018 and 2019 SMART surveys, of the 21-livelihood based SMART surveys conducted in 12 governorates representing 165 districts in Yemen, 8 of the surveys indicated a deteriorating nutrition situation, 9 remained in the same level and only 4 indicated an improvement. In 2021, overall 16 percent increase in global acute malnutrition caseload at national level from 1.96million in 2020 to 2.26million children.

Over 2.25 million cases of children aged 0 to 59 months, and more than a million cases of pregnant and lactating women, are projected to suffer from acute malnutrition in the course of 2021 in Yemen. Among them, 21% of were under 6 months of age, 26% were found suffering from wasting and referred to the appropriate nutrition programmes, Hodeida and Taizz had the highest proportions of acute malnutrition, and 47% were underweight.

**Chronic malnutrition (stunting)** remains of high concern affecting 45% of screened children, and exclusive breastfeeding among infants under 6 months of age shows very low average rates (11%), which still lags behind the WHO global targets 2025 (at least 50%) suggesting causal linkages between suboptimal breastfeeding practices and high levels of acute and chronic malnutrition.

Sub optimal IYCF practices significantly increases the risk of acute and chronic malnutrition and micronutrient deficiencies. Based on the 2013 DHS report, only 10.3 per cent of infants under 6 months were exclusively breastfed, and only 59.7 per cent of children 6-9 months were given timely introduction of complementary food.

Furthermore, 2.3 million of PLWs and 4.7 million of children under 5 need micronutrient supplementations, considering that anemia prevalence in children aged 6-59 months is 86 per cent and in PLWs 71 per cent. The total population in need of nutrition services is estimated to be about 7.1 million relatively similar to 2018 estimates based on under-fives in need of micronutrient supplementation and PLWs that in need of IYCF counseling.

Aiming to address direct, underlying and basic causes of malnutrition, the MSNAP is structured around three main priority areas: i) Increase in access and utilization of nutrition-specific services and sensitive interventions. This includes improving infant and young child feeding practices, preventative and curative nutrition, maternal and child health and nutrition interventions; 2) Increase in access to nutrition-sensitive activities. This comprises the areas of social protection; food production; processing and retail; fisheries; water, sanitation and hygiene; and education and school-based interventions; 3) Strengthening government leadership, national policies and capacities.

Yemen hosts over 141,000 refugees and asylum seekers in almost all governorates but majority are in Aden, Sana'a and Hadramout. In addition to a refugee camp in Lahj governorate. Majority of refugees are from Somalia. UNHCR provides health and nutrition support to Kharaz camp clinic and two governmental clinics- in Aden and Sana'a.

Depletion of government funding resulted in a discontinuation of many public services, including health and education. Furthermore, food insecurity is driven by high food prices, unemployment and disrupted livelihoods, which are exacerbated by the economic crisis. Currency fluctuations, fuel shortages and an increase in national prices provide an additional burden on the economy and increase households' expenses, hence jeopardizing households' access to food. Domestic agriculture, livestock and fish production has the potential to contribute to improvements, but Yemen's actual domestic production only covers around 25 to 30 percent of its actual food needs, and there is a high reliance on imports where, for example, 90 percent of the wheat consumed is imported.

Women's social and economic empowerment also has a strong impact on family and child welfare, and the low status of women and poor maternal reproductive health continues to impact malnutrition. In addition, early, frequent and closely spaced pregnancies affect maternal health, as well as pregnancy outcomes. There has been an increase in a number of risk factors, including maternal malnutrition, continued high numbers of teenage pregnancies and poor access to adequate pre- and postnatal care services in a number of governorates.

**Child malnutrition** causes about 40 percent of childhood mortality globally (Independent Expert Group of the Global Nutrition Report, 2018). The United Nations Inter-Agency Group for Child Mortality Estimation put the figures for child mortality per 1,000 live births in Yemen at 55.4, 43.2 and 27.0 for children under five years of age, infants and neonates, respectively, in mid-2017 (World Bank, 2016). As of November 2018, an estimated 85,000 child deaths from malnutrition and associated diseases had occurred since the conflict escalated (Dyer, 2018). Causes of malnutrition in Yemen include deterioration of food insecurity, limited access to WASH and health services, poor infant and young feeding practices, high prevalence of morbidities (Malaria, diarrhea, respiratory infections among under-fives), the ongoing conflict, other various economic shocks and further compounding impact of COVID-19 pandemic.

Substantially higher levels of all childhood morbidities (diarrhea, acute respiratory infections, unspecified fever) have consistently been reported across SMART surveys conducted in Yemen from 2015 to 2019. The recent cholera outbreak in Yemen was the largest recorded since epidemiological records began, with immense consequences to human life and well-being. Rates of infection remain high. The cumulative total number of suspected cholera cases between January 2018 and 1 September 2019 only was almost a million (991,674), with a fatality rate of 0.14 percent, accounting for 1,350 deaths. One-quarter of those cases were children under 5 years of age. The outbreak is widespread, having affected 305 of 333 districts in Yemen by September 2019 (WHO, 2019). The YNHDS reported only 10.3 percent of infants were exclusively breastfed for the first 6 months of life. Only one-fifth of children between 6 and 24 months of age met the recommended Minimum Dietary Diversity.

Inadequate food consumption, referring to an inadequate quality and quantity of the daily diet, is one of the key drivers/causes of child and maternal undernutrition. Hunger and inadequate food intake are widespread in Yemen. The percentage of households experiencing hunger, at least for one night over the month prior to the survey, increased dramatically from 13.5 percent in 2014 to 43.0 percent in 2016. Only 37 percent of the households consumed an acceptable diet in 2016. This indicates a steady decline in the quality of the diet from 2014, 2011 and 2009, when 59, 66 and 68 percent of households, respectively, were found to consume an acceptable diet (WFP, FAO, UNICEF, Food Security Cluster and GOY, 2017).

A national survey conducted in 2016 found the food types consumed on a daily basis and most frequently in Yemen were staples such as rice, bread and pasta, as well as sugar and fats. Other food items that are highly recommended and important sources of essential vitamins, minerals and proteins—such as pulses, vegetables, fruits or animal-sourced foods—were found to be eaten less frequently. Eggs were reported not to be part of the diet. Households of poorer or borderline consumption consumed bread, sugar and fats equally often but other nutritionally valuable items less frequently. Approximately half of households did not meet their energy requirements, and almost two-thirds of the households (62 percent) reported reducing the number or meals and portion sizes as a consequence of the rising food shortage (WFP, FAO, UNICEF, Food Security Cluster and GOY, 2017). Data on food consumption in Yemen disaggregated by gender is sparse. The Minimum Acceptable Diet for Women was assessed by the WFP's regular Vulnerability Analysis and Mapping exercise amongst a relatively small sample of 432 women in May 2019. Results showed that more than 90 percent of the women surveyed did not reach the minimum requirements of consuming at least five out of the ten food groups, and 75 percent consumed only three food groups, indicating serious shortcoming in the quality of women's diets (WFP and World Bank, 2019).

The majority of food for household consumption in Yemen is either purchased from markets, using household income and cash-based payments or credits, or received through community or local support networks. Humanitarian food assistance has also become increasingly important, reaching about one-third of the population in 2019, or approximately 6 to 7 million people, on a monthly basis. The Social Welfare Fund (SWF) supports approximately 9 million most vulnerable households with payments covering about one-third of the cost of a minimum food basket. About nine out of ten beneficiaries use those transfers to purchase basic foods (FEWSNET, 2019a).

**Key drivers:**

The UNICEF conceptual framework identifies three levels of causes of malnutrition which are contributing factors to acute malnutrition that are common in the majority of the zones and typically co-exist. These can be categorized as:

**I. Immediate causes**: operating at the individual level as:

1. **High prevalence of communicable diseas**es is one of the most common immediate causes of acute malnutrition among children. Two in every five children were suffering from diarrhea in the north and one in four children was affected by diarrhea in the south. About 60% of the children in the north and 25% of the children in the south were affected by malaria/fever. More than 50% of the children are affected by Acute Respiratory Infections (ARI) in the north and more than 25% in the south. High morbidity burden in some of the zones are also linked to disease outbreaks, such as suspected cases of cholera, particularly in governorates – Abyan, Marib, Hodeidah, and Hajah – that were affected by extensive flooding during the rainy season.
2. **Poor quality and quantity of food consumption** among children is a major contributing factor to acute malnutrition. Minimum Dietary Diversity is less than 40% in the north and around 50% in the south, indicating low levels of nutrient adequacy in children's food consumption.

**II. Underlying causes: influencing households and communities**

1. **Elevated levels of acute food insecurity** is a major contributing factor to acute malnutrition, both in the north and in the south. While all the 22 zones in the north are projected to be in IPC Acute Food Insecurity Phase 3 or above, 17 of the 19 zones in the south are most likely to be in IPC Acute Food Insecurity Phase 3 or above between January and March 2021.
2. **Poor Infant and Young Child Feeding practices:** The exclusive breastfeeding prevalence is <35% across all zones in the north and it is <25% in more than 60% of the zones in the south.
3. **Poor access to nutrition and health services** as a result of the conflict is a major problem in several zones. In addition, a decline in access and utilization of health and nutrition services as a result of the COVID-19 pandemic has been noted across all zones. As of July 2020, there was an estimated 25-49% decrease in health programme coverage, severely reducing the provision of routine health and nutrition services. This pattern was not only attributed to reduced utilization due to fear and anxiety associated with contracting COVID-19 at the health facilities, but also due to disruption caused by floods and conflict in some places. Furthermore, the pre-existing vulnerabilities in the health sector, mainly related to inadequate and ill-resourced health facilities, the decrease in coverage of health and nutrition programme activities (nutrition screening at community level and inability of many children to access child health and nutrition services;) have further rolled back the gains made in preceding seasons. As a result, the majority of children below five years are at increased risk of acute malnutrition or experiencing further deterioration in their nutrition status.
4. **Poor water, sanitation and hygiene (WASH) servic**es are a major concern in all zones.

**iii. Basic causes around the structure and processes of societies:** These causes are the direct and indirect effect of COVID-19, economic shocks and conflict.

1. **The COVID-19 pandemic has caused a reduction in** remittances as a result of a number of factors. Lockdown in neighboring countries, reduced access to markets, difficulty maintaining employment and an oil price drop, affecting foreign currency contribution to the local economy, had a compounding negative effect on acute malnutrition. Fear and anxiety related to COVID-19 have been an impediment, although community awareness programmes have been mounted to increase the uptake of services.
2. **Economic shocks** such as delayed salary payments have also had an adverse effect on acute malnutrition by reducing household purchasing power and impacting food consumption.
3. **The escalating armed conflict** remains one of the main root causes of acute malnutrition during the current analysis period in several zones. New conflicts in Marib and Al Jawf have caused displacement, especially in Marib city, which was already hosting more than half a million IDPs before the conflict. Surrounding governorates, in particular Ad Dhale'e and Al-Bayda, are expected to receive an influx of new IDPs due to the new conflict in Marib and Al Jawf. The conflict not only affects the delivery of health and nutrition and other humanitarian interventions, but also the markets and supplies. Additionally, new and protracted conflict has caused damages to livelihoods.
4. **Several natural disaster**s occurred during the period of January to July 2020. They include flooding and desert locusts that have negatively impacted nutrition by affecting food supplies to the markets and households, particularly in Marib Rural, Aljawf and part of Hadramout.
5. **Humanitarian food assistance programmes w**ere halved in parts of the country because of funding cuts in April 2020 due to the worldwide spread of COVID-19. The halved rations continued during the analysis period. Furthermore, access has been limited in some areas, particularly those affected by conflict such as Marib and Al Jawf.

**GAP Roadmap and SDG**s:

The sectoral plans for achieving the SDGs have a strong focus on improving the nutrition situation. The nutrition interventions go beyond the SDG2 in tackling undernutrition and hunger and play a critical role in the transformation of the global agenda where nutrition is in the heart of sustainable development. Linkages between SDGs 1,2 and 3 are broad-spectrum in ensuring access to basic services and easing the global and national efforts to end poverty. The Yemeni government is stressing that successful nutrition interventions are a prerequisite for successful emergency response and health and sustainable development.

**Goal:**

By 2030, End all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

Indicators:
• Prevalence of undernourishment.
• Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale (FIES).
• Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age.
• Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight).
• Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (percentage).

**Yemen Operational Roadmap's Goal:**
Reduce all forms of malnutrition in Yemen and ensure Yemeni children reach their full potential and contribute to the social and economic development of their families, communities and country.
Strategy and Methodology:
Considering that the underlying causes of maternal and child morbidities are critically linked to the nutritional situation among women and children, this roadmap strategy focusses on the required advocacy efforts to enhance multi-sectoral coordination as part of the SUN-Yemen interventions. SUN movement promotes the positioning of nutrition agenda in the center of national planning for development for achieving nutrition security and resilience.
The Global Action Plan on Wasting has identified specific effective and cost-effective pathways to achieve 4 outcomes. These four pathways will not be the only approach that will be required, and it is anticipated and encouraged to adopt more actions across other complementary pathways. Nevertheless, these pathways will represent the primary focus of the collective response and as such, they provide the key path for identifying operational priorities and the individual commitments towards this Plan. Finally, in developing and implementing the GAP on Child Wasting, seven common principles will drive the process:
1. Promote government leadership and ownership of prevention and treatment of wasting in all contexts and at all levels.
2. Re-position prevention at the center of our collective efforts to reduce the number of children suffering from wasting and increase the efficiency of our collective efforts.
3. Prioritize scalable responses that are cost-effective, efficient and designed to be practical and feasible at scale, increasing access to hard-to-reach populations.
4. Enhance the life cycle approach to ensure inclusion of adolescents, pregnant women, breastfeeding women, infants 0-5 months and children 6-59 months in prevention, protection and treatment.
5. Ground the design of wasting interventions on key present and future factors that impact on wasting, including urbanization, climate change, demographics shifts and increasing inequalities.
6. Commit to gender, equality, women's empowerment, community participation and ownership and inclusion of excluded groups and responsiveness to special needs, including populations on the move.
7. Encourage iterative action and learning, acting on what we already know and gradually adapting on the basis of emerging evidence and data to ensure maximum effectiveness.

**In Yemen, the four outcomes list the priority interventions attributed to the most relevant system:** health, food, water, hygiene and sanitation, or social protection.
Nutrition security approach has two arms as strategy, immediate lifesaving intervention in one arm and long term intervention on the other arm through MSNAP sets out key priority actions across sectors which have been identified by the government and partners as being most likely to have an impact on the nutrition status of the population . Thus, the intervention across the districts/governorates for both the immediate/short-term and sustainable/longer-term timeframe based on:
• The situation analysis: specific response actions focusing on prevention, treatment, WASH, infrastructure development, integrated primary health care services, social and behavior change communication, strengthening data collecting& information systems and improving monitoring will then need to be outlined along with resource requirements for each governorate/ zone through an integrated multi-sectoral response analysis.
• Establish, promote and strength multi-sectoral engagement, closely cooperation and collaboration to ensure coordinated efforts and synergy to address acute malnutrition.
• Policies, guidance's, legalizations, capacity mapping , capacity building ,Data collecting ,need assessments , supplies ,resources mobilization and planning ,coordination and cooperation implementation ,M&E ,control ,better together .

**i. Immediate/short term Intervention**: for host and IDP communities in need of treatment (GAM >15%) as the following activities:
**Nutrition activities: Assessment, Prevention and Treatment**
• Implement Blanket Supplementary Feeding Programmes (BSFP) targeting vulnerable groups (U2 and PLW) for prevention of malnutrition based on solid needs assessment and identified gaps in priority locations;
• Strengthen CMAM program - ensuring optimal coverage of SAM and SAM with medical complication and MAM treatment, expansion of appropriate treatment services based on solid needs assessment and identified gaps; and strengthening community screening and referrals from community to facility and from Out-patient Therapeutic Programmed (OTP) to Therapeutic Feeding Centre (TFC) (support transport and caregiver costs);
• Strengthen Micronutrient Powder supplementation programme (Iron and folate for PLW and Vit A for children <5 y).
• Strengthen IYCF messaging and counselling at HFs and community level;
• Plan for timely nutrition assessments including the Nutrition SMART surveys, integrating and mainstreaming key nutrition indicators in multi-sectoral assessments.
**Health activities**:
• Continue provision of primary health care including vaccination services and referrals of medically complicated cases of acute malnutrition;
• Scale-up of health system capacity especially in under-covered zones including areas with IDPs, including the use of mobile clinics for health and nutrition service delivery;'
• Ensure adherence to Infection Prevention and Control procedures during healthcare interaction, provision of nutrition services, assessments and surveys, to protect
• Nutrition/health workers and populations from risks of exposure to COVID-19;
**WASH activities:**
• Strengthening WASH interventions including e.g. water chlorination, distribution of chlorine tablets for water chlorination and handwashing;
Social and community:
• Scale up efforts for community awareness-building on COVID-19, children health and nutritional need for a healthy growth and engagement with the relevant authority to mitigate the likely impact on food and nutrition security.
**ii. long term Intervention:**
**Health Intervention:**
• Advocate for strengthening disease surveillance and maintain updated preparedness and response plans for health outbreaks and seasonal increase of malnutrition;
• Strengthen resilience and shock recovery action to reduce the impact of flooding in low lying areas – e.g. Hajjah Lowland

**GEOGRAPHIC PRIORITY AREAS**

Based on the IPC AMN current analysis, covering 35 zones between January and July 2020, seven zones were in Alert (IPC AMN Phase 2), 26 zones were in Serious (IPC AMN Phase 3), and the remaining two were in Critical (IPC AMN Phase 4). The two zones with Critical levels of acute malnutrition were Taizz Lowland and Hajah Lowland. More than 80% of the zones (28 of the 35 zones) were in IPC AMN Phase 3 or above during this analysis period, indicating severe conditions. It should be noted that there were several districts within the zones with higher acute malnutrition than the zonal average, but the quality of the data on acute malnutrition outcomes at the district level is deemed inadequate to classify these districts.

The period of August – December 2020 was characterized by a significant deterioration in the acute malnutrition situation. While two zones were projected to be in Alert (IPC AMN Phase 2) and 20 zones in Serious (IPC AMN Phase 3), 13 zones were projected to be in Critical (IPC AMN Phase 4). A total of 33 zones (more than 90% of the areas analyzed) were projected to be in IPC AMN Phase 3 or above in the projection period, compared to 28 in the previous analysis period. An additional analysis of 22 zones in the north for the period of January – March 2021 (for which adequate data is available) suggests that all the 22 zones will most likely be in IPC AMN Phase 3 or above between January – March 2021. Seven of the 22 zones are expected of to be in IPC AMN Phase 3 with Serious levels of acute malnutrition and the remaining 15 zones will most likely be in IPC AMN Phase 4 with Critical levels of acute malnutrition. It should be noted that this additional analysis was not feasible for the zones in the south because of lack of data that meet the IPC AMN criteria for such analysis.

According to IPC classification in 2020, there are 192 high priority districts(deteriorated) within 19 governorate of Yemen as included in the file #1.
Furthermore , and based on projected caseload of acute malnutrition from Jan to Dec2021 (GAM prevalence), the high priority governorate/districts will be classified into 4 sub group as :
**a) The Highest Priority governorates GAM% >20**
Number of Governorates is 6 , as the fallowing:
- Al-Hodeida with GAM% 31,
- Abyan lowland 27.
- Lahj lowland 24 (Refugee camp located in this governorate).
- Taizz Lowland 23.
- Hajja lowland 21.
- West Dhamar 20.

**b) The higher Priority governorates/Districts: GAM% between 15- 19**
Number of governorates is 11, as the fallowing
- Al-Mahwait lowland with GAM% 19.
- Al-Dhalei 18.
- Sada'a lowland 18.
- Taizz highland and city 19&17.
- Aden 17 (Presence of Urban refugees in Darsa'ad).
- Costal Hadramaut 16 (Presence of Urban refugees).
- Hajja highland 16.
- Marib city 15.
- Socotra 15.
- Al-Jawf 15.
- East Dhamar 15.

c) The high Priority governorates/Districts: GAM% between 10-14
Number of governorates is 11 , as the fallowing :
- Abyan highland with GAM % is 14.
- Amran 13.
- Al-Baydaa 13.
- Lahj highland 13.
- Raymah 13.
- Sada'a highland 12.
- Sana'a 11. (Urban refugee's presence)
- Shabwah 11.
- Marib - Rural 11
- Valley Hadramaut 10.
- West Ibb 10.

d) The low Priority governorates/Districts: GAM% <10
Number of governorates is 3, as the fallowing:
- East Ibb, with its GAM % 9.
- Highland Al-Mahwait 8.
- Al-Ma

In addition to above of IPC classification, the selection criteria used, should have included (but not limited to) for the high priority governorate/district in YAP operational roadmap:
- High prevalence of Global Acute malnutrition, Severe acute malnutrition and Stunting.
- High rates of maternal malnutrition, low birthweight and complementary feeding practices, SAM caseloads.
- Health vulnerability matrix, HeRAMS.
- Food insecurity levels and/or quality of diets (e.g. household minimum dietary diversity or minimum dietary diversity of women of reproductive age).
- Valid Need assessments findings,
- TFPM and presence of the most vulnerable populations including displaced or refugee populations or other affected people mentioned above.
- HNO findings,
- MOPHP and related authority's data.
- WASH gap analysis and cholera priority mapping.
- High priority of H, N, FS&WASH gaps interlinked critically.
- Availability of government and partners.
- No access constraints (security, physical and administrative).

**OUTCOME 1. REDUCED LOW BIRTHWEIGHT BY IMPROVING MATERNAL NUTRITION**

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|---|---|
| Global Target (2025) | **By 2025, reduce low birthweight by 30%** |
| National Target (2025) | 16.1 |
| Current National % of Low-Birth-Weight newborns (2020 or most recent data) | 23 |

**OUTCOME 1: OPERATIONAL FRAMEWORK**

| System | National Policy Commitment | Operational Accelerator for: [Name of sub-national area] | | | Stakeholder Support | |
|---|---|---|---|---|---|---|
| | | Intervention | Delivery Platform | Target Population | Responsible | Non-Government Support (e.g., UN Agencies, Civil Society, Donors, Academics) |
| Health | Iron and Folic Acid supplementation for pregnant and lactating women (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021 - 2030) | Micronutrient Supplementations (Iron folate) | HFs/Community | PLWs | National Government (MoPHP) responsible for coordination and supervision<br>Local Government (GHO,DHO) responsible for regular request the quantities | Nutrition and FSAC clusters/<br>WFP/UNICEF responsible for provide the quintities and transportation, UNHCR responsible for provision and transportation of supplies to the UNHCR's supported clinics /WHO technical support<br>NGO responsible for provide the quintities and transportation<br>Community leaders |
| | Infants born safely at health facilities having received appropriate antenatal care support (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021 - 2030) | Promote Skilled birth attendants/deliveries in Health Facilities | HFs/ community | Skilled birth attendants/CHVs | Ministry of Public Health and Population (MOPHP)<br>Governorate Health Offices (GHO)<br>Distrect Health Offices (DHO)<br>Local councils | UNICEF/WHO<br>NNGOs / UNHCR /INGOs |
| | | Promote antenatal care and Post-natal Care | HFs/ community | PLW / Children <1y /HWs | MOPHP/Governorate Health Offices (GHO)/Distrect Health Offices (DHO)<br>Local councils | UNFPA/UNICEF/WHO/UNHCR<br>INGOs/NNGOs |
| | Scale up quality and quantity of sexual and reproductive health and family planning services with special emphasis on reducing teenage pregnancies and LBW prevalence (Multi-Sectoral Nutrition Action Plan - 2021-2023/ National maternal and child health strategic plan 2021-2025) | Develop/Update a national Guid/action plan addressing the adolescents and youth RH issues including early pregnancy and back to schools as well | National Level/Community | National level/local authorities/Officials/leaders | National Government (MoPHP) responsible for coordination/Implementation/supervision.<br>National Government (MoPHP) responsible circulate the laws/ print and transportation the brochers .<br>Governorate authorities responsible for laws enforcement control/Local Government (GHO,DHO) responsible for selection CHNVs and the implementation<br>Local councils | Unicef responsible for technical support /Donars responsible for costs<br>INGOs/NNGOs responsible for activity implementaion |
| | | Set up youth friendly Reproductive Health services, BMI assessments, MUAC screening and Hemoglobin in universities and community level | Universities/community level | University- aged ladies/PLW | MOPHP/Ministry of High Education (MOHE)<br>Gove Universities<br>Local councils | UNICEF/WHO responsible for technical support / Donars responsible for costs<br>NGO responsible for activity implementaion |
| | Prevention of malnutrition in pregnant woman (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021-2030) | MUAC screening of all Pregnant and Lactating women | Community | PLWs | MOPHP/GHO/DHO | UNICEF/WHO<br>NNGOs/INNGOs/UNHCR<br>Nutrition cluster<br>Community leaders |
| | | Treatment and Prevention of acute malnutrition in pregnant and lactating women | HFs/community | PLWs | MOPHP/GHO/DHO | UNICEF<br>WFP/ UNHCR<br>FSAC/Nutrition clusters<br>Community leaders |
| | | Promotion of Adolescent/teen Girls' Nutrition In Yemen (School-base and out-of-school activities) | Schools | school-aged girls | Naional government, coorindation and supervision.<br>Ministry of Education (MOE)<br>Local Government responsible for implementation and supervision<br>MOPHP | UNICEF responsible for technical support and provide the Iron folic icid /WHO technical support & deworming and WFP for school meal<br>NGO responsible for activity implementaion |
| Food | Strengthen food value chains that aim to increase the accessibility and affordability of sustainable healthy diets for women of reproductive age (minimum diet diversity with an emphasis on animal source foods, pulses, fruits and vegetables and fortified foods as needed) (Multi-Sectoral Nutrition Action Plan - 2021-2023) | Establish and support small and medium sized enterprise projects for women and youth groups within the framework of the Agricultural and Fisheries Production Promotion Fund | Costal /Rural Communities | Women in reproductive age 15-49y | MOPHP / Ministry of Agriculture and irrigation (MOAI)<br>Ministry of Fishe Wealth (MOFW)/<br>Social Fund for Development (SFD)<br>Local Authoritis<br>Social Welfare Fund (SWF)<br>Micro Finice Institutions (MFIs) | World Bank/USAID<br>EU/UNDP<br>FAO/WFP<br>ACF<br>FSAC<br>MFIs<br>Community leaders |
| | Develop general training and extension programs for rural and coastal women to increase productivity in horticulture, livestock rearing, dairy products, beekeeping, and community and credit organization (National Agricultural Sector Strategy (2012-2016)) | Promotion of diversified agriculture and fisheries production targeting women households | Costal Community | Women in reproductive age 15-49y | MOAI/Sana'a Uni/SDF/Micro Finice Institutions(MFIs) | EU/UNDP<br>Enterpren/MFI<br>FAO/WFP |
| Social Protection | Improve the use of school platforms to support efforts to reach adolescent girls with school feeding and education/messaging around nutrition and reproductive health (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021 - 2030)) | Establishing Healthy School Meals Kitchens | girls Schools | School girls from 10 -18 | MOPHP/MOE - School feeding Dep<br>Local authorities | UNICEF/WFP<br>NNGOs & INNGOs |
| | Conditional cash incentives for families of girl students (Multi-Sectoral Nutrition Action Plan - 2021-2023) | Provision of conditional cash incentives for families of girl students | Households wih girls Slums | Familes with girls<br>The most poor and morganalised girls and women from 15-40y | MOE/SWF/SFD<br>Ministry of Planning, implementation, standardized M&E<br>Ministry of Technical Educaction and Vocational Training/MFIs/Ministry Of Social Affairs and Labor /Al-Amal Microfinice Bank | UNICEF /WFP Partners: Support with funding, planning, implementation, standardized M&E<br>Food Security and Agricultural Cluster<br>local community/<br>Al-Amal foundation,SMEPS,..ect |
| | Increase quantity and quality of sanitation facilities (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021 - 2030)) | Provide water tanks, clean safe drinking water and enhance the healthy nutrition and hygiene practices in the targeted schools | MOE/Schoold | School girls/boys from 10 -18 | MOE/MOPHP /Ministry of Planning (MOPIC) | GIZ / UNICEF<br>WASH/Edu/H and Nutrtion cluster<br>INGOs/NGOs |

**OUTCOME 2. IMPROVED CHILD HEALTH BY IMPROVING ACCESS TO PRIMARY HEALTH CARE, WATER, SANITATION AND HYGIENE SERVICES AND ENHANCED FOOD SAFETY**

| | |
|---|---|
| **Global Target (2030)** | **By 2030, achieve universal health coverage, including access to quality essential health-care services for all** |
| **National Target (2025)** | **54,6** |
| **Current National Universal Health Coverage Index** ***(2020 or most recent data)*** | **42** |

**OUTCOME 2: OPERATIONAL FRAMEWORK**

| System | National Policy Commitment | Operational Accelerator for: [Name of sub-national area] | | | Stakeholder Support | |
|---|---|---|---|---|---|---|
| | | Intervention | Delivery Platform | Target Population | Responsible | Non-Government Support (e.g., UN Agencies, Civil Society, Donors, Academics) |
| Health | Strengthening Integrated Management of Childhood Illness (IMCI); (National Children and Youth Strategy of the Republic of Yemen 2006 – 2015/ National Child Health Priorities action plan 2021-23) | Provision of Integrated Management of Neonatal and Childhood Illness (IMNCI) - special focus on diarrhea, pneumonia, malaria in endemic areas) | Community/HFs | HWs/U5 children | MOPHP: coorindation and supervision /GHO/DHOs | Unicef responsible for technical support<br>Donars responsible for costs<br>NGO responsible for activity implementaion and Nutrition cluster |
| | | Establishing the electronic child health information registry | PHCs,GHO,DHO | Information staff/Management staff | MOPHP/GHO/DHOs | Unicef responsible for technical support<br>Donars responsible for costs<br>NGO responsible for activity implementaion and Nutrition cluster |
| | | Provision and scale up of Minimum Service Package (MSP), (health and nutrition services) | 3rd level of targeted districts | Community/PLWs& U5 | MOPHP/GHO/DHO/Local Authority | WB<br>Unicef responsible for technical support<br>NGO responsible for activity implementaion and Nutrition cluster |
| | | Increase immunization coverage | National level/HFs/Community /Schools | National/U2 children | MOPHP/GHO/DHOs | Donars responsible for costs<br>UNICEF responsible for technical support and distroputionthe infrastructure and equipment<br>WHO/<br>NGOs/INGOs |
| Food | Capacity building on good dietary and food safety and hygiene practices, good nutrition in setting standards and institutionalizing best practices (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021-2030) | Reduce chemical risk in production by regulating use of agricultural chemicals (pesticides) | National/ Governorates level Agricultural institutes | Community /Agri technicians/farmers/ MoPHP | MOPHP/MOAI/MOTI /Yemen Standardization, Metrology and Quality Control Organization (YSMO)<br>National Committee for Regulating the Food Safety | WHO/FAO/IFAD<br>NGOs/INGOs |
| | | Purification of irrigation water from pest and fungal infections | Community level/National/ Governorates level | Community/U5 children/farmers/ MoPHP | MOAI/MOWE/MOTI<br>MOPHP/local authorities | UNICEF/ FAO/WASH/FSAC cluster<br>Oxfam/IFAD<br>NGOs/INGOs |
| | | Promote household and small scale food preservation and storage practices (targeting women) | HHs/Community | Rural women | MOPHP/MOAI/MOAFW/Agriculture College in Sana'a Univ | WHO/FAO/IFAD<br>NGOs |
| | | Revitalize the national Codex committee (Food hygiene and food regulation) | National level | Codex Committee members/ MoPHP | MOPHP/YSMO/MOAI/Agriculture College in Sana'a Univ | Donors to provide technical and financial support<br>FSAC/NNGOs/INGOs |
| | | Strenghthen national Food Safety interventions and Mobilizing and advocationg decision makers to include nutrition and food safety interventions in all relevant national development policies. | National level/Community | Nationa/IHHs/Community Food safety department in MOPHP | MOFW/MOAI/MOPHP/YASMO/MOWE/MOTI<br>Ministry of Law Affairs (MOLA) /MOAI<br>SFD/<br>/Ministry of legal Affairs (MOLA) | WHO/UNICEF/WFP/FAO ( Nutrition & Food Security) Clusters /<br>FSAC/EU/IFAD<br>WB/Codex Alimentarius<br>Academic ent |
| | | Establish a surveillance of food and water borne diseases | Community/ health facilities | HHs/community/ MoPHP/ GHOs | National Committee for Regulating Food Safety / MOPHP/YASMO/ | WHO/UNICEF/FAO<br>Academic |
| | | Enhancing community knowledge on food safety and hygiene practices | National and sub national | Community/ GHOs/ MoPHP | National Committee for Regulating Food Safety / MOPHP/YASMO/Ministry of Information (MOI)/Local authoritis | Donors to provide technical and financial support<br>WHO - FAO<br>FSAC/H&N clusters/NGOS/INGOs<br>community leaders |
| WASH | Improve WASH in schools and Community (Multi-Sectoral Nutrition Action Plan - 2021-2023) | Improve WASH sector capacity for multisectoral coordination and emergency response | National | National | MWE HRD Centre and specialized consultants<br>Water Sector, Environmental Sector and Partners<br>Water Agencies/MWE( Epidemological and water sector)<br>GARWAP/Water Agencies | UNICEF/WASH cluster<br>NGOs/INGOs |
| | | Provision of Safe drinking water to the vulnerable communities (including IDPs) | Vulnerable Communities | IDPs | MOWE/General Authority of Rural Water supply Projects-Emergency Unit local authorities/Local Water and Sanitation Corporations(LWSC) | UNICEF/IOM,UNHCR /UNOPS |
| | | Promotion of good hyiene and sanitation | Vulnerable Communities | Field team memebers/women prefere/IDPs/community | MOWE/GARWAP-ER/LWSC<br>Loacal authority | UNICEF/ Oxfam/CARE int<br>IOM, UNHCR /UNOPS<br>/NNGOs/INGOs |
| | | Rehabilitation and maintenance of all school toilet facilities | MOE/Schoold | Schoold age students | MOE/Ministry of Planning (MOP)/MOPHP | GIZ<br>UNICEF/WASH/Edu/H and Nutrtion cluster<br>INGOs/NGOs |

**OUTCOME 3. IMPROVED INFANT AND YOUNG CHILD FEEDING BY IMPROVING BREASTFEEDING PRACTICES AND CHILDREN'S DIETS IN THE FIRST YEARS OF LIFE**

| **Global Target (2025)** | **By 2025, the rate of exclusive breastfeeding in the first 6 months will increase up to at least 50% and at least 40% of children between 6-23 months consume a minimum diet diversity with an emphasis on animal source foods, pulses, fruits and vegetables** |
|---|---|
| National Target (2025) | 30 |
| National % Exclusive breastfeeding under 6 months (in 2014) *(2020 or most recent data)* | 20 |

**OUTCOME 3: OPERATIONAL FRAMEWORK**

| **System** | **National Policy Commitment** | **Operational Accelerator for: [Name of sub-national area]** | | | **Stakeholder Support** | |
|---|---|---|---|---|---|---|
| | | **Intervention** | **Delivery Platform** | **Target Population** | **Responsible** | **Non-Government Support (e.g., UN Agencies, Civil Society, Donors, Academics)** |
| Health | Improve Infant and Young Child Feeding (IYCF) practices (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021-2030) | Implement and expand Baby-Friendly Hospital Initiative - BFHI | Community/HFs/Hospitals of maternity and newborn | Academic maternal and Pediatric ,WHO,UNICEF experts. HF staff/Coordinators/HWs on IYCF services trained/Trainer's trained for BFHI in hospital/ | MOPHP/GHOs/DHOs local authorities/DHO/ | Donars responsible for costs UNICEF/WHO responsible for technical support NGOs/INGOs Academic schools,pediatric experts /Academic Universities,pediatric,maternity and newborn |
| | | Implement and expand Baby-Friendly Community Initiative- BFCI | MOPHP,GHO,DHO and Clusters Community/HFs/Hospitals of maternity and newborn Targeted Hospitals that providing IYCF services Targeted HFs providing IYCF services CLSs pharmacies and Community | Academic maternal and Pediatric experts HF staff/Coordinators/ CHVs in targeted hospitals HWs, CHVs, community HWs and Health staff Targeted Community MOPHP and H&N clusters staff PLW and U2 children trained/Trainer's trained for BFHI in hospital/ | MOPHP/GHOs/DHOs local authorities/DHO/ | Donars responsible for costs UNICEF/WHO responsible for technical support NGOs/INGOs Academic schools,pediatric experts /Academic Universities,pediatric,maternity and newborn |
| | | Maintain and scale up IYCF Corners services | National level/Tageted Hospitals of maternity and newborn services /HFs/Community/National and hub Clusters | HWs on IYCF services in maternity hospitals/PLWs-U2-U5Humanitarian Partners/decision makers in MOPHP/leaders,decision makers,officels/HFs Staff/ | National Government (MoPHP) responsible for coordination and supervision Local Government (GHO,DHO) responsible for supervision Ministry of Imfprmation (MOI) /local authorities/supportive clusters entities MOLA/lawyers | Donars responsible for costs UNICEF /WHO responsible for technical support Nutrition cluster |
| | | Strengthening monitoring BMS code violations | CenteralGovernmental/HFs providing counselling services /supervisors/ and Pharmacies/Private sector / Public sector service providers/ Media ( TV,Radio) | PLWs/Community / HFs providing counselling services /supervisors/ and Pharmacies/MoPHP,UNICEF,WHO partners/ | MOPHP/GHOs/DHOs MOLA/MOI/ | Donars responsible for costs UNICEF /WHO responsible for technical support Nutrition cluster Acdemic institutions,experts /gynecologists/Lawyers physicians/Pediatricians |
| Food | Support and scale up small scale food production and livelihood productions and diversification. (Multi-Sectoral Nutrition Action Plan - 2021-2023) | Promote home gardening programmes to produce nutritious foods, including seeds and mini-irrigation kits | Rural community | HHs,especially women | MOAI / MOAFW/SFD Agri offices/local authorities/ | FAO/WFP/IFAD/FSAC ACF/NNGOs community leaders |
| | | Cash support for small food industries for rural and coastal households | Rural HHs/ Community level | RURAL WOMEN/farmers/ | MOAI / MOAFW/SFD Agri offices/local authorities | FAO/WFP/IFAD/FSAC ACF/NNGOs community leaders |
| | | Development of Children's recipes for Complementary Foods | NationalCommunity | Women/Children 6 - 23 months | MOFW/MOPHP local authorities/ | FAO/WFP/FSAC NNGOs/INGOs community leaders |
| Social Protection | Improve access to age-appropriate nutritious, affordable and sustainable foods through social protection transfers (cash or in kind) targeting at risk children and women (GAP potential narrative statement adopted) | Cash vouchers,particularly targeted at improving dietary consumption of fruits and vegetables at household level | HHs/Community | PLW/U2 children | MOPHP/MOTI local authorities | FAO/WFP/SFD/UNDP/ACF Nutrition cluster&FSAC NGOs/INGOs |
| | | General food assistance (GFA) | OTPs/Community | U5 SAM cases Families | MOPHP/GHOs/DHOs/SFD/ local authorities | WFP/UNICEF/WHO/FAO |
| | | Cash vouchers to household targeting the 1000days | households | Children 0 - 23 Months/PLW | SFD/SWF/MOPHP/health centers to provid services for WOMEN | UNDP/Al-Amal Micrfinance Bank /ROWAD Org /REYADAH foundation |

**OUTCOME 4. IMPROVED TREATMENT OF CHILDREN WITH WASTING BY STRENGTHENING HEALTH SYSTEMS AND INTEGRATING TREATMENT INTO ROUTINE PRIMARY HEALTH SERVICES**

| | |
|---|---|
| **Global Target (2025)** | **By 2025, we will increase by 50% the coverage of treatment services for children with wasting** |
| **National Target (2025)** | **Increase 15% more coverage every year** |
| **National Coverage: Management of severe acute malnutrition (SAM) – Inpatient** *(2020 or most recent data)* | **SAM with complications Coverage against Annual Caseload 2019 was 35% compared with Annual caseload according to 2020 Nutritional cluster data.** |
| **National Coverage: Management of severe acute malnutrition (SAM) – Outpatient** *(2020 or most recent data)* | **SAM and MAM U% and MAM PLW Coverage against Annual Caseload 2020 was 52% and 40% and 45% respectly with cure rate 87% ,90% and 92% respectively(.according to 2020 Nutrition cluster data)** |

**OUTCOME 4: OPERATIONAL FRAMEWORK**

| System | National Policy Commitment | Operational Accelerator for: [Name of sub-national area] | | | Stakeholder Support | |
|---|---|---|---|---|---|---|
| | | Intervention | Delivery Platform | Target Population | Responsible | Non-Government Support (e.g., UN Agencies, Civil Society, Donors, Academics) |
| Health | Strengthen the integration of early detection and treatment for wasting as part of routine primary and community health care services and ensure referral systems are in place for appropriate management of wasting in children (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021-2030) | Development and improvement of nutrition curriculum for health institute and universities to include nutrition in the preservice training | National/GHO levels | Nurses/ Clinical officers/ Medical students/HFs Hws | MOPHP/Univ/GHO/DHOs | UNICEF/WHO/Nutrition cluster<br>NNGOs/INNGOs<br>Academic , experts |
| | | Activate the role of health supervisors and volunteers in improving the nutritional and health status of mothers and children through school-based activities | Central in Aden and Sana'a/Govermental&District level/Schools/Community | Health supervisors of schools/Community outreach teams& schools representatives /mothers&children | MOE /MOPHP/Schisostomaisis programm/MOE offices/GHO/DHO | UNICEF/WHO<br>Education and Nutrition Clusters /<br>GIZ/NNGOs and INGOs/H/N clusters |
| | | Activate the role of health supervisors and volunteers in improving the nutritional and health status of mothers and children through Health Facilities , community and school based activities improving the nutritional and health status of mothers and children through HFs , community and school-based activities | HFs/Community/TFCs/Targeted Districts | Children 6-23 month/6-59 months children /HWs/SAM Children 6-59 months/SAM complicated Children 0-59 months | National Government (MoPHP) responsible for coordination and supervision<br>Local Government (GHO,DHO) responsible for coordination and supervision<br>Local authorities/ | Donars responsible for costs/Nutrition clusters<br>WFP responsible for Provide the commudities<br>UNICEF/WHO responsible for technical support and TFCs operations<br>FSAC&Nutrition clusters/NGO responsible for activity implementaion/MSF |
| | Increase coverage, timeliness, reliability and availability of nutrition related data in Yemen (Multi-Sectoral Nutrition Action Plan - 2021-2023) / Draft National Nutrition Strategy 2021-2030) | Strengthen the nutrition surveillance system at all settings (HFs, community, schools and others) | National/Governorate/Community level | Centeral/gover nutrition surveillance team and health workers/ Survillance team/RRTs/Community outreach teams& schools representatives | MOPHP/National Survillance department/ Officials /GHO/DHOs/Local authorites | Donars responsible for costs<br>UNICEF/WHO responsible for technical support /INGOS/NNGOS<br>Nutrition cluster<br>community leaders<br>Academi nutritionist |
| | | Strengthen Nutrition Information Systems | National/GHO levels | Nurses/ Clinical officers/ Medical students/HFs Hws | MOPHP/GHO/DHOs/ SUN | Donars responsible for costs<br>UNICEF/ Nutrition cluster and WHO for TFCs dashboard and surveillance system<br>SUN<br>community leaders/Academic |
| Food | Establish and operationalise Food safety in MOPHP (Multi-Sectoral Nutrition Action Plan - 2021-2023/ Draft National Nutrition Strategy 2021-2030) | Establish Food safety M&E system is for evidence-based planning and programming | National Commiitee for Regulating Food Safety/ MoPHP | Community | National Commiitee for Regulating Food Safety/ MoPHP/ YSMO/Ministry Of Trade and Industry (MOTI)/ SUN | Donors to provide lab analysis material<br>FAO/WFP/UNDP<br>Acdemic entities/experts<br>Sana'a university/Agric collage |
| | | Development of pre-service and in-service nutrition training materials for agricultural and fisheries extension workers | Media/Community level | Agr extension workers/Farmers | MOAI/MOI/MOPHP | *FAO/WFP/IFAD/ACF/FSAC*<br>*Academic* |
| Social Protectio | Provide cash assistance (condtional & unconditional) to reduce the vulnerability beneficiaries, and to enable targeted households to purchase food and necessities (Multi-Sectoral Nutrition Action Plan - 2021-2023) | Provide Conditional cash Assistance Transfer to HHs which has U5 children,to reduce AM among the vulnerability beneficiaries, and to enable targeted HHs to purchase food and necessities at targeted area. | Most vulnerable Community | U5 children at targeted areas | SFD/SWF/Ministry of Labour and Social Affairs (MOLSA)/MOPHP | World Bank<br>FAO/WFP/Al-Amal Microfininee Bank<br>FSAC/Protection cluster |