United Nations CERF Central Emergency Response Fund

YEMEN
RAPID RESPONSE
POST-CONFLICT NEEDS
2023

23-RR-YEM-58641

Julien Harneis

Resident/Humanitarian Coordinator

PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:

Please indicate when the After-Action Review (AAR) was conducted and who participated.	**5 February 2024**

The Humanitarian Coordinator (HC) a.i. chaired the AAR meeting (both in person and online) on 5 February 2024, with the support of OCHA. The meeting was attended by 40 participants (22 in person and 18 online) representing the United Nations Children's Fund (UNICEF), the International Organization for Migration (IOM), the United Nations High Commissioner for Refugees (UNHCR), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the World Food Programme (WFP) and the Food and Agriculture Organization (FAO). The IFRR coordinator as well as Health, Nutrition, FSAC and WASH clusters' representatives joined the AAR meeting. The CERF contribution to the humanitarian response in Yemen, its achievements, the added value, challenges and lesson learnt were discussed openly during the meeting. All agencies and clusters reported positive outcomes with respect to the added value of using the IFRR mechanism in this CERF allocation. However, Notable challenges that caused delays and interruptions in the implementation were noted, with important lessons learned that can be leveraged in future CERF allocations and the wider response.

Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT).	Yes ☒	No ☐
Please confirm that the final version of this report was shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?	Yes ☒	No ☐

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

This US$ 18 million CERF allocation provided critical lifesaving assistance to some 773,417 highly food insecure people in IPC 3 and IPC 4 areas of Al Hodeidah, Hajjah and Taiz governorates with nutrition severity (GAM > 20 per cent) using the Integrated Famine Risk Reduction (IFRR) mechanism that proved to be valuable in addressing immediate needs and longer-term solutions for risk reduction. The CERF allocation was particularly beneficial due to the comprehensive and integrated package of services provided though health, nutrition, WASH, food security and MPCA, which targeted the same locations to ensure convergence of the interventions, using nutrition as an entry point for the beneficiaries.

This allocation helped to reduce malnutrition and prevent famine by reaching over 200,000 of the most vulnerable people, including , children and pregnant and lactating women (PLWs), who received malnutrition prevention and treatment combined with immunization and screening services. The provision of Multi-purpose Cash Assistance (MPCA) to the malnourished beneficiaries positively resulted in a reduction of food insecurity. The CERF grant enabled the continuation of critical lifesaving reproductive health (RH) and GBV services, as well as contributed to strengthening of the health system and in the overall improvement of the livelihood conditions of the women and girls in these areas.

CERF's Added Value:

The nutrition sector was the entry point of this allocation, which had a referral system in place to ensure that the caregivers of children with severe acute malnutrition (SAM), moderate acute malnutrition (MAM) and PLW receiving nutrition support would also be targeted for cash and livelihood assistance/MPCA.

This allocation enabled the continuation of critical lifesaving interventions in crisis-affected governorates as identified under the priority strategy for the IFRR, mainly for health, RH and nutrition interventions. This scale-up of investments in existing health systems facilitated increased access to healthcare and the smooth continuation of services. Moreover, the health and nutrition cluster were able to implement robust surveillance and rapid response systems, contributing to the prevention of large-scale outbreaks.

The coordination for this allocation was decentralised to the field level. With this, UN agencies and the inter-cluster coordination mechanisms contributed to a better convergence in response activities. In addition, the hub structure of the IFRR core clusters played a crucial role in facilitating communication, case referrals, and the implementation of an integrated package of services to the beneficiaries. The collaboration between implementing agencies allowed knowledge exchange, promoting a more informed and effective response. This pilot of the multi sectorial response created good synergy among various UN agencies which can be replicated elsewhere. The proactive IFRR mechanisms engagement and collaboration with the national stakeholders throughout the CERF project timeline facilitated access to the field to monitor the projects' implementation across governorates.

Did CERF funds lead to a fast delivery of assistance to people in need?

Yes ☒ Partially ☐ No ☐

All UN recipients confirmed that as soon as the projects were approved, they were able to immediately begin delivery of assistance through joint efforts. The CERF funding was quickly disbursed, which facilitated the timely delivery of life-saving health, nutrition, WASH, livelihoods and MPCA services to vulnerable women and children living in IDP sites across Hodeidah, Hajjah, and Taiz governorates. UN agencies were able to get commodities in country and begin distribution to the affected population in a timely manner. In the After-Action-Review (AAR), participants confirmed that this CERF provided critical and time sensitive assistance which prevented further deterioration in the food insecurity and malnutrition rates in the target locations. The CERF provided the swift seed money for the continuation and operation of the targeted health facilities with an integrated approach to preventing and responding to RH and GBV needs. It sustained vital health services with life-saving interventions and reached the most vulnerable women and girls. With a well-established MPCA program in place, UNHCR and IOM responded promptly upon identification of potential beneficiaries.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

This CERF grant positively responded to the most highly food insecure people and prioritized districts with nutrition severity. According to the Nutrition Cluster IPC AMN conducted in March 2023, the level of acute malnutrition in Taiz and Hajjah Governorates worsened

in 2023 compared to the previous year. Also, FSAC 5W matrix showed 100% gap in the targeted districts of Taiz and Hajjah governorates prior to commencement of the CERF funded project. CERF enabled partners to deliver time-critical needs such as access to safe water through water trucking to IDPs and reduced the risk of WASH-related diseases such as Cholera. Access to primary health care services and referral structures was improved for children under five, pregnant and lactating women and the general and vulnerable population in the targeted districts. CERF funding allowed agencies to continue providing the services. Although, for example, WFP had to reduce and subsequently suspend its malnutrition prevention programme, the timely reception of CERF funds for nutrition allowed WFP to continue malnutrition prevention activities in high-risk districts. CERF funding also supported maintenance of existing 24/7 lifesaving health and nutrition services. MPCA recipients were able to meet nutrition needs as well as other basic needs.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The CERF funding contributed to enhanced coordination among the humanitarian community by promoting geographical convergence of response activities and inter-sectoral programming.

The coordination efforts in developing the inter-sectorial CERF response strategy under the IFRR approach, though challenged by operational factors, was an entry point to foster convergence across different projects implemented by UN recipient agencies. The collaborative work addressed malnutrition treatment and prevention, while tackling the immediate causes drivers of malnutrition (Health care, Food and WASH).

One set-back noted was that the referral system could not provide the agreed target number referrals to MPCA partners, as the quality of the data provided from the nutrition centres was not sufficient to identify and deliver MPCA. Thus, IOM and UNHCR shifted to their internal mechanisms to complete the selection of beneficiaries by identifying vulnerable food insecure households within the same catchment populations of targeted health/nutrition facilities.

This allocation identified a need for stronger and systematic engagement with the relevant authorities and affected communities on integrated responses and approaches, highlighting the importance of government understanding and early involvement in geographical and needs prioritization process and methodology. UNICEF (as nutrition cluster lead agency) was able to bring stakeholders, including government, into a unified platform for collaborative planning, progress sharing and to address challenges. Such efforts helped in reducing duplication of efforts in some instances. Two monitoring visits were conducted by UN agencies and clusters for this allocation.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

Considering that the overall HRP funding was low, UN agencies continued to advocate for additional resources to meet the increasing needs. The CERF six months implementation window allowed UN agencies to advocate for additional resources. For example, UNFPA confirmed that the seed money of this grant helped leverage additional funds for the continuation of the integrated RH and GBV services in the same 6 districts in 2024. Through the implementation of WASH activities supported by CERF, UNICEF systematically identified further WASH gaps within communities, and these are always highlighted in new proposals. The integrated CERF approach paved the way for further engagements with Donors for future funding opportunities.

Considerations of the ERC's Underfunded Priority Areas[1]:

[1] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

This CERF grant primarily focused on three out of the four priorities. Education, although not a primary Cluster under this allocation, was nevertheless also indirectly addressed.
Women and girls were at the centre of the response, as the main target groups of this allocation were children and pregnant and lactating women (PLW). Through this CERF grant, 63% of beneficiaries reached were women and girls. During the implementation, IPs ensured equal participation of women and men in project implementation. Moreover, distribution sites and facilities were strategically located and designed to ensure secure, culturally appropriate access for female recipients. To promote access to women to healthcare services and that they are reached by awareness raising activities, most of the Community Health Volunteers (CHVs) were female. At least one female health worker was part of each supported health facilities to ensure that women in the communities receive the required services. The recruitment of women allows them to further their education, employability and to a degree, financial independence. Furthermore, mothers and caregivers are provided cash support to enhance their living conditions. As best practice, health facilities ensured separate waiting areas and latrines for males and females. Cash distributions have been carried out considering a do-no harm approach, to mitigate protection risks for women. IOM, UNHCR and FAO directly targeted female-headed households as recipient of cash assistance/MPCA. In fact, out of 8,912HHs targeted by the three agencies, 12% (1,085) was female-headed households.

The allocation took disability into account as part of the larger vulnerability criteria for selecting beneficiaries. Out of the total beneficiaries, 66,266 individuals with disabilities were reached. By considering disability as an important factor that increases vulnerability, the allocation was able to provide critical humanitarian assistance to this marginalized group. Cash distribution sites weredesigned to promote accessibility and the safety of PwDs. For example, if a PwD was unable to attend a distribution, the respective agency coordinated with a member of their household and/or of the community to ensure (s)he/ was able to obtain the cash assistance.

The allocation prioritized the protection of vulnerable groups, including women, people with disabilities, and other at-risk individuals. Protection has been integrated into all sectors of the allocation, aligning with the principles of "do no harm" and the importance of protection in humanitarian responses. Distribution sites were chosen to be accessible to diverse groups, and to ensure all individuals could access services in a safe and dignified manner. Partners ensured that supported health facilities included gender and disability friendly latrines. The project has made significant contributions to improving access to life-saving inpatient care in the targeted therapeutic feeding centres, specifically targeting severely malnourished children with severe medical complications.
The collaborative actions of all partners in treating malnourished children and addressing the nutritional status of their mothers, through counselling and the utilization of nutrition facilities and primary healthcare services for measles vaccination, have had a positive impact.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**99,178,299**
CERF	18,000,658
Country-Based Pooled Fund (if applicable)	2,121,026
Other (bilateral/multilateral)	17,873,339
Total funding received for the humanitarian response (by source above)	**37,995,023**

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
FAO	23-RR-FAO-012	Food Security - Agriculture	2,900,000
IOM	23-RR-IOM-017	Multi-Purpose Cash	1,482,000
IOM	23-RR-IOM-017	Health	468,000
UNFPA	23-RR-FPA-018	Health - Sexual and Reproductive Health	900,008
UNHCR	23-RR-HCR-013	Multi-Purpose Cash	1,450,000

UNICEF	23-RR-CEF-024	Nutrition	2,294,000
UNICEF	23-RR-CEF-024	Health	1,984,000
UNICEF	23-RR-CEF-024	Water, Sanitation and Hygiene	1,922,000
WFP	23-RR-WFP-019	Nutrition	2,400,000
WHO	23-RR-WHO-019	Health	1,100,325
WHO	23-RR-WHO-019	Nutrition	1,100,325
Total			**18,000,658**

Table 3: Breakdown of CERF Funds by Type of Implementation Modality (US$)

Total funds implemented directly by UN agencies including procurement of relief goods	**14,247,037**
Funds sub-granted to government partners*	1,875,394
Funds sub-granted to international NGO partners*	147,952
Funds sub-granted to national NGO partners*	1,730,274
Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**3,753,621**
Total	**18,000,658**

* Figures reported in table 3 are based on the project reports (part II, sections 1) and should be consistent with the sub-grants overview in the annex.

2. OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation:

In Yemen, the three governorates of Hajjah, Hodeidah and Taiz are among the most affected by both food insecurity and acute malnutrition. Recent food security (Integrated Phase Classification for acute food insecurity) and other assessments (SMART - Standardized Monitoring and Assessment of Relief and Transition) show that immediate and underlying causes of acute malnutrition are on the rise in these three governorates. Food insecurity and consumption of sub-optimal diets are immediate drivers of the fragile nutrition situation. The underlying causes include insufficient access to basic services such as primary health care, maternal and reproductive health, and immunization services particularly measles vaccination and other routine vaccinations. In addition, inadequate access to safe drinking water and sanitation leading to the spread of diarrhoeal diseases among children under five years is a major cause for the persistence and increase in the incidence of acute malnutrition in these governorates.

Operational Use of the CERF Allocation and Results:

This CERF allocation aimed to provide inter-sectoral convergence to primary reduce malnutrition and prevent famine in six high severity districts with timely and high impact multi-sectoral and multi-purpose cash engagements for approximately 773,417 of the most vulnerable IDPs and host communities. The response included the health including sexual and reproductive health, water, sanitation and hygiene, food security and nutrition sectors. This allocation came at a time when the funding levels to Yemen were, and remain, critically low and the number of people in need is at an all-time high.

About 61,683 individuals benefitted from Cash and Voucher Assistance (CVA) activities either through multi-purpose cash assistance (MPCA), unconditional cash or tax-free cash (TFC) admission with a total value of US$ 3,316,563. Some 2,500 farming households were supported through the provision of two rounds of unconditional cash transfers, complemented with livestock inputs which resulted in promoting farmers' existing capacities and enabled them to better utilize their natural resources to become more resilient. To ensure integration and complementary, an eligibility verification exercise was carried out to select beneficiaries by cross-checking nutrition status with health and nutrition centres targeted by other UN agencies under the same allocation.
6,412 households (HHs) were supported with MPCA (by both IOM and UNHCR) which allowed the affected IDPs and host community to access minimum basic needs included but not limited to food, health, water, transportation, and rent. 4,029 HHs were referred from nutrition partners/Mobile teams under this allocation to benefit from MPCA, the rest of the HHs were identified from the same catchment population of the targeted health facilities.

UNICEF, WFP and WHO ensured that children under five in the targeted districts across three governorates had access to life saving, high impact and quality nutrition services. 71,478 children, 116,151 Pregnant and Lactating Women (PLWs) and 12,776 adolescent girls were enrolled in different nutrition sites either at treatment or preventive sites.

189 Health Facilities (HF) were supported with both health and nutrition services, 11 of them are TFCs and 3 are referral hospital, and 10 supported reproductive services. Over 4,151 Community Health Volunteers (CHVs) were targeted by the allocation which significantly increased the population reached. UNICEF rehabilitated 9 water system, 22 HFs (WASH), and constructed a harvesting reservoir and 835 latrines for vulnerable HHs with SAM cases.

People Directly Reached:

The total number of people reached with different services is estimated by adding the number of people reached under each sector. Therefore, the 773,417 people reached reflects the various types of assistance received by people.
The higher than targeted number of beneficiaries reached is due to multiple factors:

- High demand for the services and more individuals than expected seeking services at health facilities, which suggests the plausible positive contribution of CHVs to facilitating populations' access to health facilities.
- Seasonality factor, as the reporting period from May to October coincided with the peak of severity of malnutrition in Yemen.
- More CHNVs were supported that allowed to reach more children than initially planned.
- The implementation of continuous 24/7 services and the presence of healthcare staff made possible by the support from CERF.
- Utilizing some savings to increase the services and reach more people.

People Indirectly Reached:

In addition to the direct beneficiaries outline above, approximately 700,357 people benefited indirectly from this allocation. This includes the catchment population of the targeted Health facilities, Community health workers (CHWs), Community Health and nutrition Volunteers (CHNVs), Health Workers (HWs) who received allowances, children screened, PLWs who received IYCF and the caretakers of the targeted children who took part in the social and behavioural change communication activities.

Through spending empowered by the unrestricted cash transfers, this allocation resulted in multiplied benefits for crisis-affected populations and provided associated boosts to the vitality and resilience of local markets.

Table 4: Number of People Directly Assisted with CERF Funding by Sector/Cluster*

	Planned					Reached				
Sector/Cluster	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Food Security - Agriculture	4,200	4,375	4,375	4,550	17,500	4,200	4,375	4,375	4,550	**17,500**
Health	71,812	34,211	118,944	122,756	347,723	87,881	33,497	132,769	131,602	**385,749**
Health - Sexual and Reproductive Health	32,051	2,751	14,679	519	50,000	34,537	5,115	16,733	3,028	**59,413**
Multi-Purpose Cash	13,683	12,507	17,642	18,206	62,038	9,516	9,135	11,137	11,802	**41,590**
Nutrition	34,517	171	34,129	34,309	103,126	93,950	94	37,273	34,846	**166,163**
Water, Sanitation and Hygiene	19,200	19,600	20,400	20,800	80,000	25,012	23,928	26,700	27,362	**103,002**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Table 5: Total Number of People Directly Assisted with CERF Funding by Category*

Category	Planned	Reached
Refugees	0	750
Returnees	2,383	78
Internally displaced people	113,111	175,419
Host communities	465,355	597,170
Other affected people	0	0
Total	**580,849**	**773,417**

Table 6: Total Number of People Directly Assisted with CERF Funding*			**Number of people with disabilities (PwD) out of the total**	
Sex & Age	**Planned**	**Reached**	**Planned**	**Reached**
Women	157,580	255,096	15,173	21,233
Men	56,733	76,144	3,730	6,096
Girls	188,152	228,987	17,407	19,626
Boys	178,384	213,190	15,052	19,311
Total	**580,849**	**773,417**	**51,362**	**66,266**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 23-RR-FAO-012

1. Project Information

Agency:	FAO	**Country:**	Yemen
Sector/cluster:	Food Security – Agriculture	**CERF project code:**	23-RR-FAO-012
Project title:	Integrated livelihood support in famine risk prone areas in Yemen.		
Start date:	30/05/2023	**End date:**	29/11/2023
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 12,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 2,900,000**
Total CERF funds sub-granted to implementing partners:	**US$ [249 269]**
Government Partners	US$ **[132,298]**
International NGOs	US$ [0]
National NGOs	US$ **[116,971]**
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

In 2023, FAO implemented an integrated livelihood support project in famine risk-prone areas of Yemen through a CERF rapid response grant. The project targeted 2,500 vulnerable farming households (17,500 individuals) in Dhubab (1,500 HH) and Qafl Shammer (1,000 HH) districts to prevent famine and mitigate hunger. Among the referrals from other nutrition partners, only 50 households were eligible, meeting FAO's specific criteria. The remaining households were directly identified by FAO through the implementing partners. To ensure integration and complementary, an eligibility verification exercise was carried out to select beneficiaries by cross-checking nutrition status with health and nutrition centres targeted by other UN agencies under the same allocation.

Each household received unconditional cash transfers valued at USD 117 per month based on the minimum food basket cost, with two rounds of distributions reaching all 2,500 HHs. Of total recipients, 479 households were female-headed. The assistance package also included 4 small ruminants (goats), 150 kg of animal feed, and 15 kg of mineral supplements per HH to boost livestock health and productivity. Additionally, 19 nutrition health facilitators, predominantly women, were trained to conduct nutrition education and malnutrition/agriculture-sensitive awareness sessions. Refresher training was also provided to 6 local agricultural extension workers to deliver updated guidance on livestock husbandry to beneficiaries. Furthermore, the project provided refresher extension sessions to

agriculture extension personnel from the General Department of Extension and Agriculture Training (GDEAT) and the General Directorate of Agriculture Extension and Media (GDAEM).

Beneficiaries reported that provision of livestock, mineral blocks, feed, and cash to crisis-affected households preserves assets and livelihoods, enhancing food security and availability through increased livestock production and cash transfers, while also promoting good nutrition practices, the project aimed to reduce acute malnutrition among children under and improve food security for vulnerable households.

3. Changes and Amendments

The humanitarian situation in Yemen has continued to worsen, with heightened needs among vulnerable groups. To adapt, a small change was made to the original project plan in consultation with FSAC and OCHA. Specifically, a cost savings of $292,500 was realized on procurement of livestock (ruminants), concentrated feed, mineral blocks and supplements. With OCHA secretariat approval, these savings were allocated to an extra round of unconditional cash transfers for the 2,500 targeted households in Qafl Shammer and Dhubab districts, owing on-going cuts on humanitarian food assistance and the need to scale up livelihood's interventions to combat a deterioration in the fragile food security situation. This additional $117 per household cash transfer enabled vulnerable households to further meet critical needs given the extremely difficult operational context. Beyond this change approved by CERF-OCHA Secretariate, no other major deviations from the original proposal took place. The evolving context of Yemen and requirements of administrative approvals/permissions from Government authorities in North caused certain delays in implementation, however activities remained in line with the approved proposal. Delays of 2-3 weeks occurred in livestock distribution due to supply chain constraints, but outcomes were ultimately achieved within the project timeframe.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Food Security – Agriculture									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Returnees	0	0	0	0	**0**	21	28	7	14	**[70]**
Internally displaced people	0	0	0	0	**0**	0	7	0	0	**[7]**
Host communities	4,200	4,375	4,375	4,550	**17,500**	4,179	4,340	4,368	4,536	**[17,423]**
Other affected people	0	0	0	0	**0**	[0]	[0]	[0]	[0]	**[0]**
Total	**4,200**	**4,375**	**4,375**	**4,550**	**17,500**	**[4,200]**	**[4,375]**	**[4,375]**	**[4,550]**	**[17,500]**
People with disabilities (PwD) out of the total										
	1,050	1,095	1,093	1,137	**4,375**	**714**	**665**	**735**	**763**	**[2,877]**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Approximately 17 300 individuals (population) in the supported districts benefited from increased availability and affordability of nutritious animal products such as meat, milk, and dairy by-products. Surplus production exceeding household needs was sold in local markets, generating income for vulnerable farmers directly supported by the project, thereby boosting the local economy. The cash assistance provided to targeted beneficiaries directly stimulated local markets by increasing their purchasing power to procure basic needs, including food and services. Recipients were able to spend this assistance in local markets and businesses as they saw fit to meet their needs. Local vendors in target locations experienced a marked increase in transactions and sales, including food vendors, and general retailers. This influx of cash-based assistance and subsequent recipient spending generated heightened economic circulation at the local community level. Through spending empowered by the unrestricted cash transfers, this project resulted in multiplied benefits for crisis-affected populations and provided associated boosts to the vitality and resilience of local markets. Additionally, the field technical staff of relevant government ministries including Ministry of Agriculture & irrigation, health & nutrition and contracted FSPs and NGOs benefited from increased knowledge and skills in livestock production and nutrition through FAO's training activities and agricultural extension services.

6. CERF Results Framework

Project objective	Improved food security and nutrition status among smallholder farming households in famine risk-prone areas of Yemen.
Output 1	Increased access of smallholder farming households to cash, livestock production assets and inputs, and knowledge on nutrition and animal husbandry.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Food Security – Agriculture			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Ag3 Number of people receiving livestock inputs (animal feed/live animals/kits/packages) (2,500HH).	17,500	17,500	Inputs distribution lists, M&E Verification & monitoring report, IPs monthly/quarterly progress report]
Indicator 1.2	Ag.4 Number of animals distributed (4 per HH)	10,000	10,000	Inputs distribution lists, M&E Verification & monitoring report, IPs monthly/quarterly progress report]
Indicator 1.3	Cash.2a Number of people receiving sector-specific unconditional cash transfers (2,500HH).	17,500	17,500	Financial Service Providers (FSPs) cash disbursement update, Cash collection receipts, Cash Transfer monitoring reports, IPs monthly progress reports
Indicator 1.4	Cash.2b Total value of sector-specific unconditional cash transfers distributed in USD	292,500 (585,000)	585,000	Transfer Instructions, FSP disbursement report, Cash transfer monitoring reports, beneficiary cash receipts

Indicator 1.5	Number of individuals participating in Livestock Good Agriculture Practices awareness-raising sessions (2,500HH).	2,500	2,500	Participants attendance sheets, MoA reports, IP reports, FAO M&E field visit reports
Indicator 1.6	Number of beneficiaries receiving nutrition awareness	2,500	2,500	Participants attendance sheets, MoA reports, IP reports, FAO M&E field visit reports, Ministry reports, IP report, M&E report
Indicator 1.7	AP.2b Percentage of affected people who state that they are aware of feedback and complaints mechanisms established for their use	100%	94%	Complaint Centres report, Cash transfer Monitoing Report, PDM
Explanation of output and indicators variance:		Indicator 1.4: The variance basically refers to a cost savings of $292,500 which was realized on procurement of livestock (ruminants), concentrated feed, mineral blocks and supplements. With OCHA secretariat approval, these savings were allocated to an extra round of unconditional cash transfers for the 2,500 targeted households in Qafl Shammer and Dhubab districts. This additional US$117 per household cash transfer enabled vulnerable households to further meet critical needs given the extremely difficult operational context. Indicator 1.7: 94% of contacted beneficiaries stated that they were informed about how the feedback and complaints mechanisms work. Only 6% of respondents reported that they were not well aware of the mechanisms. This lack of awareness was due to their absence during sensitization sessions.		

Activities	**Description**	**Implemented by**
Activity 1.1	Implementing partner (IP) identification and contracting	- FAO - MOZN Charitable Social and Developmental Foundation - Bena Charity for Human Development
Activity 1.2	Identification of communities, coordination, beneficiary selection and registration (17,500 BNF/2,500 HH)	- MOZN Charitable Social and Developmental Foundation - Bena Charity for Human Development (BCFHD)
Activity 1.3	Distribution of USD 117 cash transfers under cash+ scheme to the same 17,500 beneficiaries (2,500HH/292,500 USD) (585,000 USD)	Financial Service Provider- (Al Kuraimi & Al Amal Banks), under the direct supervision of FAO assisted by Implementing Partners (BCFHD and MOZN
Activity 1.4	Nutrition sensitive awareness training (2,500 HH)	MoH, FAO, and BCFHD and MOZN
Activity 1.5	Conducting awareness sessions on Good Agricultural Practices on livestock husbandry to beneficiaries (one person per household) 2,500HH.	• FAO • General Department of Extension and Agriculture Training (GDEAT) and the General Directorate of Agriculture Extension and Media (GDAEM). • Agricultural - Veterinary Ministry (DGAHVQ)- DFA, • Veterinary Ministry - Yemen Veterinary Medicine Association (IRG)
Activity 1.6	Provision of 2,500 kits containing 4 small ruminants, 150 Kg feed concentrates and 15 Kg mineral blocks per household (2,500 HH).	• FAO • Ministry of Agricultural Veterinary Offices

		• MOZN Charitable Social and Developmental Foundation • Bena Charity for Human Development
Activity 1.7	Post Distribution Monitoring.	Implenting Parteners (BCFHD, MOZN), FAO M&E/TPM

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[2] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[3]:

FAO implemented a participatory and inclusive approach to involve crisis-affected communities, including vulnerable and marginalized groups, across all stages of project design, implementation, and monitoring. Focus group discussions and key informant interviews were held during assessments to incorporate target groups' needs and priorities from the target locations. Context-appropriate modalities like home visits and meeting community representatives were conducted with isolated groups in planning phases. Community committees with representatives from all segments of the population were established to provide input on interventions and monitor activities as well as progress. Regular post-distribution surveys were conducted to gathered beneficiary feedback on project activities including beneficiary identification, selection of Emergency livelihood packages (agriculture and livestock inputs), distribution of cash and inputs. FAO's Implementing partners held monthly review meetings with affected people to discuss progress and address complaints. Multiple communication channels like hotlines, help desks, and anonymous feedback boxes were established to receive inputs throughout the project cycle. By maintaining open communication channels, emphasizing local partnership, and adapting based on community input, FAO meaningfully engaged target. Also, regular community meetings enabled all groups to provide feedback on proposed activities and suggest adaptations to better suit their realities. Community insights drove adaptations like conditionality, adding livelihood components, and adjusting targeting criteria to be more inclusive.

b. AAP Feedback and Complaint Mechanisms:

To enable confidential beneficiary feedback, FAO established multiple access points including toll-free hotlines in local dialects. Outreach informed people of the mechanism, while banners at distribution sites displayed hotline numbers. Dedicated staff logged issues in a database to identify trends and follow-up. Over 150 complaints were received, of these 31 complaints from direct beneficiaries highlighting concerns like community selection, assistance quantity, timing of aid delivery and delays by 81 beneficiaries. By categorizing issues, FAO responded to main areas needing improvement like timing of assistance. Overall, the complaint system provided an essential confidential and accessible means for beneficiaries to voice concerns, enabling the project to analyze issues and continuously improve assistance delivery.

[2] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[3] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

FAO has zero tolerance towards Sexual Exploitation and Abuse/ Harassment (SEA/H). At country office level, FAO has a focal point for PSEA, whose role is to coordinate country level PSEA efforts by raising awareness, attending trainings, PSEA network meetings and ensuring that IP, and beneficiaries are upholding FAO SEA policies and protection of beneficiaries from sexual exploitation and abuse. As mentioned above, FAO has an established and operational Complaints and Grievance Redress Mechanism (CGRM) – a robust beneficiary feedback mechanism that is safe, which beneficiaries can use to report any form of abuse to FAO. No PSEA-related complaints or issues were reported by beneficiaries during the project period implementation.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

In order to contribute to gender equality and promote the empowerment, protection and inclusion of women, girls, and gender minorities, FAO made concerted efforts to incorporate gender considerations throughout the project cycle in Yemen. Women were intentionally included in community consultations to capture their perspectives in project implementation where allowed. 4200 women and 4375 girls out of 17500 beneficiaries benefited from cash transfers and input distribution. FAO ensured equal participation of women and men in project implementation committees. Rigorous training on protection from sexual exploitation and abuse was provided to FAO staff and Implementing Partners, alongside capacity building on international standards for Codes of Conduct. Cash and inputs distribution sites were strategically located and designed to ensure secure, culturally appropriate access for female recipients.

e. People with disabilities (PwD):

The project took disability into account as part of the larger vulnerability criteria for selecting beneficiaries. Out of the total project beneficiaries, 2,877 individuals with disabilities were reached, including 714 women, 665 men, 735 girls and 763 boys. By considering disability as an important factor that increases vulnerability, the project was able to provide critical humanitarian assistance to this marginalized group. Ensuring the inclusion of persons with disabilities allowed the project to equitably meet the needs of diverse crisis-affected populations.

f. Protection:

The project prioritized the protection of vulnerable groups, including women, people with disabilities, and other at-risk individuals. This was achieved through inclusive beneficiary selection criteria and accessible distribution modalities. Inputs and cash distributions were held at convenient times and locations for women and people with disabilities. COVID-19 safety protocols were enforced to mitigate risks. To promote accountability, all beneficiaries received information on distribution entitlements and complaint mechanisms.

Moreover, efforts were made to integrate female staff and enable their safe participation. This included hiring local women, budgeting for male guardians, and allowing flexible work arrangements. Distribution sites were chosen to be accessible to diverse groups. Separate spaces and services accommodated women and people with disabilities. Overall, protection principles of non-discrimination, dignity, access and participation guided activities. By mainstreaming protection, the project fostered the inclusion of vulnerable groups and supported equitable aid delivery.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	[17,500 (2,500 HH)]

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Yes, the project provided Cash Plus assistance to households to cover basic needs. The transfer value ($117) is indexed to match the minimum food basket value per month, as determined by the Food Security Cluster in the targeted locations. In the absence of government social safety nets, there is currently limited opportunity to link with the social protection system. However, the project sees potential to assist the government in establishing an integrated social safety net in the future. The Cash transfers with emergency livelihood package benefited households to purchase essential goods and services, including food. Cash transfers utilize common delivery mechanisms and financial service providers across locations to ensure consistency.

Parameters of the used CVA modality:

Specified CVA activity. (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Activity 1.3 – Distribution of unconditional CBT of two rounds ($117/round)]	[17,500 individuals (2,500 HH)]	US$ [585,000]	Food Security - Agriculture	Unrestricted

9. Visibility of CERF-funded Activities

Title	**Weblink**
[Beneficiaries Stories – Ali and Khamisah]	https://www.dropbox.com/scl/fo/1wb8h7jnuchrgkw6vki7c/h?dl=0&e=1&rlkey=uhswwn9w5fkfhzvinp79cvcje
[FAO Radio Campaign for CERF RR Malnutrition Programme]	FAO-2023-CERF-RADIO CAMPAIGN.mp4 (dropbox.com)
[Witten Articles – Ali and Khamisah]	[https://www.dropbox.com/scl/fo/cp109ov0ltwy96zw0156r/h?rlkey=ek7jvupn1pbisr6b7iyk8nbnt&dl=0]

Redhwan Ahmed Ahmed Saeed Alward

Redhwan Ahmed Ahmed Saeed Alward was born in 1976 in Arrowa'a Al Asfal - Al Jahili center – Dhubab district and he is a father for five children (three girls and two boys), one of his daughters is disabled in her legs. Three of his children are students in school (a girl and two boys) and he wishes them to continue studying to the last stages in the university.

Redhwan lives in a very humble house (a nest built of wood & a small yard). Redhwan is one of the BNFs in the project of " Integrated livelihood support in famine risk prone areas in Yemen in Taiz Governorate ". When he got the cash (first round), his happiness was incredible. "I could buy some sugar, fish, flour …etc. for my family", he said.

"The second round of money was spent for building new cage for the small live ruminants (female goats) that I received", he added. I live in an isolated area which suffers from the simplest conditions

of life. The nearest health facility is in Mawza'a district. It costs me a lot to reach to the nearest health facility. I am a worker with a daily wage. Sometimes, I cut & sell wood. I also breed goats. I have three goats and I wish to increase them, and animal grass is available in my village.

He received cash + fattening inputs in addition to the nutrition training for his wife and he received four female goats. These inputs helped him to overcome the difficulties of life. Small ruminants breeding and production is very important that the number of goats will increase to the double in the coming year. "My children will benefit from the milk of goats and the nutrition for my family will improve.", he said.

When asked about the impact of the project on his life, Redhwan said; "I expect, the impact of the project will be surely great".

3.2 Project Report 23-RR-IOM-017

1. Project Information

Agency:	IOM	**Country:**	Yemen
Sector/cluster:	Multi-Purpose Cash Health	**CERF project code:**	23-RR-IOM-017
Project title:	Supporting food security via the rapid provision of multipurpose cash assistance and health services in Yemen		
Start date:	24/05/2023	**End date:**	23/12/2023
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 12,500,000**
Total funding received for agency's sector response to current emergency:	**US$ 4,800,000**
Amount received from CERF:	**US$ 1,950,000**
Total CERF funds sub-granted to implementing partners:	**US$ [0]**
Government Partners	US$ [0]
International NGOs	US$ [0]
National NGOs	US$ [0]
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

In terms of direct assistance provided to vulnerable beneficiaries, through this CERF Rapid Response grant implemented in Taiz and Al Hodeidah, IOM provided 2,890 food insecure households (20,230 individuals) with cash to meet nutrition needs as well as other basic need. Among whom, 628 households were referred by UNICEF, 1,207 households were referred by WFP, and 1,055 households were referred by IOM's health teams following nutrition screenings conducted identifying cases in need of further services. Disaggregating by district, 194 households were supported in Ad Dohi, 2099 households were supported in Al Khukah, 150 households were supported in Zabid, and 447 households were supported in Dhubab. Further 12,129 individuals (all in Al Khukhah) were provided with healthcare consultations and IOM's health teams trained 40 community health volunteers and 68 healthcare workers to enhance community-based healthcare services and to help disseminate key health messaging amongst affected populations in target areas.

In total, the project directly assisted a total of 25,077 individuals (considering individuals who received both forms of assistance) through the provision of cash and health consultations. Activities were implemented over a period of seven months in Al Hodeidah and Ta'iz.

The MPCA component complimented actions carried out by nutrition actors under this RR allocation. Recipients of cash were those identified by IOM and nutrition actors as being food insecure. Cash assistance was proven to support the overall goal of reducing food insecurity among crisis affected households. As per post-distribution monitoring, 100% of surveyed HHs in Dhubab, Ad Dahi and Zabid districts and 99% in Al Khukhah district reported using the MPCA for food. Further, the intervention enhanced access to health services,

with 91% of respondents to post-project monitoring stating that they had brought their children to health facilities for consultations or treatment through the support of cash assistance. Additionally, 56% highlighted that cash enabled access to medication, 39% indicated its facilitation in accessing transportation to health facilities, 5% indicated its assistance in covering admission fees at the stabilization centre. Outpatient department consultations and the number of malnutrition screenings/ treatments at neighbouring health facilities nearly doubled after the deployment of CHVs.

3. Changes and Amendments

The health component of the intervention was implemented without any deviation from the original proposal.

However, the multipurpose cash component did require a project reprogramming and a one-month NCE due to challenges encountered with referrals from nutrition actors. Originally, it was agreed that IOM and UNHCR would receive referrals from the nutrition cluster to identify food insecure households in need of cash assistance. However, more than 60% of the datasets received through the first round of referrals did not include the necessary data points (including ID type, ID number, phone number and/or spouse name) for IOM or UNHCR to proceed with the distribution of cash, and only 30% of those with complete data points contained correct information. Further, among households referred by nutrition actors, only 17% were within districts covered by IOM. In a coordination meeting held in July 2023, IOM and UNHCR raised concerns with relative actors on the challenges with the referral modality. After further discussions, IOM and UNHCR identified the need to adapt the referral modality originally foreseen under this intervention in order to ensure reaching food insecure households with cash assistance.

IOM submitted and obtained approval (in October 2023) for a one-month NCE and a project reprogramming of this intervention. The modification included 1) the internal referral of malnutrition cases identified through IOM's mobile medical teams (MMTs) instead of relying solely on nutrition cluster referrals and 2) providing two rounds of MPCA to target households instead of one-off (therefore 2,000 households to be targeted, 50% of the initial target of 4,000 as a result of the increase in cash assistance), following global guidance on Cash and Voucher Assistance (CVA) for nutrition outcomes. Please note, the modification did not require a redeployment of funds as IOM adapted the target (reducing by 50% to change from one-off to two rounds of MPCA) to adhere to the resources available.

IOM was able to exceed the target number of individuals reached with primary health care consultations by more than 4,000 individuals and additionally trained 53 more healthcare workers than initially planned.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	978	329	686	707	**2,700**	410	251	344	364	**1,369**
Host communities	2,281	767	1,602	1,650	**6,300**	3,297	1,627	3,062	2,774	**10,760**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**3,259**	**1,096**	**2,288**	**2,357**	**9,000**	**3,707**	**1,878**	**3,406**	**3,138**	**12,129**
People with disabilities (PwD) out of the total										
	98	33	69	70	**270**	**84**	**42**	**54**	**68**	**248**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Sector/cluster	Multi-Purpose Cash									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	5,376	5,600	5,600	5,824	**22,400**	4,070	4,083	3,772	4,060	**15,985**
Host communities	1,344	1,400	1,400	1,456	**5,600**	1,081	1,084	1,002	1,078	**4,245**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**6,720**	**7,000**	**7,000**	**7,280**	**28,000**	**5,151**	**5,167**	**4,774**	**5,138**	**20,230**
People with disabilities (PwD) out of the total										
	1,008	1,050	1,050	1,092	**4,200**	**773**	**775**	**716**	**771**	**3,035**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

The health component of the project included the training of 40 Community Health Volunteers (CHVs), 68 healthcare workers and the provision of varied support to six functional health facilities (3 Mobile Medical Teams and 3 static health facilities). These individuals and facilities will continue to benefit people in the catchment area of activities long beyond the end of the project. Now trained and established, CHVs will continue to conduct awareness raising activities linked to health promotion and disease prevention, whilst the enhanced healthcare facilities will contribute to reducing the risks of communicable diseases spreading and affecting the population in the catchment area. As per the catchment population in target areas, an estimated 37,000 individuals have and will continue to benefit from

The provision of MPCA supported the local economy, as IOM expects that recipients spent a significant amount of cash received in local markets. IOM estimates that 3,000 individuals (local trader) indirectly benefit from the MPCA component.

6. CERF Results Framework

Project objective	To contribute to reducing food insecurity among crisis affected households
Output 1	Targeted communities have enhanced access to quality and gender sensitive health services and demonstrate improved health seeking behaviour especially for women, children, and other vulnerable groups.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	H.8 Number of primary health care consultations provided	8,060	12,129	Sample of health facility registers and CHV reports
Indicator 1.2	Number of community health volunteers trained	40	40	Training reports
Indicator 1.3	Number of health care workers trained	15	68	Training Reports
Indicator 1.4	H.7 Number of functional health facilities supported	6	6	Monthly Reports

Explanation of output and indicators variance:	IOM was able to exceed the target number of individuals reached with primary health care consultations by more than 4,000 individuals and additionally trained 53 more healthcare workers than initially planned. IOM was able to reach more individuals with health care consultations due to more individuals than expected seeking these services at health facilities, which suggests the plausible positive contribution of CHVs to facilitating populations' access to health facilities upon successful early identification of persons of concern (POCs) who require medical attention, defaulter tracing, and awareness raising on positive health seeking behaviour in general. In addition, three rounds of training were conducted instead of initially planned one based on the request from District Health Office (DHO) addressing the critical training needs gap in infection prevention and control (IPC) and reproductive health (RH). Please note, as these activities require human resources, this did not have budget implications. IOM was able to conduct the additional rounds via individuals already recruited and supporting the intervention.

	Less IDPs were reached than initially planned during the project development phase as areas of CHVs deployment were appointed by the local health office within the catchment areas of 3 IOM supported facilities in Al Khukhah, and less IDPs resided within these areas.

Activities	Description	Implemented by
Activity 1.1	Provision of operational support for mobile medical teams and targeted health facilities, including incentives, transportation (car rental, fuel, ambulances) and distribution of medicines and medical supplies	IOM
Activity 1.2	Provision of integrated, essential emergency and primary health-care services (including Emergency care, sexual, reproductive, maternal, neonatal, child and adolescent health; integrated management of childhood illness, immunization, nutrition services through nutrition partners and emergency medical referrals to targeted population via supported health facilities and deployment of mobile medical teams	IOM
Activity 1.3	Training of community health volunteers (40) CHV core training package to enhance community-based health-care services and 15 healthcare workers (for MMTs)	IOM
Activity 1.4	Provision of community volunteers kits and information, education and communication (IEC) materials for community outreach activity	IOM
Activity 1.5	Conducting health promotion and awareness sessions	IOM
Activity 1.6	Quarterly meetings for CHVs to review community outreach activities performance, referral and linkages between community, health facility, nutrition, CASH and WASH.	IOM

Output 2	Targeted households are able to better meet their essential basic needs, primarily food needs, through delivery of emergency one-off cash assistance
Was the planned output changed through a reprogramming after the application stage?	Yes ☒ No ☐
Sector/cluster	Multi-Purpose Cash

Indicators	Description	Target	Achieved	Source of verification
Indicator 2.1	Cash.1b Total value of multi-purpose cash distributed in USD	920,000	914,452.33	Bank invoices
Indicator 2.2	Cash.1a Number of people receiving multi-purpose cash	28,000	20,230	Referrals database, sample beneficiary list
Indicator 2.3	Number of post-distribution monitoring exercises carried out	2	1	PDM Report
Indicator 2.4	AP.6b Percentage of issues identified in feedback processes for which solutions are in process or closed	90%	100%	CFM Reports

Explanation of output and indicators variance:	((Indicator 2.1) The difference slight difference in amount of cash transferred is due to the differing exchange rates between de-facto authority (DFA) and

	Internally Recognized Government (IRG). For example, the SMEB transfer value in DFA is USD 230 while due to market fluctuations and impact on exchange rates in IRG areas, by December 2023 the SMEB transfer value was USD 190 in IRG areas. As best practice, the Cash and Markets Working Group, which IOM aligns to, advises to utilizes the DFA rate when budgeting to account for these differences and to mitigate issues of underbudgeting. The savings incurred as a result, USD 5,548 was utilized to cover the costs of additional field movements and hours IOM Cash enumerators to travel and validate the missing data from referrals received from nutrition actors (as mentioned above). (Indicator 2.2) As per the approved amendment request, IOM changed the modality of MPCA to include two-rounds of assistance instead of one-off to target households. As a result, 2,000 households (or 14,000 individuals) were to be targeted as compared to the 4,000 HHs (or 28,000 individuals) initially planned. Thus, the number of individuals reached varies from the proposal due to the approved change in approach (two rounds of assistance instead of one-off). By the end of the intervention a total of 2,890 HHs were supported with MPCA including, 2,536 HHs were supported with 2 rounds and 354 HHs with one-off assistance. IOM was able to reach more than the 2,000 planned under the NCE due to the postponing of activities in the beginning of the project in DFA areas for all partners under the RR allocation. Thus the second round could not be disbursed to target HHs in DFA areas and due to the differing exchange rates (in which the transfer value in IRG areas is lower) IOM was able to target additional households in IRG areas. (Indicator 2.3) Due to delays in cash distributions, IOM was not able to conduct the 2 foreseen PDMs prior to the end of the intervention.

Activities	Description	Implemented by
Activity 2.1	Identification and verification of target households (via registration of referred cases from IFRR actors)	IOM
Activity 2.2	Distribute of one-off MPCA to 4,000 HHs throughout project period	IOM
Activity 2.3	Conduct two post-distribution monitoring among samples of recipient households	IOM

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[4] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

[4] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

a. Accountability to Affected People (AAP)[5]:

A key component of this intervention involved Community Health Volunteers (CHVs) who are themselves members of the target community. By selecting members of the community to directly carry out project components, CHVs were able to influence appropriate messaging for the affected population, explain activities to their peers and support in the identification of vulnerable households in need of nutrition support. Further, IOM carried out sessions on AAP and Code of Conduct with field teams, health workers and local authorities throughout the project period, facilitated by the Senior Community Feedback Assistant.

Post distribution monitoring (PDM) exercises also presented an opportunity for members of the target community to provide their perspective, needs and suggestions to improve future interventions of a similar nature. IOM utilized a third-party monitor (TPM) to conduct monitoring exercise of activities carried out under this intervention. The exercise provided the beneficiaries' perspective on cash registration and distribution process, how the cash was utilized and recommendations for future cash assistance programs linked to nutrition outcomes. Due to the short time frame of this intervention, recommendations could not be implemented before the end of the project, however, will be utilized to improve and inform future interventions.

b. AAP Feedback and Complaint Mechanisms:

Throughout the project period, IOM teams ensured to promote the Community Feedback Mechanism (CFM), which includes a toll-free hotline, email, social media, and suggestion boxes (where feasible) in IOM-managed sites. The information was provided as part of cash distributions, via information materials available in supported health facilities and mobile medical teams. Community Health Volunteers also provided relevant information on feedback pathways available as part of IOM's CFM. A total of 2,334 cases linked to Health and MPCA programming were received during the project period via the toll-free hotline only. The majority (2,311 cases) were linked to cash assistance in which individuals reached the CFM to request for this support. The remaining cases (23 cases) were related to requests for assistance with health services. Nearly all cases (99%) came from individuals in Al Hodeidah. All cases were closed within the project period. IOM's dedicated CFM team in Aden utilized Frequently Asked Questions (FAQs) as well as liaised with program teams as needed to address all inquiries in a timely and appropriate manner.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

IOM maintained its zero tolerance policy, in which all IOM staff members or any other persons engaged by IOM must undergo PSEA training. Individuals are obligated to report SEA allegations, concerns or suspicions to their supervisor or PSEA focal point (1 male and 1 female have been nominated for the IOM Yemen mission) who is required to report all cases to IOM's Office of the Inspector General. In addition, IOM operates the "We Are All in" platform (https://weareallin.iom.int) which allows confidential reporting of PSEA related misconduct (please note the platform is accessible to anyone). All PSEA cases are handled by IOM's Office of the Inspector General who is mandated to carry out proper investigation and advise relevant mission personnel on action to be taken.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project was implemented considering the inclusion of vulnerable and marginalized groups, notably women and girls, by utilizing various methods to reduce related protection risks and address their specific needs. Under this intervention, to promote access to women to healthcare services and that they are reached by awareness raising activities, 40 women Community Health Volunteers (CHVs) were trained to carry out household level nutrition screenings in case women are unable to travel to nearby facilities and conduct awareness raising activities. Further, among the 68 healthcare workers trained, 20 midwives on reproductive health. In particular, due to a lack of a qualified gynaecologist in Al Khukhah district and importance for women's health, the District Health Office underlined the specific need for reproductive health training for midwives. Further, healthcare workers at support facilities and operating mobile teams are trained on the principles of gender-based violence prevention, response and referral pathways. As best practice, health facilities ensured separate waiting areas and latrines for males and females. Cash distributions are carried out considering a do-no harm approach, to ensure

[5] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

distribution times and areas do not exacerbate protection risks for women. 10% (277) of the targeted HHs with MPCA are female headed households

e. People with disabilities (PwD):

The needs of persons with disabilities were integrated throughout project implementation. Cash distributions sites are designed to promote accessibility and safety of PwDs. For example, if a PwD is unable to attend a distribution, IOM coordinated with a member of their household and/or of the community to ensure they are able to obtain their MPCA. In the case this is not feasible, IOM teams provide the MPCA directly at the household (where feasible) to eliminate the need to travel to distribution points. IOM-supported health facilities aim to ensure tailored access for persons with limited mobility. Further, mobile medical teams eliminate the need for persons who are unable to do so, to travel to a nearby health facility by offering essential services within their community. Protection of these vulnerable groups was further ensured by dedicated consultation and waiting area as well as the inclusion of women staff (particularly to support women and girls).

f. Protection:

As part of health activities implemented under this intervention and to ensure all individuals could access services in a safe and dignified manner, IOM ensured supported health facilities included gender and disability friendly latrines. Further, standard health care waste management measures were adopted (color-coded bin and incineration) to reduce risk of health-care associated infections among patients. Health care workers in support facilities and providing services via the mobile team report and refer beneficiaries with protection concerns to the relevant protection agency within the target area. These measures are key components incorporated as standard best practices throughout IOM's regular health programming.

Further, as previously mentioned, cash distributions are carried out with key protection principles in mind. Crowd control measures, distribution times and locations are strategically identified to ensure the safety of MPCA beneficiaries while receiving their assistance. Further data collected from MPCA and Health programming is appropriately stored in line with IOM's Data Protection Principles, among whom a secure data base is utilized and from the onset only the minimum information is collected for the purpose of service provision.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	20,230

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

IOM utilized multi-purpose cash assistance to assist 2,890 HH (20,230 individuals) to meet their basic needs. According to post-distribution monitoring, 91% of respondents brought their children to a health facility with the support of cash assistance received, 56% indicated utilizing cash assistance to access medication, 39% for transportation to health facilities and 5% for assistance in covering admission fees at the stabilization center.

Further, 96.77% of respondents reported utilizing cash assistance for food expenses in the last 30 days. While 2.57% of the assistance was spent on shelter and 0.63% spent on water and hygiene items. A small proportion, 0.03%, indicated using cash support for communication. Furthermore, (72%) of targeted beneficiaries have debts owed to various sources, ranging from YER 15,000 to YER 1,000,000. Among those in debt, 49% stated their households struggled to pay off debts after receiving cash assistance, while 51% managed to pay some debts. Although IOM is exploring linkages with social protection systems, this aspect has not yet been concretely implemented.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Activity 2.2	20,230	US$ [914,452]	Multi-Purpose Cash	Unrestricted

9. Visibility of CERF-funded Activities

Title	**Weblink**
FB Post	IOM Yemen - In December, IOM continued to provide... | Facebook
Monthly External Dispatch	en-iom-yemen-dispach-december-2023.pdf

3.3 Project Report 23-RR-FPA-018

1. Project Information

Agency:	UNFPA	**Country:**	Yemen
Sector/cluster:	Health - Sexual and Reproductive Health	**CERF project code:**	23-RR-FPA-018
Project title:	Providing emergency life-saving RH services in areas with high food insecurity, 2023		
Start date:	26/05/2023	**End date:**	25/11/2023
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 12,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 2,002,000**
Amount received from CERF:	**US$ 900,008**
Total CERF funds sub-granted to implementing partners:	**US$ [531,981]**
Government Partners	US$ [0]
International NGOs	US$ [0]
National NGOs	US$ [531,981]
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

UNFPA and its partners provided lifesaving Reproductive Health and GBV-centred response services in the targeted HFs in Hajjah, Hodaidah and Taizz as outlines in the project document. UNFPA advocated for women and girls' rights as well as mobilized funds to sustain the interventions in these critical locations beyond the implementation duration. Through intensive coordination and field visits, the project coordinated its responses with other actors for complementarity in service provision to the affected targeted communities. The health facilities were equipped, supported and fully functional with medical service providers. UNFPA partners meet the 24/7 comprehensive healthcare standards outlined by the Ministry of Public Health and Population (MoPHP). These standards stipulated the continuous availability of all healthcare staff, including General Practitioner (GP) doctors, within our Basic Emergency Obstetric and Newborn Care (BEmoNC) Health Facilities and OBGYNs in the Comprehensive Emergency Obstetric and Newborn Care (CEmoNC).

The CERF funding enabled the scaling up and establishment of RH interventions in some of the most affected yet remote underserved areas of Yemen, where access to life-saving services was limited or absent. It facilitated the provision of integrated RH and GBV services through health facilities and safe spaces for women and girls experiencing GBV, reaching the most vulnerable populations such as IDPs and host communities, and complementing services with other service providers and multisectoral service provision. The project targets in the IRG controlled areas under DEEMs operations were in Dhubab Hospital (BEmONC), Al Khukhah Al Jadeed HC (BEmONC) in Taizz Governorate. In the DFA/AA controlled areas, the project targeted under BFDs operations Qofl Shamr hospital in Hajah Gov (CEmONC), Zabid hospital (CEmONC), Ad Dahi hospital (CEmONC), Mahal Al Sayid in Dahi (BEmONC), Muwaqar- in Zabid (BEmONC), Al Hitar in Zabid Hodeida (BEmONC). 1,867 malnourished pregnant and lactating women were referred to the IFRR agencies under this allocation, as well as 150 GBV were referred to the UNFPA supported WGSS.

The project reached an overall 59,413 beneficiaries with a slight increase to the originally proposed beneficiaries of 50,000 beneficiaries.

These RH interventions were integrated with GBV and also addressed malnutrition, livelihood, and protection issues thanks to the enhanced teamwork among UN recipients due to a great coordination mechanism and some joint field missions. To enhance the localization approach, it has been implemented by some NNGOs like DEEM and BFD. This CERF funding contributed to strengthening the health system by supporting functional health facilities with RH supplies, operations, equipment, and medicine, and staff incentives. These interventions helped to protect the rights and dignity of the women who were exposed to various forms of violence. Another key achievement of the project was coordinating and integrating RH and GBV services with other humanitarian actors, such as MSF, GHO, health cluster, women's safe space, and Handicap. This ensured complementarity and avoided duplication of services, as well as enhanced the quality and accountability of the interventions.

This project served as a seed project, and future interventions will build upon these achievements to continue providing an integrated set of basic social services. As an added value, the project also enhanced relevant coordination mechanisms, such as the Health Cluster, the Protection Cluster, the GBV Sub-Cluster, the RH Working Group, and the Inter-Cluster Coordination Group (ICCG), to share information, identify gaps, prioritize needs, mobilize resources, monitor progress, and advocate for issues related to RH, GBV, nutrition, etc.

3. Changes and Amendments

In the beginning of the project, UNFPA replaced two HFs that were proposed initially to be targeted in Mighlaf district (Al mawab and Der Mahdi) with other two HFs (Al sayed and Al Mawaqer health centers in Dahi and Zabid districts). This was due to lack of space to implement RH, lack of laboratories and lack of pharmacy in the initially targeted facilities.

There was slight increase in some of indicators' targets which attributed to the high demands for the services.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health - Sexual and Reproductive Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	13,570	1,310	4,018	292	**19,190**	14,469	3,268	5,580	1,817	**[25,134]**
Host communities	18,481	1,441	10,661	227	**30,810**	20,068	1,847	11,153	1,211	**[34,279]**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**32,051**	**2,751**	**14,679**	**519**	**50,000**	**[34,537]**	**[5,115]**	**[16,733]**	**[3,028]**	**[59,413]**
People with disabilities (PwD) out of the total										
	4,807	412	2,201	77	**7,497**	**611**	**331**	**177**	**26**	**[1,145]**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

People indirectly targeted in the project are the family members of the mothers and girls who received maternity services in the supported health facilities. Although RH services are purely meant for women and girls, men and boys were included in the awareness-raising activities and the referrals where they act as a Mahram for the patient. The total indirect beneficiaries are estimated at 40,000 individuals.

6. CERF Results Framework

Project objective	To improve access and utilization of Emergency Obstetric and Neonatal Care (EmONC) services building on the IRFF malnutrition criteria, for women and girls affected by humanitarian crisis in Taiz, Hajjah and Hodaidah governorates.
Output 1	Improved availability of Basic Emergency obstetric and new-born care services within 5 health facilities and 2 mobile teams

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health - Sexual and Reproductive Health

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	H.7 Number of functional health facilities supported (to provide reproductive health services)	7	7	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 1.2	SP.2b Number of people accessing services enabled by inter-agency emergency reproductive health kits	20,000	21,358	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 1.3	SP.2a Number of inter-agency emergency reproductive health kits delivered	77	77	UNFPA records, IPs records
Indicator 1.4	Number of Adolescent, Youth reached by RH awareness information and services	14,679	15,143	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 1.5	Number of HF BEmONC provided with incentives	5	5	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 1.6	AP.4b Percentage of affected people who state that the assistance, services and/or protection provided correspond with their needs	90%	94%	PDMs analysis and main findings

Explanation of output and indicators variance:	There was an increase in the number of people who received medications under the RH IAWG kits and in the awareness of RH among the youth population – especially in the IRG-controlled areas. The increase is attributed to the high demand among the beneficiaries for RH activities and RH rights.

Activities	**Description**	**Implemented by**
Activity 1.1	Support 5 Health facilities and 2 mobile teams to provide of life-saving reproductive health services by incentives for workers, RH kits, supplies and medicine for the delivery of BEmONC services.	UNFPA, BFD, DEEM

Activity 1.2	Provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) and Basic Emergency Obstetric and Newborn Care (BEmONC) to 20,000 women and girls.	UNFPA, BFD, DEEM
Activity 1.3	Strengthened referral of complicated obstetric emergencies from BEmONC to CEmONC	UNFPA, BFD, DEEM
Activity 1.4	Provision of RH services to outreach communities with the support of midwives, nurses (ANC, FP, Birth attendance, Post-natal Care.	UNFPA, BFD, DEEM
Activity 1.5	Provision of awareness activities to youth and adolescent on RH.	UNFPA, BFD, DEEM

Output 2	Improved availability of Comprehensive Emergency obstetric and new-born care (CEmONC) services within the 3 hospitals
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Health - Sexual and Reproductive Health

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	H.7 Number of functional health facilities supported (to provide CEmONC services.	3	3	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 2.2	RH.1 Number of births attended by skilled health personnel (in the supported health facilities.	1,000	1,920	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 2.3	Number of other reproductive healthcare consultations provided in the supported health facilities (ANC, PNC and FP, Post abortion care.	30,000	28,657	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 2.4	Number of live births supported through caesarean sections within the 4 hospitals.	450	502	UNFPA RH dashboard, IPs reports, hospitals registries
Indicator 2.5	Number of health care providers trained on CMR.	12	25	UNFPA RH and GBV dashboard
Indicator 2.6	PS.2 Number of people receiving GBV psycho-social support and/or GBV case management	800	1,130	UNFPA GBV dashboard, IPs reports, hospitals registries
Indicator 2.7	Number of fistula cases diagnosed and referred	30	18	[UNFPA RH/GBV dashboard, IPs reports, hospital registries]

Explanation of output and indicators variance:	UNFPA ensured healthy lives and promoted well-being for all at all ages by access to maternal and newborn health services/ family planning services with a focus on underserved areas and humanitarian emergencies in targeted sites increased through supporting the district hospitals at the targeted governorate and district. • A slight decrease in the anticipated number of RH consultations compared to the achieved based on the needs in the targeted locations. The targeted

	beneficiaries under the RH consultations represents 95% of the initial proposed beneficiaries. • A slight decrease in the number of identified Fistula cases as those were the only cases identified in the area. • An increase in all the remaining indicators is attributed to the high demands for the services, which puts the supported hospitals with large crowds and long waiting lists. • A slight increase in the health providers who received the CMR training, due to the needs, which covered by UNFPA costs. Referral case of vulnerable women and girls identified through the UNFPA supported HFs and MTs were documented to showcase the integrations and complementarity and meet the initial agreed mode of implementation of the CERF, building on the Humanitarian, Peace Development Nexus HPDNx. GBV integration focal persons were identified by the GBV partner that were working closely with the RH partners to address GBV survivor needs and further triangulate to subsequent services including SRH, nutrition and MPCA (more details are reflected in the attached human-interest stories). Moreover, medical capacity building on GBV case management and CMR were identified as a gap and were implemented in the second half of the project duration, a total of 25 health workers received technical training on Clinical Management of Rape CMR and were able to address the needs of GBV survivors in the main hospitals.

Activities	Description	Implemented by
Activity 2.1	Incentive payment to medical doctors, midwives, nurses, and laboratory technicians to ensure the provision of CEmONC services within the 4 hospitals	UNFPA, BFD, DEEM
Activity 2.2	Conducting training on CMR and case management of GBV cases and STI	UNFPA
Activity 2.3	Support the management and referral pathways of complicated cases like fistula and obstetrical complications.	UNFPA, BFD, DEEM
Activity 2.4	Provide Case management and multi-response services to identified GBV cases in the supported HFs or through the MTs.	UNFPA, BFD, DEEM

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[6] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

[6] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

a. Accountability to Affected People (AAP)[7]:

UNFPA continued to build its partners' capacities to ensure adherence to the accountability framework and measures, minimum standards based on international best practices, and a rights-based approach and code of conduct to ensure do-no-harm principles. The partners provided beneficiaries with information about the type of assistance, eligibility criteria, locations of services, and timing, during one-to-one consultations and service provision. At the initial phase of the project start, IPs were inducted on the IFRR criteria and the integration / complementarity approach among the UN agencies, joint meeting between UNFPA and other CERF receipt agencies and the IPs were held at the field levels to address integration and complementarities. In some cases, UNFPAs IPs are IPs of other UN agencies, and this eased the integration, the agencies and IPs agreed on sharing contact focal persons for referral of cases and regular meetings took place at the field level to follow up on the referrals and integration, although some challenges were experienced at the first months of the project implementation, referrals and complementarity responses took place. It's also worth mentioning in some of the selected HFs multiple agencies were providing different services to the same beneficiaries and this reflects on the complementarity of the responses. They also assessed the beneficiaries' satisfaction with the quality, timeliness, and relevance of the offered services.

The project was informed by cumulative organizational knowledge that consulted the local authorities, GHOs, communities, people with disabilities, and Muhamasheen, in the design phase, implementation, and monitoring and evaluation process. Modalities used included focus group discussions, surveys, and pilot testing.

b. AAP Feedback and Complaint Mechanisms:

The complaint mechanism was fully implemented within the CERF-supported facilities. UNFPA M&E team addressed 9 complaints and feedback received from the beneficiaries through direct interaction with the beneficiaries during the field visits. The mechanism included hotlines, social media, phone number, and WhatsApp. The system is anonymous and confidential. UNFPA maintained confidentiality of the complaints and feedback system by not asking people to reveal their identity, assigning only the UNFPA officer in charge to receive and respond to the complainer, and not sharing the complaints with anyone, only the relevant program staff for his/her did follow-up. In addition to the UNFPA run feedback mechanism, the IPs had and acted on their own mechanisms (. e.g., suggestion and complain boxes) and contributed to the CFM maintained by OCHA.

During the reporting period the UNFPA CFM received 15 complaints from the project beneficiaries and other community members through UNFPA CFM. The average of the complaints varied from GBV-CVA beneficiaries selection criteria and time of enrolment to the income generation programs. All the received complaints were addressed by the UNFPA and reported as resolved in the CFMs system.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

No reports related to SEA were raised during the project implementation. The UNFPA standard procedure and measures which were implemented during this project in all sites are stated below:

UNFPA maintained its standard mechanism for recording and handling SEA-related complaints. No PSEA complaints were received during the CERF implementation period. UNFPA and its implementing partner have all been trained on PSEA, including reporting, handling, and follow-up actions. Yearly updates on the PSEA e-training are compulsory for the UNFPA and the Implementing Partner staff members, including those based at the field.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Women and girls are the primary targets in this project. The identified 150 GBV cases in the supported health facilities were referred to the nearest UNFPA-supported Women and Girls Safe Spaces for centered GBV response services. Additional referrals were made available to other UN agencies via the case management group.

[7] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

e. People with disabilities (PwD):

UNFPA targeted women and girls with disabilities and ensured that the targeted Health Facilities were as disabled-friendly as possible; through the implementation of international guidelines in facilitating the access of women and girls with disabilities to the Hospitals, facilities, and outreach teams. This included the physical safety of the health centers, as well as the orientation of the facilities staff on how to deal with PwD. UNFPA with its partner took into consideration instalment of necessary measures in the services to make them accessible, and training of the staff in providing services to women and girls with disabilities.

The project took actions to ensure that women and girls with disabilities are protected and have easier access to the various services. The response services include disabled women and girls as a vulnerability criterion.

f. Protection:

The project responded to the protection needs of women and girls -especially lactating, pregnant and the most vulnerable women and girls and ensured they have dignified access to lifesaving pregnancy and childbirth care in a safe environment. The service providers in the supported health facilities received sensitizations sessions on PSEA preventions, as well as on how to ethically deal with identified GBV survivors.

g. Education:

[NA]

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	**Achieved**	**Total number of people receiving cash assistance:**
No	Choose an item.	[Fill in]

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

NA

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
CERF Media Coverage	https://www.facebook.com/UnfpaYemen/posts/pfbid02mz1RYbTukea3wconCq3cZQB3cFzKDCGRWoyNhL7u9SUKyFam61xRcSyR1rB89ssbl
CERF Media Coverage	https://www.facebook.com/UnfpaYemen/posts/pfbid0cDRkTcSQeC61caeWngF5584kAzTgbwUJWdgeTThsA63JSVFCoYCy5kKvyVTnCXKkl
CERF Media Coverage	https://www.facebook.com/UnfpaYemen/posts/pfbid0X5B4atcoRjs1QQy6mmSt8bVpoynTrytb6SMDc6cAiXMdid3pswRD358nVS8hu2ZLl
Press release to highlight the CERF support	https://yemen.unfpa.org/en/news/cerf-supports-provide-maternal-health-services-high-food-insecurity-areas-yemen
Press release to highlight the CERF support	https://arabstates.unfpa.org/en/news/cerf-supports-provide-maternal-health-services-high-food-insecurity-areas-yemen-0
Press release to highlight the CERF support	https://reliefweb.int/report/yemen/un-central-emergency-response-fund-supports-unfpa-provide-lifesaving-maternal-health-services-high-food-insecurity-areas-yemen-enar
Media Coverage	https://sahafaty.com/news18649797.htm https://daffaqnews.com/?p=37750 https://sahafaa.net/show120758876.html https://yemennownews.com/article/2225664 https://alsjl-news.com/n/5333601 https://www.sahafahh.com/show16561633.html https://samaaden.news/archives/89169 https://shorturl.at/bBDK5 https://shorturl.at/lpqx6 https://www.alwfaqnews.net/index.php/local-news/2023-06-05-14-15-59 https://www.aden-alhadath.info/index.php/posts/111930 https://www.adentodey.net/archives/104493 https://sahafaty.com/news18649797.htm https://daffaqnews.com/?p=37750 https://sahafaa.net/show120758876.html

	https://yemennownews.com/article/2225664 https://alsjl-news.com/n/5333601 https://www.sahafahh.com/show16561633.html https://samaaden.news/archives/89169 https://shorturl.at/bBDK5 https://shorturl.at/lpqx6 https://shorturl.at/bswzG https://shorturl.at/syHU2 https://shorturl.at/aJKNT https://rb.gy/t7pepx https://rb.gy/9p5fq6 https://yemenfuture.net/news/14800 https://sabapost.net/?p=2636 https://yementdy.tv/news30857.html https://www.almashhad-alyemeni.com/256251 https://yem-now.net/news87244648.html https://www.ye-now.net/news87244648.html https://newsformy.com/news-1668234.html https://yemennownews.com/details/2220833 https://www.alayyam.info/news/9FMGR25K-H19KF6-A6D8 https://www.alwfaqnews.net/index.php/local-news/2023-06-05-14-15-59 https://www.aden-alhadath.info/index.php/posts/111930 https://www.adentodey.net/archives/104493
Double the joy after a harrowing ride to give birth - Human interest stories mentioning CERF support	https://yemen.unfpa.org/en/news/double-joy-after-harrowing-ride-give-birth-yemen
The woman who travelled seven hours by camel to give birth - Published in BBC News to highlighting the urgent reproductive	https://www.bbc.com/news/world-middle-east-65362736

health needs of women and girls in Yemen	
Situational Reports mentioning CERF support	https://yemen.unfpa.org/en/publications/situational-report-04-october-december-2023 https://yemen.unfpa.org/en/publications/situational-report-02-april-june-2023
Social media posts	https://x.com/UNFPAYemen/status/1748950358510928276?s=20 https://x.com/UNFPAYemen/status/1698231514264125890?s=20 https://x.com/UNFPAYemen/status/1665609526228267009?s=20 https://x.com/UNFPAYemen/status/1665342983527452678?s=20

3.4 Project Report 23-RR-HCR-013

1. Project Information

Agency:	UNHCR	**Country:**	Yemen
Sector/cluster:	Multi-Purpose Cash	**CERF project code:**	23-RR-HCR-013
Project title:	Provision of multipurpose cash assistance to displaced Yemeni families facing acute food insecurity		
Start date:	26/05/2023	**End date:**	25/12/2023
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 22,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 1,450,000**
Total CERF funds sub-granted to implementing partners:	**US$ [0]**
Government Partners	US$ [0]
International NGOs	US$ [0]
National NGOs	US$ [0]
Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

Through this CERF UFE grant, UNHCR provided multi-purpose cash assistance (MPCA) to 3,522 households and 21,360 individuals facing acute food insecurity. Particularly vulnerable households received two transfers, thus enhancing the impact on these food insecure families. A total of 5,689 transfers were made, enabling the most vulnerable HHs to receive a second instalment of MPCA. The assistance supported 3,968 men, 4,365 women, 6,664 boys, and 6,363 girls.

The assistance was delivered in Al Hodeidah and Hajjah governorates in Al Mighlaf (650 households, 3,854 individuals, and 956 transfers), Zabid (1,796 households, 10,907 individuals, and 3,261 transfers), and Qafi Shammar districts (1,076 households, 6,599 individuals, and 1,472 transfers). The transfers were made between 10.08.2023 and 25.12.2023.

The project designed envisioned the referral of MPCA beneficiaries from Nutrition Partners. Due to the challenges faced by Nutrition Partners, these implementing partners were only able to refer 1,139 HHs, while 2,383 HHs were identified through UNHCR direct targeting within the same targeted locations by other partners under this allocation. These figures compose the total number of unique beneficiaries reported in this intervention (3,522 HHs). UNHCR considered food security criteria to target the population and to align to the project design. The population receiving the second instalment (2,167 HHs) has been prioritized out of the group identified by UNHCR. Unfortunately, the referral from Nutrition Partners did not include any socio-economic information that could have been used for prioritization, while UNHCR identification process collected a comprehensive dataset.

The intervention bridged a critical gap in the implementation of nutrition activities, through the inclusion of cash assistance (MPCA), as a complementary intervention to expand the impact on food insecure populations. The assistance contributed to reducing food insecurity and meeting nutrition needs during the implementation period. Moreover, the targeting method, through household level assessments

and referrals from nutrition partners (UNICEF, WFP), ensured only those who were vulnerable and in need were supported with MPCA. es."

The project reached the expected outcome and impact, by delivering life-assistance assistance to food insecure households. UNHCR closely coordinated the intervention with the other MPCA partner (IOM), ensuring no overlap in the geographical coverage within this project. UNHCR also led the coordination with Nutrition Partners, facilitating the referral process, despite the limitations and challenges faced by other implementing partners.

3. Changes and Amendments

Challenges arose related to the referral of beneficiaries from agencies implementing nutrition programmes (UNICEF, WHO, WFP) to agencies implementing MPCA (IOM, UNHCR). The mechanism originally envisioned and agreed was unable to provide enough vulnerable beneficiaries eligible for MPCA, according to the criteria. Specific issues included: referral data lacked key points (e.g. phone and ID number) despite clarity on requirements from the proposal stage; local authorities did not timely provide clearance to nutrition programme agencies to share beneficiary data.

To resolve this, UNHCR and IOM implemented alternative methods to identify eligible beneficiaries in target locations (household assessments). Due to delays caused linked to the need for a different approach to identify beneficiaries, a project re-programming and extension request (for one month) was submitted to CERF. Changes included assisting a portion of the beneficiaries with two transfers, thus reducing the overall target, but enhancing impact on those reached. The request was approved, and implementation proceeded accordingly.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Multi-Purpose Cash									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	476	379	757	771	**2,383**	2	1	3	2	**8**
Internally displaced people	4,967	3,953	7,890	8,037	**24,847**	3,512	3,246	5,514	5,718	**17,990**
Host communities	1,520	1,175	1,995	2,118	**6,808**	851	721	846	944	**3,362**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**6,963**	**5,507**	**10,642**	**10,926**	**34,038**	**4,365**	**3,968**	**6,363**	**6,664**	**21,360**
People with disabilities (PwD) out of the total										
	286	223	418	435	**1,362**	**489**	**408**	**480**	**532**	**1,909**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

The assistance only targeted direct beneficiaries. However, other indirect benefits of the intervention include business owners and others who benefit from the additional cash in the market and the purchase of goods and services that are locally available, thus having a positive impact on the economy. Unfortunately, it is not possible to quantify how many people benefitted in this manner.

6. CERF Results Framework

Project objective	Provide multipurpose cash assistance in support of the most vulnerable internally displaced Yemenis facing high acute food insecurity in Al Hodeidah and Hajjah.
Output 1	Sectoral cash grants distributed to support 34,038 of the most vulnerable Yemenis

Was the planned output changed through a reprogramming after the application stage? Yes ☒ No ☐

Sector/cluster	Multi-Purpose Cash			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Cash.1a: Number of people receiving multi-purpose cash	34,038	21,360	Bank reconciliation report
Indicator 1.2	Cash.1b Total value of multi-purpose cash distributed in USD	1,293,426	1,316,611	Bank reconciliation report
Indicator 1.3	# of post distribution monitoring (PDM) surveys conducted	1	0	N/A

Explanation of output and indicators variance:

The original target of people receiving MPCA was reduced in the project amendment signed on 11 October 2023. Due to challenges in the referral of beneficiaries from nutrition partners, UNHCR had to request a no-cost extension, as well as a project reprogramming, to modify the identification process of beneficiaries. While the full caseload of beneficiaries was initially agreed to be generated by referrals from nutrition partners, only 1,139 HHs (6,916 individuals) received cash assistance through this identification modality. The remaining population was identified through household level assessments conducted by UNHCR partners. To respond to the acute food insecurity of the targeted population, the project reprogramming also envisioned the need for the provision of a second instalment to the most vulnerable households, thus reducing the overall number reached, but increasing impact on those reached. UNHCR identified 2,383 HHs for the first instalment of MPCA, out of them, 2,167 HHs have been prioritized for the second instalment. The response implemented was aligned to the original objectives of the project and enabled the delivery of life-saving cash assistance to 21,360 vulnerable and food insecure Yemenis.

During the implementation of the project, UNHCR faced a rejection from DFA on the Post-Distribution Monitoring template, with the request for removing critical questions. UNHCR has negotiated with the Authorities, but no agreement was reached during the implementation time. Due to the substantial removal of critical questions, UNHCR put on hold its PDMs activities (not limited to this project) and continued the negotiation with the authorities, with the aim of maintaining the critical questions and conduct a meaningful PDM. UNHCR is following up with the Authorities on the PDM and is expecting to reach an agreement within the first quarter of 2024. As soon as PDM activities resume, UNHCR will target beneficiaries of this intervention (through internal funding) and will report the findings to OCHA. Meanwhile, during the

	implementation of the project, UNHCR allocated the savings from the PDM activities to cash assistance, as can be seen in the final amount disbursed to vulnerable population (USD 1,316,611).

Activities	Description	Implemented by
Activity 1.1	Identification and verification of target households (via registration of referred cases from IFRR actors)	Partially from Nutrition partners (UNICEF, WFP) and UNHCR direct targeting
Activity 1.2	Monthly provision of multipurpose cash grants	UNHCR
Activity 1.3	Conduct post distribution (PDM) survey	UNHCR (not implemented)

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[8] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[9]:

In compliance with the AAP framework and UNHCR age, gender, and diversity (AGD) policy, UNHCR's MPCA programming mainstreams protection and AGD considerations in all interventions to effectively identify and address the different protection and assistance needs of various segments of the population and with attention towards the most marginalized.

Further, UNHCR and its partners ensure the availability of CFMs, giving people a range of channels to make complaints or provide feedback. Moreover, through household level assessments, individual families are considered and have a direct communication channel and are also referred to additional services as needs are identified. In this way, the various capacities and priorities of women, men, girls, and boys of diverse backgrounds, minority groups, persons with disabilities, and older persons are considered.

During the implementation of the project, UNHCR faced a rejection from DFA on the Post-Distribution Monitoring template, with the request for removing critical questions. UNHCR has negotiated with the Authorities, but no agreement was reached during the implementation time. Due to the substantial removal of critical questions, UNHCR put on hold its PDMs activities (not limited to this project) and continued the negotiation with the authorities, with the aim of maintaining the critical questions and conducting a meaningful PDM. UNHCR is following up with the Authorities on the PDM and is expecting to reach an agreement within Q1 of 2024. As soon as PDM activities resume, UNHCR will target beneficiaries of this intervention (through internal funding) and will report the findings to OCHA. Meanwhile, during the implementation of the project, UNHCR allocated the savings from the PDM activities to cash assistance, as can be seen in the final amount disbursed to vulnerable population (USD 1,317,760). The additional cash assistance delivered through the savings generated by the freeze of PDM activities targeted population following the identification modality agreed in the project amendment (UNHCR direct targeting).

b. AAP Feedback and Complaint Mechanisms:

[8] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[9] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

UNHCR continued to support safe and accessible Community-Based Complaints Feedback Mechanisms (CFM) to gather feedback and complaints that may arise, including confidential pathways to report on sexual exploitation and abuse (SEA). Confidential feedback mechanisms were in place for UNHCR and partners, and hotlines, emails, physical complaints boxes in partners' offices/distribution points, and dedicated partners' staff to manage such mechanisms and ensure follow-up.

According to UNHCR Yemen's national level CFM dashboard, during the implementation period and in the target governorates, a total of 67 instances of complaint or feedback were recorded. Of these 47.8 per cent were information requests, 37.3 per cent were complaints, and 14.9 per cent were requests for assistance. In three per cent of cases, the case was closed through counselling on the spot with no need for further referral. In 97 per cent of cases, the individual was referred for further assistance (in 70 per cent of cases for general protection assistance).

c. Prevention of Sexual Exploitation and Abuse (PSEA):

UNHCR trains staff on the complaints feedback mechanisms (CFM) and the UNHCR Code of Conduct and Protection against Sexual Exploitation and Abuse (PSEA). Furthermore, UNHCR ensures partners employ male and female staff to conduct awareness-raising activities to enhance access, facilitate communication and mitigate the risk of SEA. Messages and information on PSEA channels were shared with communities during activities, at service points and distribution sites, and leaflets were available at partners offices/distribution points. No PSEA complaints were reported during the implementation of this project.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Gender equality is central to UNHCR's AGD approach, which is applied to all interventions. The commitments to Women and Girls implicitly recognize the diversity amongst them, including older women; adolescent girls and female youth; women and girls belonging to national or ethnic, religious, and linguistic minorities or indigenous groups; women and girls with disabilities; and women and girls of diverse sexual orientations and gender identities. Though the focus of these commitments is on women and girls, UNHCR recognizes that gender inequalities also negatively impact men and boys. Therefore, it is essential to promote equal rights, integrity, well-being, and equitable access to services for all persons of concern. Within the population identified by UNHCR (2,383 HHs), 329 are female headed households (14% of the total households). Due to limited information included in the referrals received from nutrition partners, it is not possible to share information on this population group.

Through this funding, UNHCR channelled cash funding directly towards food insecure households via its firmly established unconditional multi-purpose cash program, focusing on women, children, the elderly, and persons with disabilities. Beneficiaries of assistance through this project were identified via referral from nutrition partners and direct targeting operated by UNHCR, prioritizing food insecure households.

e. People with disabilities (PwD):

The intervention covered persons with specific needs, including heads of households with disabilities, single parents taking care of a child with a disability, and other persons with disabilities unable to support themselves. Through this intervention, UNHCR and its partners identified and assisted 1,909 persons with disabilities with MPCA.

f. Protection:

UNHCR and its partners ensure the availability of CFMs, giving people a range of channels to make complaints or provide feedback. Moreover, through household level assessments, individual families are considered and have a direct communication channel and are also referred to additional services as needs are identified. In this way, the various capacities and priorities of women, men, girls, and boys of diverse backgrounds, minority groups, persons with disabilities and older persons are considered.

For example, according to UNHCR Yemen's national level CFM dashboard, during the implementation period and in the target governorates, a total of 67 instances of complaint or feedback were recorded. In 97 per cent of cases, the individual was referred for further assistance (70 per cent of these cases were referred to additional general protection assistance).

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	21,360

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

UNHCR defines priority needs and builds programmatic interventions based on field assessments, carried at the household level, resulting in evidence-based programming. Further, individual beneficiaries were selected through UNHCR's household level assessment tool, and MPCA scorecard was modified to address food security needs of the most vulnerable displaced people and host community members. This allowed UNHCR to target the most vulnerable and in need among Yemeni displaced communities in the prioritized areas of the intervention.

The distribution of multi-purpose cash benefited members of the receiving households, helping them decide what their needs are and how best to address them, which in turns gives them the dignity and control over their lives. In areas where markets are functioning and accessible, this type of intervention activates local economies and contributes to market development, a critical aspect in the Yemen context.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Activity 1.2	21,360 individuals	US$ [1,316,611]	Multi-Purpose Cash	Unrestricted

9. Visibility of CERF-funded Activities

Title	Weblink
UNHCR Yemen Tweet	https://twitter.com/UNHCRYemen/status/1739939181051187521
Cash Based Interventions Factsheet – UNHCR Yemen	https://reporting.unhcr.org/yemen-cash-based-interventions-factsheet
Tweet on cash-based interventions	https://twitter.com/UNHCRYemen/status/1757694380461179235

3.5 Project Report 23-RR-CEF-024

1. Project Information

Agency:	UNICEF	**Country:**	Yemen
Sector/cluster:	Nutrition Health Water, Sanitation and Hygiene	**CERF project code:**	23-RR-CEF-024
Project title:	Multisectoral health, nutrition, WASH response to malnutrition and food insecurity in Taiz, Hajjah and Hodeidah		
Start date:	26/05/2023	**End date:**	25/11/2023
Project revisions:	No-cost extension ☐ Redeployment of funds ☐ Reprogramming ☐		

Funding

Total requirement for agency's sector response to current emergency:	**US$ 20,707,844**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 6,200,000**
Total CERF funds sub-granted to implementing partners:	**US$ 1,954,129**
Government Partners	US$ 1,652,422
International NGOs	US$ 0
National NGOs	US$ 301,707
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

UNICEF through the CERF contribution implemented multisectoral health, nutrition and WASH interventions to respond to malnutrition and food insecurity in Taiz, Hajjah and Hodeidah. As part of the health interventions, UNICEF contributed to maintaining primary health care (PHC) services benefitting 231,254 vulnerable people in the selected districts in Hajjah, Hodeidah and Taiz by providing operational support to 60 health facilities, capacity building support on integrated management of childhood illness (IMCI) to 196 health workers and provision of 861,700 doses of lifesaving vaccines and medical supplies. The support also included improving access at community level by providing performance-based allowances to 117 Community Health Workers (CHWs) to bring services closer to the most in need.

As part of the nutrition interventions, , UNICEF reached 120,225 people [21,190 boys and 23,642 girls under five and 75,393 pregnant and lactating women (PLW)] with an integrated package of nutrition services, including support to 7 mobile teams (MT)s, 60 health facilities and 7 therapeutic feeding centres (TFCs), training 104 health workers on Community Management of Acute Malnutrition (CMAM) and Infant and Young Child Feeding, 716 supportive supervision visits and 2 SMART surveys conducted (one in Taiz and one in Al-Hodeida), and procurement of 17,308 hygiene kits distributed to children with Severe Acute Malnutrition (SAM). 5,607 children under five with SAM without complications were enrolled in the 7 supported MTs and the supported 60 health facilities in the targeted governorates. Between May and November 2023, 2,593 SAM children with complications (1,271 boys and 1,322 girls) were successfully admitted for treatment in the supported TFCs and were supported with nutrition cashed vouchers to admit their children to the nearest TFCs in targeted governorate as part of UNICEF's Nutrition Voucher Scheme (NVS) programme. 3,522 female community health and nutrition volunteers (CHNVs) were supported with performance-based allowances to for the months of June to September 2023 and reached to 35,991 children under five (18,120 boys and 17,871 girls), 12,776 adolescent girls, and 99,376 PLW with preventive nutrition services. As a result of these interventions, the cure rate for both the outpatient and inpatient programs surpassed the Sphere standards, reaching an impressive 98.3% and 98.6% respectively.

UNICEF reached 103,003 people with provision of integrated lifesaving WASH services aimed at improving health and nutrition status of vulnerable women and children in the targeted districts in Hodeidah, Hajjah and Taiz, including 50,586 people provided with access to safe drinking water , rehabilitation of WASH facilities in the OTPs and TFCs targeted by the health and nutrition interventions; 49,654 people were provided with access to basic sanitation services and 63,002 people received awareness messages on positive WASH behaviours through hygiene promotion initiatives.

UNICEF, WFP and WHO worked with IOM, UNHCR FAO and the nutrition cluster and food security cluster to ensure that the children with SAM and moderate acute malnutrition (MAM) and PLW receiving nutrition support from UNICEF, WFP and FAO under the CERF would be also targeted for cash and livelihood assistance.

3. Changes and Amendments

No change to the health and nutrition interventions were made.

The nutrition activities were successfully implemented as planned. However, it is worth noting that a higher number of children under the age of five and PLWs were reached through various platforms during the project. This increase in reach can be attributed to several factors, including the seasonality factor, as the reporting period from May to October coincided with the peak of severity of malnutrition in Yemen. The CERF funding supported the monthly review meetings for 3,522 CHNVs (instead of 896 CHNVs) which led to expanded beneficiaries' coverage by different services such as screening, referral, micronutrient supplementation, and infant and young child feeding counselling for PLWs within their communities. Consequently, more SAM admissions were observed at health facilities and MMTs. In addition, UNICEF managed to procure a higher number of hygiene kits than originally planned, as the actual unit cost was lower than initially estimated.

For the WASH activities, UNICEF implemented most of the activities as planned. Due to an oversight, Qafl Shammar district in Hajjah and Meghlaf, Zabid and Ad Dohi districts in Hodeidah were not included in the logframe description, but form part of the approved budget, project summary and planned beneficiary targets.

Given the needs on the ground, the number of health facilities was increased from 10 to 20 and number of distributed hygiene kits was increased from 10,000 to 22,236, allowing UNICEF to reach a higher number of beneficiaries. The increase did not affect the budget allocated to each activity, or the outputs planned under the project. For rehabilitation, the initial plan was to carry out major rehabilitations and construction of new WASH facilities, however upon realizing that the need was more, UNICEF focused on rehabilitations only aimed at restoring functionality to existing systems. This costed less hence the ability to cover more.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	5,530	0	13,382	12,858	**31,770**	5,972	0	14,453	13,887	**34,312**
Host communities	31,338	140	72,834	75,859	**180,171**	33,845	140	81,030	81,927	**196,942**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**36,868**	**140**	**86,216**	**88,717**	**211,941**	**39,817**	**140**	**95,483**	**95,814**	**231,254**
People with disabilities (PwD) out of the total										
	3,687	0	8,922	8,572	**21,181**	3,982	0	9,548	9,581	**23,111**

Sector/cluster	Nutrition									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	3,615	0	4,298	4,324	**12,237**	15,079	0	4,728	4,238	**24,045**
Host communities	12,588	0	16,287	16,408	**45,283**	60,314	0	18,914	16,952	**96,180**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**16,203**	**0**	**20,585**	**20,732**	**57,520**	**75,393**	**0**	**23,642**	**21,190**	**120,225**
People with disabilities (PwD) out of the total										

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

	1,602	0	2,058	2,073	**5,733**	**7,539**	**0**	**2,364**	**2,119**	**12,022**

Sector/cluster	Water, Sanitation and Hygiene									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	6,480	6,615	6,885	7,020	**27,000**	8,770	8,339	9,366	9,603	**36,078**
Host communities	12,720	12,985	13,515	13,780	**53,000**	16,242	15,589	17,334	17,759	**66,924**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**19,200**	**19,600**	**20,400**	**20,800**	**80,000**	**25,012**	**23,928**	**26,700**	**27,362**	**103,002**
People with disabilities (PwD) out of the total										
	570	582	605	617	**2,374**	750	718	801	821	**3,090**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

While the project targeted SAM children through provision of facilities like improved latrines, other children and caregivers also benefited from the provided facilities. The project targeted children receiving services from OTP/TFCs; however, the rehabilitation of WASH facilities in Health Care Facilities benefitted the whole catchment population. Though special focus was on communities with high SAM cases, hygiene promotion and distribution of hygiene kits benefitted more communities reaching to more than 80,949 people (21, 405 boys, 20,911 girls, 19,383 men and 23,016 women). In addition, more than 101,166 families indirectly benefited from active screening in their community by the CHNVs as it prevented them from being severely malnourished and they also received the needed IYCF counselling in the six prioritised districts.

6. CERF Results Framework

Project objective	Alleviate the immediate suffering of food insecure populations in Hajjah, Hodeidah and Taiz with timely and high-impact multisectoral assistance (health, nutrition, WASH)
Output 1	211,624 vulnerable children in the selected districts for Hajjah, Hodeidah and Taiz have sustained access to essential lifesaving health care services through support to health facilities, capacity building of health staff and provision of lifesaving vaccines and medical supplies

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	H.7 Number of functional health facilities supported	60	60	Payments to HFs
Indicator 1.2	H.8 Number of children and women accessing PHC services	211,624	231,254	MoPHP information system
Indicator 1.3	Number of health workers trained	200	196	Training reports and monitoring visits reports
Indicator 1.4	Number of CHWs supported with refresher training and per diems	117	117	UNICEF MIS
Indicator 1.5	Number of doses of vaccines procured	550,000	861,700	Vaccine Arrival reports
Indicator 1.6	AP.5b Percentage of affected people who state that they were able to access humanitarian assistance and services in a safe, accessible, accountable and participatory manner	95%	95%	Third Party Monitoring reports

Explanation of output and indicators variance:

- Indicator 1.2 Number of children and women reached is slightly higher than the target as improving quality of care has increased the services uptake.
- Indicator 1.4 Out of the planned 200 health workers to be trained through 10 trainings for 20 health workers each, some health workers could not attend and could not be replaced.
- Indicator 1.5 UNICEF effectively utilized the allocated funds to procure a greater quantity of doses than originally projected (550,000 doses), thanks to cost-efficient measures. This was achieved because the unit cost for the vaccines was lower than initially expected.

	Independent third-party monitoring was conducted to ensure performance-based allowance recipients received their entitled amount and that agreed processes and protocols were followed. The results from third-party monitoring include allowance recipients whose allowances were covered by other donors and are as follows: - 95 per cent of the respondents received their correct amount. - 94 per cent of the respondents were able to collect allowance on their first attempt. - 100 per cent of the respondents reported being treated very politely (59 per cent) or politely (41 per cent). - 99 per cent of the respondents were highly satisfied (45 per cent) or satisfied (54 per cent) with the project. High satisfaction was mainly attributed to a well facilitated and smooth payment process (88 per cent), a fast payment process (68 per cent), polite and friendly staff (42 per cent) and well-organised payment sites (21 per cent).

Activities	**Description**	**Implemented by**
Activity 1.1	Support service delivery gap for PHC facilities for 5 months focusing on measles vaccination through outreach and mobile teams	MOPHP and Governorate Health Offices (GHOs) Hajjah, Hodeidah and Taiz
Activity 1.2	Support training of 200 health workers on IMCI latest guidelines including the case management of measles	MOPHP and GHOs in Hajjah, Hodeidah and Taiz
Activity 1.3	Support CHWs on health education and mobilization of communities for increased uptake on measles vaccination	MOPHP and GHOs in Hajjah, Hodeidah and Taiz
Activity 1.4	Procurement of vaccines to improve vaccination coverage and prevent vaccine preventable disease outbreaks including measles	UNICEF

Output 2	57,520 children 6 – 59 months and women in Hajjah, Taiz and Hodeidah have access to life-saving preventive and curative nutrition services through improved access to TFCs, provision of hygiene kits and nutrition vouchers, active screening for malnutrition, provision of preventive nutrition services, capacity building and evidence generation.
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Nutrition

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	N.3a Number of people admitted to SAM treatment programmes (therapeutic feeding)	3,570	5,607	CMAM monthly reports
Indicator 2.2	Number of hygiene kits distributed to children with SAM with/without complications	15,000	17,308	UNICEF supply reports and delivery notes
Indicator 2.3	Number of children receiving SAM treatment through supported TFCs	3,214	2,593	CMAM monthly reports
Indicator 2.4	Cash.5a number of people receiving conditional vouchers	3,214	2,593	UNICEF MIS/reports
Indicator 2.5	Number of CHNVs participating in review meetings	896	3,522	The CHVs reports

Indicator 2.6	N.4 Number of people screened for acute malnutrition	51,520	96,827	CMAM monthly reports
Indicator 2.7	N.5 Number of people receiving vitamins and/or micronutrient supplements	34,533	38,284	CMAM monthly reports
Indicator 2.8	Number of SMART surveys conducted	2	2	SMART final report
Indicator 2.9	Number of health workers receiving training	168	104	Training reports
Indicator 2.10	Number of supportive supervision visits conducted	344	716	Supportive supervision reports
Indicator 2.11	Cash.5b Total value of conditional vouchers distributed in USD	498,170	500,500	UNICEF data/ Exchange agency report
Explanation of output and indicators variance:		• Indicator 2.1: Originally, the indicator was calculated from the MTs only, but the achievement is calculated from both the supported 60 HFs and the 7 MTs in Hajjah, Taiz and Hodeidah. CERF supported the health facilities under the health component, and the HFs allowed to admit more children with SAM, therefore the change in approach. • Indicator 2.2: UNICEF was able to procure a higher number of hygiene kits than planned as the actual unit cost was lower than initially estimated. • Indicator 2.3: Around 81% of the target was achieved as total of 2,593 SAM children under five with complications were admitted to the 7 TFCs in the targeted districts. This can be attributed to the comprehensive nature of the program, which involved the participation of multiple UN agencies, including WHO, who also managed a similar program in the same governorates and districts that reached other children. • Indicator 2.5: 3,522 CHNVs were supported to attend monthly review meetings in the targeted districts for a period of 3 months, instead of the initially planned support for 896 CHNVs over 6 months. The standard rate per CHNV per quarter is set at 50 USD, but due to variations in their performance, not all volunteers were eligible for the full entitlement. As a result, some funds became available, allowing for the inclusion of additional CHNVs within the same targeted districts. • Indicator 2.6 and 2.7: This increase in reach can be attributed to several factors, including the seasonality factor, as the reporting period from May to October coincided with the peak of severity of malnutrition in Yemen and the fact that more CHNVs were supported that allowed to reach more children than initially planned. • Indicator 2.9: The indicator was partially achieved, with 104 health workers receiving a 6-day refresher training on Community-Based Management of Acute Malnutrition (CMAM) and Infant and Young Child Feeding (IYCF). The training duration was extended to include additional subjects such as Infection Prevention and Control (IPC) for Cholera and COVID-19 because of the cholera outbreak. As a result, a smaller number of health workers were trained using the budget allocated for this activity. • Indicator 2.10 The increase in CHNVs was linked to the increase in supportive supervision visits (one visit for one CHNVs)		

	Details of beneficiaries reached through integrated package of health and nutrition services provided by the MTs (only not including the HFs) can be found below: • 60,836 children aged 6 – 59 months (29,149 boys and 31,687 girls) were screened for malnutrition using MUAC, weight for height measurement and oedema check, out of which 5,607 SAM children were admitted for treatment. • 28,724 children aged 6 – 59 months (13,683 boys and 15,041 girls) received micronutrient supplementation, and 11,367 children aged 12 – 59 months (5,444 boys and 5,923 girls) received deworming tablets. • 5,336 PLWs received iron – folic acid supplementation while 13,174 PLWs received educational messages and counselling on children feeding and optimal nutrition during pregnancy and lactation. • 16,515 under five-year children (7,884 boys and 8,631 girls) received management of common childhood illnesses. • More than 4,664 under two years children and 3,316 mother at reproductive age received routine immunization. • 7,782 PLWs received antenatal and postnatal care.

Activities	Description	Implemented by
Activity 2.1	Support treatment of 3,570 children with SAM through the deployment of 7 mobile teams (MTs) in Hajjah, Taiz and Hodeidah to conduct integrated health and nutrition services in the focus districts	UNICEF, Governorate health offices (GHOs), District Health Offices (DHOs)
Activity 2.2	Support treatment of 3,570 children with SAM through the provision of hygiene kits	UNICEF, GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs
Activity 2.3	Support the treatment of 3,214 severely malnourished children with complications by ensuring the functionality of 7 UNICEF supported therapeutic feeding centers (TFCs) in the catchment areas of the focus districts	UNICEF, GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs
Activity 2.4	Provision of nutrition vouchers to 3,214 mothers of children enrolled for treatment in UNICEF supported TFCs	UNICEF, GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs
Activity 2.5	Support active case finding for severe acute malnutrition and delivery of preventive nutrition services at community level (including IYCF counselling, micronutrient powder supplementation for children under 5, iron folic acid supplementation for pregnant and lactating women (PLW)s and adolescent girls) by supporting 896 CHNVs to attend monthly review meetings at their nearest health facilities within the focus districts.	GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs
Activity 2.6	Support the implementation of 2 Nutrition SMART surveys.	UNICEF, GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs
Activity 2.7	Support the 5 days refresher training course for 168 health workers on Community-Based Management of Acute Malnutrition (CMAM) and Infant and Young Child Feeding (IYCF)	UNICEF, GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs
Activity 2.8	Support 344 monitoring and supportive supervision of nutrition interventions at districts and governorate levels.	UNICEF, GHOs (Hodeida IRG GHO, Hodeida DFA GHO, Hajja GHO, Taiz GHO), DHOs

Output 3	80,000 vulnerable people in selected districts in Hajjah, Taiz and Hodeidah have access to sufficient water of appropriate quality for drinking, cooking, and maintaining personal hygiene, providing access to basic sanitation services and hygiene promotion for preventing the risk of having WASH related diseases.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	WS.6 Number of people accessing a sufficient quantity of safe water for drinking, cooking and personal hygiene use as per agreed sector/cluster	60,700	50,586	cluster reports, IP reports Program Monitoring Visits (PMVs) reports
Indicator 3.2	WS.9a Number of people who report directly using safe and dignified toilet/latrines with functional handwashing facilities, (with soap/cleaning agent and water)	35,669	49,654	List of beneficiaries, cluster reports, IP reports PMVs reports.
Indicator 3.3	WS.16b Number of WASH/hygiene kits distributed	10,000	22,236	List of beneficiaries, cluster reports, IP reports PMVs reports.
Indicator 3.4	Number of people demonstrating safe hygiene practices after having received awareness raising activities on hygiene promotion	40,000	63,002	cluster reports, IP reports PMVs reports.

Explanation of output and indicators variance:

Indicator 3.1: The variation is due to discrepancy between the initial estimates received by the Local Water and Sanitation Corporation (LWSC) and the actual number of beneficiaries reached by the end of the activities.

Indicator 3.2. Overachievement was due to the influx of IDPs to the targeted sites.

Indicators 3.3 and 3.4 -Based on the identified needs on the ground, the number of distributed hygiene kits were increased based on the needs and utilizing the savings, subsequentially increasing the number of people reached by awareness raising activities.

Specific activities implemented by partners through UNICEF support included:

Rehabilitation of water systems in OTP/TFCs and IDP sites and host communities in Hodeidah (Al Khukhah) and Taiz (Dhubab) including:

- Rehabilitation of 9 water systems in Al Mighlaf- Ad Dohi- Zabid districts in Hodeidah benefitting 19,561 people and 2 solar water supply schemes projects in Al Khukhah district, Hodeidah benefitting 11,558 people.
- Rehabilitation of WASH facilities in 22 Health Care Facilities offering OTPs/TFC services in 6 districts of Hajjah (Qafl Shammar) and Hodeidah (Ad Dohi, Al-Mighlaf, Zabid, Al Khukhah) governorates, benefiting 43,800 persons in communities with high SAM cases.
- Construction of a new water harvesting reservoir in Qafl Shammar hospital of Hajjah benefiting 10,000 individuals.

	Improvement of sanitation services for households who reported malnutrition cases and in need of sanitation: • Construction of 835 latrines for vulnerable households with SAM cases in Hajjah (Qafl Shammar district), Hodeidah (Al Khukhah - Ad Dohi, Al Mighlaf, Zabid districts) and Taiz (Dhubab district), to improve access to proper sanitation for 5,854 people. • Supporting care and maintenance of WASH facilities in IDP and informal settlement sites in Hodeidah (Al Khukhah district) and Taiz (Dhubab district) through rehabilitation, repairs, desludging of septic tanks, cleaning campaigns, solid waste collection and disposal, benefitting 10,000 people. Supporting hygiene promotion through procurement and distribution of WASH supplies • UNICEF distributed WASH non-food items, including 22,236 consumable hygiene kits (CHKs) and additional 2,500 jerry cans, through community-based structures and community volunteers in IDP sites and surrounding host communities with high risk of malnutrition in Hajjah (Qafl Shammar district), Hodeidah (Al Khukhah - Ad Dohi, Al Mighlaf, Zabid districts) and Taiz (Dhubab district). The distributions were supported with intensive awareness raising activities for adoption of positive WASH behaviours in IDP and host communities reaching 80,949 people.

Activities	Description	Implemented by
Activity 3.1	Rehabilitation of the water systems (Water quality monitoring, provision of pumping stations, protection, solar systems, networks, water distribution points, chlorination) in OTP/TFCs and in IDP sites and host community in the selected villages surrounding the selected HFs governorates in Hodeidah-(Alkhoka,) and Taiz (Dubhab)	General Authority for Rural Water Supply Projects (GARWASP) in Hajja and Hodeida, GARWASP Emergency Unit (GARWASP-EU), Emergency Unit (EU)[10], Taybah Foundation
Activity 3.2	Improvement of sanitation services for 700 households who reported malnutrition cases and in need of sanitation services (constructing/installation of latrines in host communities and IDP sites, cleaning campaigns, community mobilization).	General Authority for Rural Water Supply Projects (GARWASP) in Hajja and Hodeida, GARWASP Emergency Unit (GARWASP-EU), Taybah Foundation
Activity 3.3	Support hygiene promotion through procurement & distribution of WASH supplies (Hygiene kits, water tanks)	General Authority for Rural Water Supply Projects (GARWASP) in Hajja and Hodeida, GARWASP Emergency Unit (GARWASP-EU), Taybah Foundation
Activity 3.4	Support hygiene promotion through awareness raising activities in IDPs and host communities' sites	General Authority for Rural Water Supply Projects (GARWASP) in Hajja and Hodeida, GARWASP Emergency Unit (GARWASP-EU), Taybah Foundation

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and

[10] GARWSASP EU for the northern authorities and EU for the southern authorities.

Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[11] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[12]:

UNICEF trained its 117 staff members both at the central and field offices level on AAP and the importance of receiving stakeholders' feedback and complaints to improve programming and include communities during all the stages of programme lifecycle.

The Community Engagement and Accountability to Affected Populations Working Group (CEAAP WG) has been actively engaged in a range of activities to strengthen AAP efforts in Yemen, For example, the collective feedback mechanism led by the CEAAP WG is based on the existing complaint feedback mechanisms (CFMs) managed by humanitarian agencies. This CFM provides insights on the complaints received by member agencies who participate in the CEAAP WG. Findings from the collective feedback are shared with the Integrated Community Case Management (ICCM) and Humanitarian Country Team (HCT) to inform policy decision-making and improve operational effectiveness. The collective feedback mechanism provides insights on the complaints received by member agencies who participate in the WG. A dashboard has been developed and rolled out based on the existing complaint feedback mechanisms (CFMs) managed by humanitarian agencies, informing decision making on community and stakeholder engagement priorities. Findings from the collective feedback are shared with the Integrated Community Case Management (ICCM) and Humanitarian Country Team (HCT) to inform policy decision-making and improve operational effectiveness. The community perceptions survey on the delivery of humanitarian response in Yemen was conducted in 2023. The key findings of the survey have been shared with the relevant partners at inter-agency level and informed the preparation of the Yemen Humanitarian Response Plan (YHRP) 2024.

b. AAP Feedback and Complaint Mechanisms:

UNICEF has a complaints and feedback mechanism (CFM) that covers all UNICEF programmes, with the primary channel being a Call Centre with toll-free number housed in UNICEF premises in Sana'a. The CFM is available to all those, including the beneficiaries of this project, who wish to file a complaint or inquiry or provide feedback. The CFM is connected to the Management Information System (MIS) with all feedback/complaints/inquiries automatically saved, analysed and referred for redressal using predetermined protocols.

UNICEF received 7,428 inquiries and 1,269 complaints related to Health, Nutrition and WASH programmes from Taiz, Hajjah & Hodeidah during the period of May-Nov 2023. The call centre agents were trained on health, nutrition, and WASH interventions to respond to general queries and UNICEF programme redressal team to handle complaints and feedback.

To raise community awareness on CFM, UNICEF displayed banners in health facilities and at programme sites and used radio campaign for WASH interventions. Using other funding sources, SBC community volunteers and partners were also trained on AAP to raise community awareness. From May to November 2023, UNICEF continued building the capacity of implementing partners by training 385 staff on the principles of effective and quality humanitarian response that put people at the centre of humanitarian actions and recognizes dignity, capacity and abilities of the affected people while promoting respect for their fundamental rights including protection and security. Additionally, the participants were sensitized on the importance of community feedback mechanisms ensuring that mechanisms are in place at the community level to solicit feedback and complaints from communities.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

[11] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[12] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

UNICEF has existing gender-based violence (GBV) and protection from sexual exploitation and abuse (PSEA) specialist posts which support office-wide programme delivery for UNICEF Yemen. As part of its PSEA commitment, UNICEF has a PSEA action plan, providing mandatory GBV risk mitigation and PSEA training to all UNICEF staff and implementing partners to ensure that GBV mitigating measures are integrated into all UNICEF supported programmes. UNICEF carried out mandatory assessment for implementing partners on their capacity on PSEA. All the new partnerships are conditioned to standard set of proved PSEA capacity. UNICEF staff have been undertaking sessions on how to conduct the assessment and capacity building when necessary, receiving update on the mandatory assessment policy and procedure, monitoring/follow-up.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

UNICEF utilised gender-disaggregated data for monitoring during all stages of the project implementation cycle. The health and nutrition activities for children under five were designed to be inclusive for both boys and girls, while specific activities were created solely for women and adolescent girls. All CHWs as well as CHNVs are females, which is an explicit programmatic design considering the cultural barriers and to be sensitive to the preference of communities' traditions. The recruitment of women allows them to further their education, employability and to a degree, financial independence. Furthermore, at least one female health worker is part of each UNICEF's supported health facilities to ensure that women in the communities receive the required services.
The unique needs of women and young girls regarding WASH services were taken into consideration and addressed. The provision of WASH facilities close to the communities contributed to enhancing the protection of women and girls from violence and harassment as they are responsible to fetch the water. Women and young girls were encouraged to participate in community hygiene promotion activities, manage water points, and report any water-related violence or abuse during water collection.

e. People with disabilities (PwD):

Accessibility of health services to all, including people with disabilities was ensured. The WASH activities were mainstreamed to ensure priority accessibility for people with special needs, especially at the sites of distribution and of basic hygiene kits (BHKs). People with disabilities were targeted without any additional criteria based on a verified list provided by the community leader. The BHKs were distributed directly to them or at suitable separate places. For the nutrition intervention, PwD are prioritized during the delivery of services. The admission criteria for malnutrition were simplified when screening children with disability, i.e., only Mid-Upper Arm Circumference (MUAC) measurement is required for admission.

f. Protection:

WASH and health and nutrition facilities all considered the accessibility and safety of girls and women and ensured services for all. The TFCs are located in public hospitals and health centres, which are intended to be secure and protected from any form of targeting ensuring that the beneficiaries can receive their nutrition assistance without any fear of harm or danger. Only mothers or female caregivers are allowed to stay all the time with children admitted to the TFCs. This arrangement is in place to ensure privacy and a safe environment for breastfeeding. All TFCs are staffed by female health workers, further ensuring a secure and private space for mothers and children.

g. Education:

NA

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	2,593

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

A total of 2,593 caregivers of SAM children with complication were supported with nutrition cash vouchers to admit their children to the nearest TFCs in targeted governorate as part of UNICEF's Nutrition Voucher Scheme (NVS) programme. The NVS is aimed at increasing access to and use of SAM with complications treatment services at TFC level for children until completion of treatment. The NVS provides support to the caregivers to cover transportation costs to/from TFCs for treatment and to cover accommodation and food costs incurred by the caregiver during the period the child is admitted at the TFCs. The NVS covers the period of admission for treatment up to 14 days while the transportation amounts are determined by the distance from the OTP to the TFC and are divided into three zones. Upon enrolment in the NVS, a voucher booklet is given to the caregiver, and can be cashed at dedicated payment agents of the contracted financial service provider (FSP) located near the TFCs. Additionally, through CERF funding, once a child completed his/her treatment, the household was eligible to receive a discharge package intended to cover basic needs like food after discharge with an aim of preventing relapse in the first month after discharge.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Activity 2.4	2,593	US$ [500,500]	Nutrition	Restricted

9. Visibility of CERF-funded Activities

Title	**Weblink**
Press release	https://bit.ly/42wC4rc
Press release	https://bit.ly/3OZzmHO
Press release	https://bit.ly/3CeWU3F
Human Interest Story	https://www.unicef.org/yemen/stories/battling-acute-malnutrition-yemen
Social media post	https://bit.ly/3siThZj
Social media post	https://bit.ly/3QnXO4F
Social media post	https://twitter.com/UNICEF_Yemen/status/1719368647158755586
Social media post	https://twitter.com/UNICEF_Yemen/status/1719353536918827330
Project photos	https://weshare.unicef.org/Share/h0p60a737nbf1833shtm8unad7bh3u10
Social media post	https://www.facebook.com/unicefyemen/posts/pfbid0n2vQNJNRtNdaQ4rJxUmMR6fgg8eqptJYWuon8iryU7VXvf47ZUur2onC6hWZUFPgl
Social media post	https://www.facebook.com/unicefyemen/posts/pfbid04NeXpGroiARQvRivuXdrvrEabLmiKdi8iS6aBciaXpaYSjqKWHTSnruVoCreQFVZl
Social media post	https://twitter.com/UNICEF_Yemen/status/1734619122602795357
Social media post	https://twitter.com/UNICEF_Yemen/status/1734611925106147791
Social media post	https://www.instagram.com/p/C0wnwLUocNH/
Social media post	https://www.instagram.com/p/C0wrY9hKCAQ/

3.6 Project Report 23-RR-WFP-019

1. Project Information

Agency:	WFP	**Country:**	Yemen
Sector/cluster:	Nutrition	**CERF project code:**	23-RR-WFP-019
Project title:	Treat and prevent acute malnutrition by the provision of nutrition assistance through the distribution of specialized nutritious food.		
Start date:	01/06/2023	**End date:**	30/11/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 12,470,455**
Total funding received for agency's sector response to current emergency:	**US$ 10,070,455**
Amount received from CERF:	**US$ 2,400,000**
Total CERF funds sub-granted to implementing partners:	**US$ 453,728**
Government Partners	US$ 90,674
International NGOs	US$ 147,952
National NGOs	US$ 215,102
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

WFP appealed for funding from the CERF to assist in its response to dire malnutrition prevention needs. Specifically, WFP aimed to support women and children at high risk of malnutrition or suffering from moderate acute malnutrition by providing both prevention and treatment support to the targeted groups, which included Pregnant and Lactating Women and Girls (PWLG).

WFP aimed to target 42,186 and was able to reach 100% of the planned figures (25,411 children and 16,775 PLWG) of which 29,179 children aged 6-23 months and PWLGs received malnutrition prevention commodities and 13,007 children aged 6 to 59 months and PWLGs received malnutrition treatment commodities in six supported districts (Ad Dohi, Al Mighlaf, Al Khukhah, Dhubab, Qafl Shammar, Zabid) across three governorates (Al-Hodeidah, Hajjah and Taiz), in accordance and alignment with priority districts to prioritize coordination with other agencies recipient of this Rapid Response Allocation. With CERF funding, WFP procured a total of 689MT of specialized nutrition commodities (LNS-MQ, LNS-LQ, and WSB+) which were received in country and ready for distribution within two months of funding confirmation. Additionally, WP promoted community awareness of nutrition and health issues, thus ensuring community ownership while providing technical assistance and capacity to CMAM-related workers, involving community health volunteers (CHVs) and mother to mother support groups in service delivery at all levels.

The CERF allocation was particularly beneficial due to the integrated approach done though the CMAM framework through referrals to SAM (UNICEF led) and vaccination checks (UNICEF and WHO led). The interventions in this project contributed to the overall nutrition cluster objective by increasing access to nutrition and other lifesaving supplies and services through the Integrated Famine Rapid

Response (IFRR) package, which helps to prevent famine and addresses rising levels of malnutrition and food insecurity caused by conflict, economic shocks, and climate change. WFP in collaboration with other partners provided a multi-sectoral response in the targeted districts, taking into account the specific needs of people with disabilities, IDPs, women, and children at risk, with additional coordination with health authorities and relevant Clusters to ensure maximum coverage of the most vulnerable populations.

This funding allowed WFP to maintain its malnutrition treatment programme going for a few months in high-risk districts before having to suspend it due to lack of funding.

3. Changes and Amendments

After having received this CERF contribution, WFP experienced sever funding shortfalls causing it to suspend its malnutrition prevention activities. The CERF grant allowed WFP to continue providing assistance to the most vulnerable districts without interruption. Due to favourable market prices, WFP managed to purchase additional tonnages (+39mt) of specialized nutrition commodities for both treatment and prevention of malnutrition. This was pre-emptively communicated in the Interim Update report.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Nutrition									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	16,775	0	12,655	12,756	**42,186**	16,775	0	12,655	12,756	**42,186**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**16,775**	**0**	**12,655**	**12,756**	**42,186**	**[16,775]**	**[0]**	**[12,655]**	**[12,756]**	**[42,186]**
People with disabilities (PwD) out of the total										
	1,677	0	1,265	1,275	**4,217**	**1,677**	**0**	**1,265**	**1,275**	**4,217**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

In addition to the targeted beneficiaries as broken down above, this action was also at the benefit of the caretakers of the targeted children under two along with health workers who took part in the social and behavioural change communication activities (SBCC), namely the sensitization sessions providing appropriate maternal, infant, and young child feeding and care practices. The SBCC activities targeted over 12,000 people.

6. CERF Results Framework

Project objective	Provide vulnerable children and PBWGs with MAM treatment and prevention
Output 1	Treat and prevent acute malnutrition through the distribution of specialized nutritious food to 42,186 children and PBWGs.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	N.1 Number of people receiving blanket supplementary feeding (MAM prevention)	42,186	42,186	Distribution Reports- CMAM reports
Indicator 1.2	FN.1b Quantity of food assistance distributed in MT (specialized nutritious foods)	650	689	Distribution Reports
Indicator 1.3	N.2b Percentage of people who were admitted for MAM treatment who recovered (MAM recovery rate)	75%	89%	Post-Distribution Monitoring- CMAM reports
Indicator 1.4	AP.2b Percentage of affected people who state that they are aware of feedback and complaints mechanisms established for their use	50%	46%	Quarterly monitoring report
Explanation of output and indicators variance:		Due to favourable market prices, WFP managed to purchase additional tonnages (+39mt) of specialized nutrition commodities for both treatment and prevention of malnutrition.		

Activities	**Description**	**Implemented by**
Activity 1.1	Procure and dispatch specialized nutrition commodities	WFP
Activity 1.2	Children aged 6–23 months and PBWGs receive specialized nutritious foods that prevent acute malnutrition.	WFP and Cooperating partners (CPs): - Building Foundation for Development - Abs Development Organization for Women and Child - Medical Mercy Foundation - Society for Humanitarian Solidarity - Islamic Relief Yemen
Activity 1.3	Children aged 6–59 months and PBWGs receive specialized nutritious foods that treat moderate acute malnutrition.	WFP and CPs: - Building Foundation for Development - Abs Development Organization for Women and Child - Medical Mercy Foundation

		- Society for Humanitarian Solidarity - Ministry of Public Health and Population

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[13] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[14]:

WFP maintained communication with its beneficiaries through various mechanisms such as the complaints and feedback mechanism, allowing for proper processing of beneficiary feedback into further programme design. For this nutrition project, WFP also worked with the community health volunteers (CHVs) and the mother-to-mother support groups through consultations in the design, and implementation of the project. The beneficiaries were reached through house-to-house visit by the CHV, group discussions through the mother-to-mother support groups and at the health facilities the health workers conducted individual counselling to the mothers and caretakers.

Throughout all WFP funded project in Yemen, the Yemen Protection and Accountability strategy (2021 – 2023) is applied and ensures that the assistance reaches targeted group in a safe and dignified manner.

b. AAP Feedback and Complaint Mechanisms:

WFP actively seeks feedback from beneficiaries throughout the programming cycle. In line with WFP's commitment to accountability, WFP has put in place several mechanisms through which affected populations can provide feedback, and voice concerns and complaints. To collect community feedback, WFP utilized and triangulated information from various sources, including third-party monitoring of distribution, post-distribution and activity implementation, remote monitoring through call centres and direct monitoring by WFP staff. WFP also has a toll-free hotline through which beneficiaries can reach out to WFP with their concerns in addition to in- house call center that reaches out to beneficiaries to inquire about their experience during WFP activities, their preferences, and concerns. The operators flag the concerns on a WFP internal online platform which refers the cases to different departments (i.e., protection, programme etc.) to take the relevant action. The feedback loop is closed after the beneficiary is called back.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

WFP has a zero-tolerance policy for sexual exploitation and abuse committed by all WFP, cooperating partner, supplier, contractor, and service provider staff associated with WFP regardless of the contract type or duration, during and outside working hours. WFP has multiple mechanisms through which beneficiaries are able to submit complaints, including a toll-free hotline in case of any feedback, queries or complaints, including PSEA related issues, which are followed up at the Area Offices and at the Country Office level. It is accessible from telecommunication networks across the country and is staffed by both male and female operators that speak the local language. For any SEA related complains, there is an internal dedicated channel for the cases to be reported and follow up ensuring full confidentiality. Concerning beneficiaries, SEA related complaints are handled in a similar manner than hotline's process. In addition, all other monitoring mechanisms can be used by beneficiaries to raise such issues (TPM, complaint boxes on distribution sites, partners).
WFP in 2022 finalized a set of standard operating procedures (SOPs) that embed protection from sexual exploitation and abuse (PSEA) in its activities: These provide actionable guidance for WFPs response to allegations of sexual abuse and exploitation against people who

[13] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[14] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

receive WFP assistance. The SOPs also formalize the introduction of a PSEA network composed of a male and female PSEA focal point in all WFP offices across Yemen.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

WFP's nutrition programmes in Yemen respond to the needs of specific gender and age groups, and thus fully integrate gender and age in line with the assigned Gender and Age Marker - Monitoring (GAM - M) code 4. This project at its basis, recognizes the added layer of risk faced by women and children (particularly girls) in facing malnutrition, it aims to directly addressing it by targeting through identification (with support from community) of those most vulnerable and providing prevention or treatment assistance to those identified.

WFP ensure that distribution/activity sites remain safe and secure for women and girls through the presence of dedicated women volunteers at distribution sites; gender-segregated queues, and by distributions timed to ensure the access, safety, and security of women. In 2022, WFP also continued the roll-out of the Yemen Inclusion and Empowerment Initiative in areas under the internationally recognized Government of Yemen. Under the initiative, capacity-strengthening sessions were held for WFP and cooperating partner staff on social inclusion, empowerment, and participation.

e. People with disabilities (PwD):

The CERF-funded project is not specifically targeting households with disabled people, however, the inclusion of vulnerable households headed by persons with disabilities and the chronically ill is one of WFP's beneficiary targeting criteria. These HHs are included through the community- based targeting exercise. WFP is an active member of the Inclusion Taskforce, does work on developing the capacity of CP and WFP staff on the importance of disability inclusion in its programmes through the collaboration with organizations specialized in different types of disabilities.

f. Protection:

Like all WFP programmes, this project is designed and implemented in ways which contribute to the safety, dignity, and integrity of all persons with respect for people's needs, rights and capacities. In particular, this project mainly targeted the needs of women and children who are more at risk of being malnourished. The project is designed and implemented in a protection sensitive manner, identifying protection risks faced by women, children (particularly girls), designing, and implementing strategies and measures to mitigate and prevent those protection risks, and evaluating the impact of those measures, in cooperation with key stakeholders such as health workers.

g. Education:

Not applicable to this project.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

CVA is not applicable to this specific project.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
N/A	0	US$ 0	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	**Weblink**
NA	WFP has been implementing a media black-out due to the sensitivities regarding its General Food Assistance pause in the North and negotiations with authorities to agree on a reduction of the caseload. There have been no posts during the reporting period.

3.7 Project Report 23-RR-WHO-019

1. Project Information			
Agency:	WHO	**Country:**	Yemen
Sector/cluster:	Health Nutrition	**CERF project code:**	23-RR-WHO-019
Project title:	An integrated response to emergency health and nutrition needs in the targeted priority districts in Yemen		
Start date:	30/05/2023	**End date:**	**29/11/2023**
Project revisions:	**No-cost extension** ☐	**Redeployment of funds** ☐	**Reprogramming** ☒

Funding		
	Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 7,500,000**
	Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 1,000,884**
	Amount received from CERF:	**US$ 2,200,650**
	Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex.	**US$ [564,514]**
	Government Partners	US$ [0]
	International NGOs	US$ [0]
	National NGOs	US$ [564,514]
	Red Cross/Crescent Organisation	US$ [0]

2. Project Results Summary/Overall Performance

During the project duration, the CERF RR grant enabled WHO to successfully achieve its goals. Working in collaboration with the IFRR partners, nutrition cluster, and MOPHP, WHO effectively reached its targets. The hub structure of the IFRR core clusters played a crucial role in facilitating communication, case referrals, and the implementation of an integrated package of services to the beneficiaries. This is evident from the number of reported cases. The partners working at the community and primary healthcare levels also played a significant role in laying the groundwork, resulting in increased utilization of supported services at the secondary healthcare facility level. Specifically, during the reporting period, a total of 1,876 cases of severe acute malnutrition (SAM) with complications were admitted to the four WHO-supported Therapeutic Feeding Centers (TFCs), as well as the linked referral paediatric ward located in Al Hodeidah (Ad Dohi, Al Mighlaf, Zabid) and Hajjah (Qafl Shammar). Overall, this project provided critical lifesaving services and counselling to a total of 3,752 children and caregivers. In addition to that, the integration of immunization and screening prompted an integrated approach between nutrition and child health services. This indicates a significant response to the nutritional needs of affected children.

In order to improve the integration and utilization rates, WHO established six nutrition surveillance sites (NSS) in five out of six targeted districts with support from the project. Unfortunately, the Hays NSS could not be established due to security concerns. During the project period, the five NSS screened a total of 8,703 children under the age of 5 to assess their nutrition status. Piloting the integration of Family Approach to Psychosocial Support Services (FAPSS) in TFCs helped mobilize resources based on positive results. Screening children also led to extended support from the World Bank for nutrition surveillance sites (NSS) to ensure sustainability of the interventions.

WHO supported the FMF NGO in Dhubab district hospital in Taizz governorate, the Al Jadeed Health Center (a referral hospital) in Al Khoka district, Hodeidah governorate, and the BFD NGO in Qafl Shammar district, Hajjah governorate. These interventions provided outpatient and emergency healthcare services to children under five, mothers, and the vulnerable population in the targeted districts. The NGO partners offered incentives to healthcare staff, covered operational costs, supported basic rehabilitation, provided essential equipment, medicines, medical supplies, and offered technical support. Overall, the CERF-supported intervention directly benefited142366 individuals, including 38,481 consultations, Out of the consultations, 31,582 were in outpatients, and 6,899 in emergency room patients with severe conditions.

The project also enhanced the disease surveillance system in the six covered districts by providing refresher training for rapid response team staff, covering operational costs, and supplying equipment and materials for outbreak investigations. A total of 73 rapid response team members received training in the targeted and surrounding districts, and 121 healthcare workers from various facilities underwent Integrated Case Management training. The CERF grant effectively supported the implementation of a robust surveillance and rapid response system, contributing to the prevention of large-scale outbreaks.

Collaboration with IFRR partners, the nutrition cluster, and MoPHP facilitated effective communication, case referrals, and the delivery of integrated services. The hub structure of IFRR core clusters also enhanced the coordination efforts in the implementation of the project's activities. WHO ensured collaboration with nutrition and health clusters, UNICEF, and WFP that contributed to a continuum of care for children's full recovery and prevention of malnutrition. This collaborative effort addressed immediate causes such as health, food security, caregiving, and water, sanitation, and hygiene (WASH) practices. WHO's coordination with subnational teams facilitated access to nutrition data, contributing to the distribution of cash assistance (CASH), thereby ensuring the sustainability of interventions beyond the project duration.

3. Changes and Amendments

CERF approved reprogramming of health activities under output 2 in relation to the number of the targeted referrals structures on 18th July 2023. To avoid duplication with other agencies, WHO targeted 3 hospitals in their project (Qufl Shammar, Dubab and Al Khowkha hospitals), instead of 5 hospitals and excluded two hospitals (Zabid and Al-Dohi hospital). The savings from the allocated budget of the excluded HFs were utilized to increase the services in the other three hospitals.

The project exceeded its target due to the substantial increase in patients seeking healthcare services once 24/7 coverage and adequate personnel were available. This achievement demonstrates the project's success in improving healthcare access and contributing to the intended continuum of care in the targeted districts.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	4,753	4,946	4,566	4,752	**19,017**	6210	4407	4749	4571	**19937**
Host communities	26,932	28,029	25,874	26,930	**107,765**	38147	27072	29131	28079	**122429**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**31,685**	**32,975**	**30,440**	**31,682**	**126,782**	**44357**	**31479**	**33880**	**32650**	**142366**
People with disabilities (PwD) out of the total										
	2,578	2,686	2,198	2,286	**9,748**	4436	3148	3388	3265	**14237**

Sector/cluster	Nutrition									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	356	19	195	180	**750**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	539	60	311	287	**1,197**	267	14	146	135	**562**
Host communities	1,000	111	578	534	**2,223**	1159	61	635	585	**2440**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**1,539**	**171**	**889**	**821**	**3,420**	**1782**	**94**	**976**	**900**	**3752**
People with disabilities (PwD) out of the total										
	154	17	89	82	**342**	178	9	98	90	**375**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

The health services component of the project indirectly benefited approximately 400,000 individuals, out of which 57,000 were IDPs. In the nutrition component, around 110,000 children under the age of five were indirect beneficiaries, with approximately 15,400 of them being IDPs. In total, the project had approximately 510,000 indirect beneficiaries, including approximately 72,400 IDPs.

6. CERF Results Framework

Project objective	To contribute to the reduction of food insecurity and malnutrition through provision of integrated response of nutrition and health services to the most acutely vulnerable people in the targeted districts.
Output 1	Improved access to life-saving inpatient care in 4 therapeutic feeding centres for 1710 severely malnourished children suffering from severe medical complications targeting TFCs in/or covering Aldhahi, Almghlaf, Zabid and Qafl Shamr.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	N.3a Number of people admitted to SAM treatment programme (therapeutic feeding BOQ D 4.1	1,710	1876	TFCs monthly reports, M&E reports
Indicator 1.2	N.6 Number of people receiving training and/or community awareness sessions on maternal, infant, and young child feeding in emergencies BOQ D 4.1	1,710	1876	TFCs monthly reports, M&E report]
Indicator 1.3	Number of health workers receiving service delivery cost on performance-based approach to ensure continuum of care and service provision BOQ D 4.1	112	112	TFCs monthly reports, M&E reports
Indicator 1.4	Number of TFCs supported by the list of operation cost items BOQ: B 2.1, B 2.2, B 2.3, B 2.4, and B 2.5	4	4	TFCs monthly reports, M&E reports
Indicator 1.5	Number of supportive supervision and monitoring visits conducted	20	20	M&E Reports
Indicator 1.6	N.4 Number of people screened for acute malnutrition	9,000	8,703	NSS Reports

Explanation of output and indicators variance:	The admission rate in the 4 TFCs was overachieved due to the increased caseload at the supported TFCs in these governorates, compelling more affected populations from neighbouring districts to seek care at these supported TFCs. This includes the movement of IDPs, leading to a clustering of cases around the supported facilities Indicator 1.6: About 8,703 achieved which is less than the planned target, as the NSS was not established in Hays district due to security reasons. During the project period, the five NSS screened a total of 8,703 children under the age of 5 to assess their nutrition status. Of these children, 40% were identified as having acute malnutrition and were referred to therapeutic feeding programs based on their nutritional needs. The WHO-supported NSS

	also screened children under the age of 2 to determine their vaccination status and referred them to EPI clinics to improve vaccination coverage in the targeted areas. It was found that 15% of the children had an interrupted vaccination schedule, primarily due to rumours against vaccination. The NSS staff provided counselling and encouragement to parents, utilizing existing advocacy and messaging materials, to ensure adherence to their children's vaccination schedule. To maintain service quality, the WHO followed WHO standards, provided continuous capacity building, and supported regular monthly monitoring and supportive supervision by focal points from the District Health Office (DHO) and Governorate Health Office (GHO), as well as WHO hubs and central technical and monitoring and evaluation (M&E) officers. Through the support of the project, 90 SAM kits were procured to meet the caseload requirements. WHO also covered operational costs in four supported Therapeutic Feeding Centers (TFCs), ensuring quality service provision for the management of 1,876 children and providing improved accommodation for the accompanying caregivers. The operational cost coverage included basic laboratory tests for admitted children, provision of three meals for caregivers during their stay in the hospital, and the distribution of WASH admission kits (Hygiene kits) to ensure basic sanitation and clothing changes, promoting dignified stays for admitted children and their caregivers. To ensure continuity of care in these TFCs, the WHO, with support from the CERF RR fund, provided incentive payments for 112 health workers for a period of six months. The support provided in these TFCs also included preventive measures such as counselling sessions on infant and young children feeding (IYCF) and mental health and psychosocial support (MHPSS).

Activities	Description	Implemented by
Activity 1.1	Maintain lifesaving support for 1710 SAM/MC cases in 4 TFCs embedded in paediatric wards with one referral paediatric ICU amongst them, through supporting service delivery cost of the health workers in targeted TFCs/ ICUs. The deliverables of this activity are to: Provide life-saving services to all admitted children	WHO/MOPHP
Activity 1.2	Conduct counselling sessions on IYCF and MHPSS to all caregivers accompanying their children during the hospital stay (i.e., an average of five counselling sessions) and Support early childhood developmental activities in baby friendly spaces to enhance their recovery progress	WHO/MOPHP
Activity 1.3	Sustain 4 TFCs operation cost and lifesaving supplies and medicines of service free of charge for the most vulnerable population this support includes: Provision of PED/SAM kits, admission kits, provision of minimum acceptable diet to caregivers accompanying their children and enabling environment during their hospital stay. It also includes payment of lab investigation cost for the admitted children, WASH material and oxygen refilling cost as well as 2 ways transportation cost for the caregivers as well as health workers.	WHO/MOPHP
Activity 1.4	Ensure service quality and adherence to the donor agreement as well as technical guidelines and	WHO/MOPHP

	administrative SOPs by supporting regular monitoring visits at all levels of operations.	
Activity 1.5	Enhance under 2 years vaccinations pickup in the targeted districts WHO by supporting nutrition surveillance screening and referral activities (training and monitoring) as well as integrating nutrition assessment and referral into maternal and child health services.	WHO/MOPHP
Activity 1.6	Payment of 112 TFCs health workers performance based service delivery cost to ensure continuum of care and service provision.in the 4 target TFCs.	WHO/MOPHP

Output 2	Improved access to primary health care services and referral structures for children under five, pregnant and lactating women as much as the general and vulnerable population of the 6 targeted districts

Was the planned output changed through a reprogramming after the application stage? Yes ☒ No ☐

Sector/cluster	Health

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	H.1a Number of emergency health kits delivered to the 5 referral healthcare facilities (2 per referral facility)	10	10	Supply chain report
Indicator 2.2	Number of health care workers trained	40	121	M&E Reports Training list of Participants Training Reports
Indicator 2.3	Number of healthcare consultations provide in 5 referral structures	25,000	38,481	Health facilities reports, M&E Reports

Explanation of output and indicators variance:	The number of consultations greatly surpassed the projected target due to the implementation of continuous 24/7 services and the presence of healthcare staff made possible by the support from CERF. Initially, the estimates were based on non-continuous services, but the availability of round-the-clock, free-of-charge healthcare services was warmly welcomed by the local vulnerable population. This project successfully addressed a significant gap in healthcare delivery for this highly vulnerable population throughout the implementation period. Additionally, it should be noted that the reprogramming approval resulted in the support of three referral structures instead of the initially planned five. To improve the quality of healthcare services, the CERF Project supported the capacity building of health workers in targeted health facilities and main surrounding health facilities in targeted districts. A total of 121 health workers trained in integrated case management.

Activities	**Description**	**Implemented by**
Activity 2.1	Procurement and supply of essential medicines, medical supplies, and Rapid diagnostic kits for supported 5 supported referral structures and 15 PHCs	WHO/FMF/BFD
Activity 2.2	Capacity building in clinical case management of outbreak prone diseases, emergency care, and IPC for health care workers in primary health care and referral structures	WHO/MoPHP

Activity 2.3	Support to 3 referral health structures through 2 NNGOs (FMF and BFD)	WHO/FMF/BFD
Output 3	Enhanced disease surveillance and early detection, verification, and control of potential outbreaks through strengthening of the existing RRTs in the targeted districts	

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of health care workers trained	34	73	M&E Reports Training list of participants Training Reports
Indicator 3.2	Percentage of public health alerts generated through community-based and/or health-facility-based surveillance or alert systems investigated within 48 hours	80	98	RRT Dashboard & RRT Reports
Indicator 3.3	Number of RRT kits delivered to the RRTs in the 6 districts	36	36	Waybills Receipts from HFs/DHOs

Explanation of output and indicators variance:	Indicator 3.1: Capacity building was expanded to RRT health staff from adjacent districts since disease outbreaks are not limited to district borders. CERF contributed to covering the training of 73 RRT members. The intervention aimed to strengthen the resilience of the system and to detect and prevent outbreaks among targeted populations. Indicator 3.2: Ninety-eight percent of the reported alerts were responded to within 48 hours. Moreover, more than 95% of the responses were conducted within 24 hours, which exceeds the targeted 80%. Throughout the project duration, 154 alerts were reported from the targeted districts. The reported alerts included cases of measles, diphtheria, pertussis, rabies, scabies, and others. The district with the highest number of reported alerts during the project period was Zabid, with 52 alerts.

Activities	**Description**	**Implemented by**
Activity 3.1	Capacity building of the district based Rapid Response teams in the 6 targeted districts	WHO/MoPHP
Activity 3.2	Operational support to the assessments and response to epidemiological alerts through RRT in the 6 targeted districts	WHO/MoPHP
Activity 3.3	Procurement of supplies for outbreak investigation and emergency interventions of RRTs	WHO

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and

Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[15] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[16]:

WHO implemented a comprehensive strategy in their projects to prioritize APP. The strategy incorporates several key elements, including collaboration with local authorities, community engagement, and the establishment of feedback mechanisms.

- Identification of Actual Gaps and Collaboration with Local Authorities:
  - ✓ The WHO's technical team on the ground works closely with local authorities, particularly the ministry of health, as well as the affected communities.
  - ✓ Requests from the Ministry of Health are thoroughly reviewed, discussed in meetings, and prioritized based on eligibility and urgency.

- Monitoring and Evaluation (M&E) Activities:
  - ✓ A dedicated M&E team conducts ongoing assessments through field visits to closely monitor the progress of the projects.
  - ✓ The M&E team also evaluates the impact of the support provided to health facilities.
  - ✓ In the most recent survey, beneficiaries were interviewed, and the results showed high satisfaction rates, with 91% expressing satisfaction with the care received and 90% with the overall health facility environments.

- Field Visits and Interviews with Beneficiaries:
  - ✓ During field visits, the M&E team conducts interviews with beneficiaries to assess their satisfaction levels with the services provided, the behaviour of the staff, and the overall hospital performance.
  - ✓ Recognizing the challenges posed by high illiteracy rates, particularly among Yemeni women, efforts will be made to encourage the establishment of feedback mechanisms such as Grievance Redress Mechanism (GRM) boxes and to provide education to mothers during these visits.

b. AAP Feedback and Complaint Mechanisms:

WHO implemented various feedback mechanisms to gather input from the targeted beneficiaries involved in the project. These mechanisms are as follows:

- Complaint boxes at health facilities: Complaint boxes have been placed in health facilities that are part of the primary healthcare services, particularly the Maternal and Child Health Services component of the project. These boxes provide a platform for individuals to submit their complaints or provide feedback.

- Exit interviews with patients: During supervision and monitoring visits, both the implementing partner and WHO staff conduct interviews with patients who have received healthcare and emergency services at supported health facilities. These interviews serve as an opportunity for patients to share their feedback and experiences.

- Mobile-based groups: Mobile technology is utilized to facilitate real-time exchange of information, enabling effective communication and feedback from the community.

- Findings from M&E: Feedback collected through the M&E process, specifically regarding the health and nutrition services provided in targeted health facilities. The feedback loop is completed through the M&E Action Log, where WHO technical officers review the issues raised by beneficiaries through the reporting modalities mentioned above and take appropriate actions.

[15] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[16] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

- WHO prioritizes the confidentiality of beneficiaries' identities, and individuals have the choice to withhold their full personal details during interviews.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

No cases of Protection from Sexual Exploitation and Abuse (PSEA) have been reported during the project. WHO is actively working on strengthening its policies and protocols regarding PSEA and is aligning its efforts with the PSEA strategy. As part of this strategy, WHO has conducted training for staff members and integrated PSEA considerations into programs and responses.

Regular training sessions are provided to suppliers, partners, collaborators, and communities to ensure their understanding of WHO's policies on PSEA and the channels available for reporting. WHO has established a network of 13 focal points, covering all hubs, the Aden Sub-Office, and various programs and units. These focal points follow up on issues related to PSEA, adopting a survivor-centered approach.

Complaint mechanisms are shared with stakeholders and beneficiaries through the CT PSEA network and directly through WHO's PSEA focal points. Any complaints received will be addressed through an independent team of qualified investigators at the headquarters level, following the guidelines of the Inter-Agency Standing Committee (IASC) and UN policies.

Throughout the project, WHO Yemen has conducted awareness sessions and consultations with beneficiaries, particularly in the area of nutrition, to actively engage them and encourage them to provide feedback and raise any concerns. WHO is committed to ensuring confidentiality and a referral approach for any complaints or concerns received from the targeted groups.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Gender equality criteria have been incorporated into the planning and execution of the project by WHO. The total number of beneficiaries is categorized by age and gender, with specific figures recorded for women and girls who will benefit from the project. These gender-specific numbers have undergone verification throughout the project cycle, including documentation at the facility level and monitoring and evaluation conducted by contracted teams.

Addressing the issue of malnutrition, which is a significant concern, the project integrates care and infant and young feeding practices based on the UNICEF acute malnutrition log frame. This integration ensures that lifesaving nutrition responses encompass these critical aspects. Mothers and caregivers accompanying children during the admission period receive a minimum of three counselling sessions on best practices for health and nutrition, including infant and young child feeding (IYCF).

Furthermore, mothers and caregivers are provided support to enhance their living conditions. This includes admission WASH (Water, Sanitation, and Hygiene) kits, three meals per day, and transportation assistance. Operational support is also extended to health facilities through implementing partners, such as BFD and FMF, to ensure the uninterrupted provision of healthcare services in targeted therapeutic feeding centers and health facilities. This enables women and girls to access necessary services without any disruptions.

The monitoring and evaluation unit conducts visits to health facilities and spot checks on records to assess the number of women and girls benefiting from the project. These figures are included in the breakdown of the total number of beneficiaries reached throughout the project.

The entire intervention is a conscious step from WHO to address gender inequality in Yemen. WHO has devoted special attention to promoting and encouraging this component as an active best practice to be followed and further elaborated in future projects.

WHO also ensured the following:

- Constant networking with GBV actors such as Yemen Women Union, GBV sub-Cluster and Gender network.
- GBV service mapping is available and is updated on an ongoing basis.
- GBV Officer responsible for technical issues related to GBV and gender equality.
- WHO staff are capacitated on GBV response and mitigation measures in the health intervention
- WHO staff capacitated on gender equality and the implementation of gender marker, gender analysis and gender mainstreaming.

e. People with disabilities (PwD):

WHO prioritized inclusive and integrated approaches to address the needs of individuals with disabilities. Tailored interventions and counselling sessions have been implemented to meet their specific requirements. Recognizing that persons with disabilities are often among the most vulnerable during humanitarian crises, WHO has taken proactive measures to ensure that humanitarian actions are inclusive and responsive to their needs. The organization is committed to meeting the essential needs of persons with disabilities, promoting their protection, safety, and dignity in situations of risk and humanitarian crises.

The primary objective of this project was to guarantee that persons with disabilities receive the same level of protection and safety as everyone else. As a result, throughout the project duration, approximately 14,237 individuals with disabilities were able to access health services, and 375 individuals with disabilities received nutrition support. These efforts signify WHO's commitment to addressing the unique challenges faced by persons with disabilities and ensuring their inclusion in essential services during humanitarian crisis.

f. Protection:

Protection was integrated into all sectors of the project, aligning with the principles of "do no harm" and the importance of protection in humanitarian responses. WHO made sure that all assistance provided promoted the protection, safety, and dignity of the affected individuals. Efforts were made to ensure that women, girls, men, and boys had secure access to services, and measures were implemented to ensure equitable access for people with disabilities, the elderly, and minority groups. The provision of operational support was instrumental in maintaining the functionality of the health system and facilitating access to healthcare services in targeted health facilities and therapeutic feeding centers.

Throughout the project cycle, including the assessment, analysis, design, implementation, and monitoring stages, WHO analysed and disaggregated data by sex, age, and disability. The needs of vulnerable and minority groups, including adults and children with disabilities, were identified, and risk factors and rights violations affecting service provision were addressed.

This allocation made significant contributions to improving access to life-saving inpatient care in four therapeutic feeding centers, specifically targeting severely malnourished children with severe medical complications. These centers are located in Aldhahi, Almghlaf, Zabid, and Qafl Shammar. The project followed the UNICEF-adopted causal framework for malnutrition, which enhanced the inter-sectoral collaboration to reduce malnutrition and prevent famine in high-severity districts in Hajjah, Hudaydah, and Taiz.

The collaborative actions of all partners in treating malnourished children and addressing the nutritional status of their mothers, through counselling and the utilization of nutrition facilities and primary healthcare services for measles vaccination, have had a positive impact. The project also focused on providing follow-up and treatment for pregnant and lactating women to reduce low birth weight and malnutrition. In addition, the support targeted vulnerable families of malnourished children and pregnant and lactating women. These efforts have been recognized and appreciated by the target communities, as evidenced by the increased utilization of the services. Many families attending health facilities have expressed a desire for the support to continue beyond the project timeline and extend to other areas.

g. Education:

NA

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	Choose an item.	[Fill in]

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Health service delivery projects primarily focus on improving healthcare access, quality, and infrastructure where applicable, cash assistance is not possible here for many reasons that have to do with the nature of the project and its planned objectives, cash assistance is designed to provide direct financial support to individuals or households for various purposes and not necessarily health.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	**Weblink**
Story (English): Yemen's children grasp life amid the crisis:	https://www.emro.who.int/yemen/news/yemens-children-grasp-life-amid-the-crisis.html
Story (Arabic): Yemen's children grasp life amid the crisis:	https://www.emro.who.int/ar/2024-arabic/yemens-children-grasp-life-amid-the-crisis.html
Video (English): Through a health worker's eyes: Giving children a chance to grow, learn, and thrive:	https://youtu.be/7LroEzZ0KdA
Social media post about CERF interventions on Twitter (English):	https://x.com/WHOYemen/status/1744624043658285308?s=20
Social media post about CERF interventions on Twitter (Arabic):	https://x.com/WHOYemen/status/1744640149844058284?s=20
Social media post about CERF interventions on Facebook:	https://www.facebook.com/WHOYemen/posts/pfbid02YFye2Hm4E559GEZJNYmNgqTbk1rjZL56Ju1ET9GGyrUX917hLvJYe7XswRfaozEkl
Social media post about CERF interventions on Instagram:	https://www.instagram.com/p/C14qw-HLw5C/?utm_source=ig_web_copy_link
Social media post about CERF interventions on Twitter (English):	https://x.com/WHOYemen/status/1750065146385293566?s=20
Social media post about CERF interventions on Twitter (Arabic):	https://x.com/WHOYemen/status/1750084775782551577?s=20
Social media post about CERF interventions on Facebook:	https://www.facebook.com/WHOYemen/posts/pfbid0XqBpAGhH5PNPnWffsSR6QTuWB5quiTzYVVrzmMGDPGyJKKWYYFiFcNEW1Wqxpjcbl
Social media post about CERF interventions on Instagram:	https://www.instagram.com/p/C2fSt5CoUL_/?utm_source=ig_web_copy_link
Social media post about CERF Story on Twitter (English):	https://x.com/WHOYemen/status/1757306109574963503?s=20
Social media post about CERF Story on Twitter (Arabic):	https://x.com/WHOYemen/status/1757311142110867695?s=20
Social media post about CERF Story on Facebook:	https://www.facebook.com/WHOYemen/posts/pfbid0g6Waj1sDXfi4r2htu5iijjs6ov4Dn1jThNmHeXRUfBJUDaiffCTa6ChLgQexFzhgl
Social media post about CERF Story on Instagram:	https://www.instagram.com/p/C3SruvXhHnS/?utm_source=ig_web_copy_link
Social media post about CERF Story on Twitter (English):	https://x.com/WHOYemen/status/1759123081388339516?s=20

Social media post about CERF Story on Twitter (Arabic):	https://x.com/WHOYemen/status/1759129372819079589?s=20
Social media post about CERF Story on Facebook:	https://www.facebook.com/WHOYemen/posts/pfbid0292sRh9Tvwn7Gzc1hDT2BDrv8tj7UNP6PnE6yr6mERmZS4iGHQ3bj4jH8fWCFT5qsl
Social media post about CERF Story on Instagram:	https://www.instagram.com/p/C3fIMNjsJaZ/?utm_source=ig_web_copy_link&igsh=MzRlODBiNWFlZA==
Social media post about CERF Video on Twitter (English):	https://x.com/WHOYemen/status/1759463976985866420?s=20
Social media post about CERF Video on Facebook:	https://www.facebook.com/watch/?v=715857220363324
Social media post about CERF Video on Instagram:	https://www.instagram.com/reel/C3hOmXvJbBT/?utm_source=ig_web_copy_link&igsh=MzRlODBiNWFlZA==

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS I

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
23-RR-FAO-012	Agriculture	FAO	NNGO	$64,973
23-RR-FAO-012	Agriculture	FAO	GOV	$54,438
23-RR-FAO-012	Agriculture	FAO	NNGO	$51,998
23-RR-FAO-012	Agriculture	FAO	GOV	$77,860
23-RR-FPA-018	Sexual and Reproductive Health	UNFPA	NNGO	$425,716
23-RR-FPA-018	Sexual and Reproductive Health	UNFPA	NNGO	$106,265
23-RR-CEF-024	Health	UNICEF	GOV	$81,451
23-RR-CEF-024	Health	UNICEF	GOV	$54,741
23-RR-CEF-024	Health	UNICEF	GOV	$45,000
23-RR-CEF-024	Health	UNICEF	GOV	$35,043
23-RR-CEF-024	Water, Sanitation and Hygiene	UNICEF	GOV	$615,573
23-RR-CEF-024	Water, Sanitation and Hygiene	UNICEF	GOV	$73,678
23-RR-CEF-024	Water, Sanitation and Hygiene	UNICEF	GOV	$344,709
23-RR-CEF-024	Water, Sanitation and Hygiene	UNICEF	GOV	$113,144
23-RR-CEF-024	Water, Sanitation and Hygiene	UNICEF	NNGO	$301,707

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS II

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
23-RR-CEF-024	Nutrition	UNICEF	GOV	$43,855
23-RR-CEF-024	Nutrition	UNICEF	GOV	$153,787
23-RR-CEF-024	Nutrition	UNICEF	GOV	$23,743
23-RR-CEF-024	Nutrition	UNICEF	GOV	$67,698
23-RR-WFP-019	Nutrition	WFP	NNGO	$92,916
23-RR-WFP-019	Nutrition	WFP	NNGO	$53,423
23-RR-WFP-019	Nutrition	WFP	NNGO	$47,513
23-RR-WFP-019	Nutrition	WFP	NNGO	$21,249
23-RR-WFP-019	Nutrition	WFP	INGO	$147,952
23-RR-WFP-019	Nutrition	WFP	GOV	$90,674
23-RR-WHO-019	Health	WHO	NNGO	$264,721
23-RR-WHO-019	Health	WHO	NNGO	$299,793