LIST OF COMMON ACRONYMS

CCRM  Cluster Coordinator Reference Module
CHS   Core Humanitarian Standards
CLA   Cluster Lead Agency
CMAM  Community-Based Management of Acute Malnutrition
ECHO  European Community Humanitarian Aid Office
ENN   Emergency Nutrition Network
FAO   Food and Agriculture Organization
GAM   Global Acute Malnutrition
GNC-CT Global Nutrition Cluster - Coordination Team
INGO  International Non-Governmental Organization
IPC   Integrated Food Security and Nutrition Phase Classification
IYCF  Infant and Young Child Feeding
MAM   Moderate Acute Malnutrition
MUAC  Mid-Upper Arm Circumference
NGO   Non-Governmental Organization
NIE   Nutrition in Emergencies
OCHA  Office for the Coordination of Humanitarian Affairs
REFANI Research on Food Assistance for Nutritional Impact
RUSF  Ready-to-Use Supplementary Foods
RUTF  Ready-to-Use Therapeutic Foods
SAG   Strategic Advisory Group
SAM   Severe Acute Malnutrition
SO    Supporting Objectives (GNC)
SOP   Standard Operating Procedure
SP    Strategic Priorities (GNC)
UNHCR Office of the United Nations High Commissioner for Refugees
UNICEF United Nations Children’s Fund
WASH  Water, Sanitation and Hygiene
WFH   Weight-for-Height
WFP   World Food Programme
WHO   World Health Organization
WP    Work Plan (GNC)
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EXECUTIVE SUMMARY

The Global Nutrition Cluster (GNC) Annual Working Meeting of Partners was held on March 29 - 30 in Beirut, Lebanon and was hosted by the GNC partner – International Orthodox Christian Charities (IOCC). The meeting brought together more than 40 nutrition cluster stakeholders and provided an opportunity for cluster partners and the Strategic Advisory Group (SAG) to endorse the new 2017-2020 GNC Strategy and review the 2017-2018 GNC Work Plan and, priorities and mechanisms for moving forward collaboratively.

The meeting had the following objectives:

- To welcome new SAG members and plan for SAG activities in 2017
- To present and endorse the 2017-2020 GNC Strategy, review and finalize a two-year GNC work plan of activities (2017-2018)
- To detail and agree on a process for costing the work plan
- To update participants on the recommendations and proposed structure for the coordination of technical NIE issues and agree on next steps for setting up the Technical NIE Advisory body
- To update participants on changes in the new version of the Nutrition Cluster Handbook

Key outcomes of the meeting included:

- Provide an overview of the major modifications of the 2017-2020 GNC Strategy.
- Review and revise the activities of the Strategic Priorities (SP) and Supporting Objectives (SO) of the 2017-2018 GNC Work Plan (WP).
- Review the costing of previous Work Plans, to inform the review process for the current workplan and agree on the agencies that will be responsible for leading the costing of activities.
- Endorse on the proposed structure for addressing and coordinating NIE technical issues and agree on next steps for setting up the Nutrition Humanitarian Technical Advisory Body. Update GNC partners on protocol for the Integrated Food Phase Classification (IPC) for Acute Malnutrition scale and agreement on a GNC call to further discussed specifics of the protocol.
- Agree on having a protocol for the measurement and treatment of adult malnutrition.
- Presentation of the updates about the Nutrition Cluster handbook and SPHERE handbook.
- Reflection on results and lessons learned from Research on Food Assistance for Nutritional Impact (REFANI) research in Niger, Pakistan and Somalia on cash transfer impact on nutritional status of beneficiaries.
- Show evidence on the use of Mid-Upper Arm Circumference (MUAC) for diagnostic and treatment purposes in most situations and conditions.
- Update GNC partners on the ongoing efforts to update the incidence factor for Severe Acute Malnutrition (SAM) as well as to have country level Joint Malnutrition Estimates modelled estimates that account for incidence.
- Update GNC partner on rational for the inclusions of Ready-to-Use Therapeutic Foods (RUTF) on the WHO Essential Drug List.
INTRODUCTION

The GNC-Coordination Team (CT) and the GNC Strategic Advisory Group (SAG) with support from the consulting firm “Avenir Analytics” have developed the 2017-2020 GNC Strategy and drafted the 2017-2018 Work Plan based on extensive consultation with GNC partners and all relevant stakeholders.

This working meeting of GNC partners was organize to facilitate the endorsement of the four-year Strategic Priorities, Supporting Objectives, Internal Development objectives, as well as the Monitoring Framework with expected outcomes and indicators of the GNC strategy. During the meeting, the GNC partners also reviewed the GNC rolling WP activities for 2017-2018 and agreed on next steps for costing the two-year WP.

This meeting was also an opportunity for sharing technical updates that are relevant to the GNC partnership. The meeting was also an opportunity to welcome new SAG members representing UN WFP and Save the Children UK and to express gratitude to the outgoing SAG members representing UNHCR and ACF-Canada.

Pre-meeting reading materials can be found along with the agenda in Annex A.

SUMMARY OF SESSIONS: DAY ONE – 29 MARCH 2017

SESSION 1: WELCOME SESSION

CHAIRLED BY: CARMEL DOLAN AND CAROLINE ABLA

The participants were welcomed Ms. Ms. Ruba Khoury, Director of International Orthodox Christian Charities, Lebanon and Mr. Luciano Calestini, UNICEF Lebanon Deputy Representative. In her opening remarks, Mrs. Khoury explained that although Lebanon doesn’t have any cluster, giving a special attention to this country is a priority as it hosts the largest number of refugees per capita. She further said that the needs in Lebanon were dramatically increasing and the situation had continuously deteriorated since the Syria crisis started six years ago. Ms. Khoury stressed on the importance of tackling the issue of Nutrition in Emergencies (NIE) in the region given the significant number of citizens (Lebanese and Syrian) living below the poverty line. She thanked the partners and the GNC Coordination Team for choosing Lebanon and welcomed everybody on behalf of IOCC.

Mr. Luciano Calestini, UNICEF Lebanon Deputy Representative in his opening remarks also highlighted the role of Lebanon in the humanitarian response as one out of three citizens is a refugee. He gave an overview of the alarming statistics of the country and the troubles faced by the region. Mr. Calestini thanked the IOCC and the GNC for organising a meeting in Beirut.

Thereafter, all participants including SAG members introduced themselves to the group. The two chairs of the day, Carmel Dolan from ENN and Caroline Abla from IMC (who are both SAG members) went over the agenda, listing the objectives of the meetings.
SESSION 2: PRESENTATION OF THE STRATEGIC PRIORITIES AND OVERVIEW OF THE DRAFT 2-YEAR WORK PLAN

PRESENTED BY: JOSEPHINE IPPE

The objective of the session was to present the GNC 2017-2020 Strategy and to introduce the audience to the draft two years rolling Work Plan that was developed to support the implementation of the new four-year Strategy. The session was divided into three main sections and each section had its main key points.

Development of the new Strategy

The GNC SAG and the Coordination Team engaged the consultancy firm “Avenir Analytics” to develop the new 2017-2020 GNC Strategy. The work began in September 2016, and data collection and analysis took place in October 2016.

The work on development of the new strategy started with revisiting the four strategic pillars of the 2014-2016 GNC Strategic Plan which were: 1. Coordination and advocacy, 2. Capacity building, 3. Operational support, and 4. Information and knowledge management.

More than 80 cluster partners, Country Cluster Coordinators, Information Management Officers, including Rapid Response Team were consulted during the development of the new strategy through face-to-face and telecom interviews, online surveys and focus group discussions. Thereafter, GNC SAG members developed the first draft of the strategy in December 2016 during the Face-to-Face meeting in Geneva. The draft was circulated amongst the partners whose feedback was consolidated. The final strategy was then delivered to the GNC in February 2017.

GNC Strategy (4 years instead of 3)

The new GNC Strategy for 2017-2020 has the following missions, vision and values:

Mission:
The GNC collective exists to safeguard and improve the nutritional status of crisis affected populations by enabling coordination mechanisms to achieve timely, quality, and appropriate nutrition response to effectively and accountably meet the needs of people affected by humanitarian crises.

Vision:
The GNC's vision is the realization of globally-agreed targets aimed at ending all forms of malnutrition, as specified in Sustainable Development Goal. The new vision is tightly linked to sustainability.

Values:
The values of the new strategies include the humanitarian principles (humanity, neutrality, and independence), developing partnerships, learning from the GNC successes and failures, prioritizing support based on context, capacity and needs, adhering to the minimum standard on humanitarian response and being accountable to affected population.

The strategies were based on the expectations of the stakeholders and partners as well emerging issues and changes in humanitarian architecture. A strong component of the current strategy is Monitoring and Evaluation (M&E). The strategy also focuses on a better links between humanitarian and development partners, especially in transition from cluster to government-led coordination of NIE interventions.

The new GNC Strategy has the following three Strategic Priorities (SPs):

1. Providing operational support before, during and after humanitarian crises
   a. Prepare for crises
b. **Respond** to crises

c. Lead timely **transition**

2. **Building the capacity of transition stakeholders**

3. **Influencing and advocating (for affected populations and partners)**

For each of the SPs, outcomes, indicators, and means of verification are suggested.

**GNC Scope of Activities:**

The GNC Scope of Activities was also revised. Among the components that were kept included coordination, preparedness, activation, coordination support, advocating internally with Cluster Lead Agencies (CLA) and partners; some of the components that were removed included building basic core nutrition in emergency capacity in NGOs/partners, and the need for the GNC-CT to the rolling out face to face trainings on basic NiE competencies cluster countries or globally. Building NiE capacity in country is still important but this will be will be undertaken by the GNC partners and the GNC-CT will only communicate to partners and country clusters on such trainings or link partners and country clusters to those trainings.

**Outcomes and indicators:**

For each strategic priority (SP) outcomes and indicators were proposed and presented.

- **SP 1:** The outcomes would be to ensure national programmes react appropriately to emergencies and transition periods. The outcomes allow the GNC to support sector coordination platforms.
- **SP 2:** The outcome is to ensure available capacity to support information management and coordination in response to humanitarian crisis.
- **SP 3:** The outcomes ensure that nutrition clusters and sector coordination groups/platforms are appropriately activated, are have the guidance to make decisions on appropriate activations. It also ensures that coordination mechanisms are put in place in close collaboration with governments. Special attention was given in providing support for the inclusion of IYCF-E specific interventions in cluster response plans within the outcomes of this Strategic Priority.

In addition to the SPs, the strategy includes two Supporting Objectives which also have suggested outcomes, indicators and means of verifications. The supporting objectives are:

- **SO1:** External engagement objectives which include Inter-cluster objective, CLA engagement objective, Donor partnership objective, and Development actor’s engagement objective. Josephine went over these objectives and highlighted the Cluster/Donor/Lead Agencies/Partner relationship. In addition, she noted that three donors have systematic engagement with the GNC and that it is important to engage new donors.
- **SO2:** Internal development objectives – which included Partnerships and communications support amongst the GNC partners in order to effectively deliver 2017-2020 GNC of strategic priorities. This supporting objective also highlights the need for ensuring that responses are improved through the capturing and application of learning and the need for the GNC to be sufficiently well-resourced to deliver its strategic priorities was also the key of this supporting objective.

Josephine ended this section with the statement “Charity begins from home, from our own agencies”, with the intention of motivating participating agencies to be more engaged.
**Workplan Template**

A 2-year rolling workplan of activities to support the implementation of the 4-year Strategy was drafted under the corresponding in the Strategic Priorities (SP) and Supporting Objectives (SO) outlined above. The consultants provided the GNC with a draft workplan (WP) template which was then populated by the GNC-CT. In the workplan, it was emphasized that actions needed to be tangible and detailed as much as possible taking into consideration the specified objectives.

**Comments, Questions and Answers**

When asked on whether the GNC coordinates its strategy with the national level strategies? Josephine clarified that this is a global level strategy that reflects how the GNC should organize itself with partners and other sectors to define the framework for common actions in order to effectively support cluster/sector countries. The strategy also have advocacy activities that needs to be undertaken to support delivering a comprehensive outcome at country level.

**SESSION 3: WORK PLAN DISCUSSIONS**

**CHAIR: CARMEL DOLAN AND CAROLINE ABLA**

In this session, participants were randomly allocated in five groups to review and discuss the Strategic Priorities and Supporting Objectives. Each group nominated a chair and a rapporteur and each groups’ work session was facilitated by a GNC SAG member. The groups were to answer the following five questions:

1. Do the activities adequately reflect the outcomes/objectives?
2. Are the activities clear?
3. Is there something missing? If so, please add and/or delete
4. Having looked at the activities, please prioritize for Years 1 and 2.
5. Think about who might be interested in taking the lead on costing each activity?

During the group work, the existing activities were rephrased/reworded or combined or split others, where other activities were removed and irrelevant ones added. In some cases, groups created new ones that suited the proposed outcomes.

**Group 1: SP 1 and 2**
- Chair: Nicki Connell
- Rapporteur: Saja Abdullah
- Members: Andrew Seal, Douglas Jayasekaran, Elsie Abou Diwan, Nanor Karagueuzian
- SAG member: Victoria Sauveplane

**Group 2: SP 3**
- Chair: Paul Wasike
- Rapporteur: Suzanne Brinkmann
- Members: Amanda McClelland, Yara Sfeir, Ellen Andresen
- SAG member: Megan Gayford

**Group 3: SO 1 (Inter-cluster and CLA Engagements)**
- Chair: Domitille Kauffmann
- Rapporteur: Linda Shaker Berbari
- Members: Lindsey Pexton, Juma Khudonazarov, Anteneh Gebremichael
- SAG members: Ruth Situma and Anthony Peter
Session 4: Protocol on Measuring/Treatment of Adult Malnutrition: Discussion

Presented by: Victoria Sauveplane

ACF is currently looking into the guidance that exists on adult malnutrition. Knowledge gaps exist in relation to the diagnostic guidance, treatment and screening of malnutrition among the adult population. The term “adult” in this context refers to adolescents, pregnant and lactating women as well as older people.

Discussions were held with the US Centers for Disease Control and Prevention (CDC) and the review will be based on compilation of lessons learned from various field experiences and contexts rather than a rigorous set of evidences (that does not exist).

The main questions raised by Victoria were:

- **Knowing that only limited work has been done on this subject; would GNC partners be interested if ACF starts working on this topic?** (Victoria asked for hand voting)
  
  Voting reflected interest and a hand endorsed the idea and it was agreed that ACF will liaise with colleagues at the CDC and will follow up on this issue using the following questions

  - **What is useful for you?**
  - **What are key points that need to be highlighted in the development of protocols for the measurement and treatment of adult malnutrition?**

**Comments, Questions and Answers**

Victoria opened the floor for questions and comments. Below is a summary of the discussions:

- Compiling and consolidating learned experience on measuring adult malnutrition would be very useful as some key aspects are still debatable. Experience in malnutrition among infants can also be shared to clarify previously raised questions related to treating packages, protocols, and challenges faced among other things.
- HelpAge are happy to share their experience with regards to assessment and interventions of older people. HelpAge have developed a rapid assessment tool for Older People, and have used and they have clear cut-offs in terms of MUAC and measurements. Others indicated that there was a group of people who substantially addressed older people’s malnutrition during the famine in Somalia; reaching out to them would be a good idea. Having this endorsed and dedicating people (consultants) can ensure this review is done fast would be the next step.
• The harmonized training package (HTP) and addendum on the nutrition of older people, developed by Help Age with financial support from GNC, however, unlike the other 21 HTP modules, the guidelines’ structure does not follow the HTP structure and there is no clarify around how to assess the nutrition needs of Older people, what interventions need to be delivered and how they should be monitoring, probably as a result of gaps and missing data around assessment and programmatic response for old people when this guidance was being developed. One proposition is to revise module 23 of the HTP (the modules for Nutrition for Older People).

• Using the same MUAC tape to diagnose malnutrition in pregnant and lactating women, adults and children is one of the thing UNICEF is now following up on. A MUAC tape is being developed by HelpAge and Médecins sans Frontières (MSF) together; it has undergone the first stage rollout and is currently undergoing the second stage.

• There was a suggestion to look at other topics such as micronutrient deficiencies. It was clarified that the focus is on acute malnutrition as a first step and that other important topics can follow as a second step in the future.

Victoria closed the session by stating that, she will be in touch with the different partner who have worked on this topic and those who have expressed interest so that they can be involved.

SESSION 5: PRESENTATION AND DISCUSSION ON IPC ACUTE MALNUTRITION

PRESENTED BY DOUGLAS JAYASEKARAN - IPC

Presentation slides

Introduction

The Integrated Food Security and Nutrition Phase Classification (IPC) for Acute Malnutrition (AMN) scale is a tool that has been recently developed by a number of agencies, some of whom are represented in this meeting (GNC, ACF, FAO, UNICEF, UCL, WFP, Food Security Cluster).

This tool classifies areas based on prevalence of acute malnutrition, identifies the contributing factors or causes, such as food insecurity, care practices, WASH and Health services and provides guidance (actionable knowledge) for implementation to address both the acute malnutrition situation as well as the underlying problems. IPC is a process for building technical consensus among key stakeholders.

Types of available tools

To date, 3 tools are available to inform short-term and long-term decision making on IPC in general:

1. IPC for Acute Food Insecurity (AFI)
2. IPC for Chronic Food Insecurity (CFI)
3. IPC for Acute Malnutrition (AMN)

These tools provide an analysis of food security and nutrition situation analysis which feed into response analysis and hence programme design and implementation. IPC for AFI analyses acute food insecurity and provides short term solutions to fulfil the short term objectives; IPC for CFI examines chronic food insecurity and meets long term objectives of resolving chronic food security problems as well as other structural problems, while IPC for AMN provides tools for conducting situation analysis of acute malnutrition and recommends actions for both short and long term. It is up to the country to choose and decide on which type of IPC analysis should be conducted based on its context.

Development of the tool

Developing IPC for AMN started in 2014. It was based on a prototype developed by the Food Security and Nutrition Analysis Unit (FSNAU) in Somalia. The prototype for Somalia was reviewed and adapted by the IPC Nutrition Technical Working Group and a piloted in 2014 and 2015. Three rounds of pilot
were conducted in 9 different countries, which helped finalize the tool at the end of 2015, and the tool was further refined in February 2017

Functions
IPC AMN has 4 core functions and each of them comes with set of tools and procedures (e.g. protocols, maps, narrative, caseloads and magnitude of the problem, among many more details):

1. **Function 1 – Building technical consensus**: helps to obtain input from different stakeholders and involving various sectors (e.g. FS, WASH, and Health, etc.) as nutrition is affected by those as well.
2. **Function 2 – Classifying severity and causes**: helps to classify the severity of acute malnutrition and identify major contributing factors.
3. **Function 3 – Communicating for action**: helps to communicate analysis to decision makers in a consistent, timely and accessible manner.
4. **Function 4 – Quality assurance**: helps to ensure the quality of the analysis

Focus on Function 2
IPC AMN classifies the severity of acute malnutrition into 5 different phases: 1 being the least critical (normal) and 5 the most critical. These are based on the prevalence of Global Acute Malnutrition (GAM) as an outcome indicator which is measured by either using Weight for Height Z-score <-2 and/or oedema or MUAC <125 mm and/or oedema). For GAM measured using Weight for Height, the WHO thresholds for severity are used. As for MUAC, no standard thresholds were previously set; these were newly developed for IPC AMN purposes.

The outcome indicator (i.e. WHZ or MUAC) can come from representative surveys, sentinel sites, or screening data. The difference in seasonality is considered as well within IPC AMN as it highly correlated with malnutrition in most areas.

For a better understanding of the situation, contributing factors of acute malnutrition are also identified and communicated (e.g. immediate causes such as inadequate food intake and diseases, underlying causes such a household food insecurity indicators, care practices, WASH and Health).

Projection of Acute Malnutrition with IPC AMN
In addition to the current situation analysis, the IPC also supports the future projection, how the situation is likely to evolve. Using the contributing factors, it predicts their statuses in the future using different assumptions (climate, season, likelihoods, etc.) and suggests their impact on the incidence of acute malnutrition.

Complementarity between the IPC AFI and IPC AMN
IPC AFI and IPC AMN complement each other. Severity of contexts may be characterized by high food insecurity and low AMN, low FI and high AMN, or both high or low.

Among the added values of the IPC AMN tool are that:
- Classification and prioritization of areas based on acute malnutrition outcome are possible even with poor data.
- Identification of contributing factors to acute malnutrition in a systematic collaborative way that helps in designing specific interventions.
- The classification is not only based on the assessed population and acute malnutrition and food insecurity, but also on non-food related factors (WASH, diseases, immunization, etc.) which allows interventions to be more strategic and coordinated with input from other sectors.
- Projection of likely trends of acute malnutrition that can be useful as an early warning or for contingency purposes.
Comments, Questions and Answers

Q: How much does the IPC for AMN cost?
A: The first round of roll-out cost around USD $15,000 to $20,000.

Q: When representative surveys are available, how can one choose one or the other method of assessment knowing that choice is not always available?
A: When both MUAC and weight-for-height are available, weight-for-height is chosen.

Q: How were the MUAC thresholds identified and how were they adopted?
A: The CDC has collected data from more than 600 surveys from different countries around the world. Since cut-offs for WFH are already agreed upon, a corresponding MUAC threshold was estimated/identified for each WFH cut off point and these cut-off points are only for IPC classification. The CDC analysis, however, could not distinguish IPC phases 2 and 3 because cut-offs in both phases were overlapping. Thus, MUAC-based classification cannot at this stage separate IPC phases 2 and 3. In addition, the MUAC cut-offs used here are only for IPC purposes; furthermore, specific parameters need to be taken into consideration if the analysis is based on MUAC screening (a minimum sample size required, the organization of screening, the design, etc.).

Q: What about the use of MUAC thresholds for IPC? Is there a technical framework to ensure the use is applicable in specific conditions (having a minimum number of children, etc.)? How can one make sure results are justifiable and that there is a need to be addressed?
A: MUAC thresholds are only applicable for the IPC AMN classification and they cannot be used as standalone thresholds. Specific parameters need to be used if based on MUAC: for example, a minimum sample size, specific screening methods, etc. For example, if a MUAC screening is done at district level, it will not be possible to generalize classification to a a larger area.

Q: In previous attempts, it was not possible to connect the projection with other elements of IPC AMN. Also, how is the projection correlated with the assessed AM status and how accurate is it?
A: The process is to start with identifying the contributing factors and how they will change and impact acute malnutrition levels. The projection phase follows this step, and it projects using the current evidence to determine whether the severity of the Nutrition situation will likely increase or decrease or remain stagnant. Thresholds are worked with in the projection phase.

Q: Where does GAM come from?
A: The sources of GAM data are: a) nutrition surveys, b) sentinel sites, and c) screening. There are minimum criteria for each of these sources. Only data that meets these criteria will be used in IPC.

Q: What about the use of IPC Chronic Food Insecurity Tool?
A: The Chronic Food Insecurity tool is a different tool, it examines the previous ten years and identifies a typical year to generate the classification and analysis of Chronic Food Insecurity. The IPC Acute Food Insecurity and Acute Malnutrition complement each other and they classify the acute types of food insecurity and malnutrition including the factors that drives those outcomes.

Q: Is there a plan to implement and monitor how these classifications are going to identify the phases?
A: The team is trying to come up with sensitivity and specificity for MUAC thresholds. One thing is that, when it comes to Phase 5 (famine classification), famine is only declared after examining Food Security, mortality and malnutrition, not just using Acute Malnutrition.

Q: What are recommended actions and timeframes for countries to undertake it?

A: IPC doesn’t perform independent data collection. It uses available data to generate the analysis and classification. There are no specific guidelines on when to conduct IPC, in the early days, it was being done when data was available and when such analysis and classification is needed to inform decision. With time, it was found that it is not synchronized and aligned with the different seasons. Today, it is suggested to do it together with the Acute Food Security analysis. Also, it was found more useful to do around the lean season.

Q: In countries like South Sudan where GAM is 15%, how could the persistent GAM be explained? How is this scenario taken into consideration when doing the IPC AMN analysis?

A: Persistently high levels of acute malnutrition above the 15% WHO threshold is a clear indicators of longer term structural issues as well as the lack of effort to address the drivers such as food insecurity, care practices, health and WASH issues. Therefore in the case of South Sudan, the analysis of the driver becomes even more important as well as the need to also look at trends and seasonality.

Q: IPC uses existing data, if there is no focus on strengthening the generation of data which feeds into IPC analysis, we are in trouble. Maybe the lack of data could act as advocacy to do more surveys.

A: The team working on IPC AMN hasn’t done an impact study on the use of the tool for AMN; it has been done for the FS tools as they have been running IPC for a while. Informally, talking with some countries, it appears that most are using findings for prioritizing programmes. The added value to AMN appears to be best when combined with FS tool.

Q: In the Syria context where the GAM is low, there are always intentions to advocate for nutrition interventions. How do we use trends from the IPC acute FS?

A: When classifying an area, the tool will only take into consideration the actual statistics (i.e. actual GAM prevalence); however, it does look at trends and highlights the finding. For example, even if the current GAM level is 5%, if the trend data shows that it was around 3%, this increase is highlighted in the IPC maps. Additionally, in the context of low GAM rate, IPC analyses highlight problems with, for example food security, care practices, etc. which could have longer terms impact on child development and survival are emphasized and in those context, caution might need to be taken in providing good analysis of the drivers and possible impact which might not be GAM.

C: Using a median approach (Oleg), when it comes to the use of MUAC, it is likely to be done in extreme situations where you are in phases 4 and 5 and where you combine with mortality data. Need to understand the risk of this classification. Need to take into account the sensitivity and specificity – it is rather hasty to adopt this threshold since sensitivity and specificity were not taken into consideration.

C: What would be useful in addition to Oleg presentation to the GNC partners is having a discussion on the minimum requirements on which data to include, what is the reliability and how to evaluate it. It would be important for the GNC-CT to organize call on this issues

Q: Where IPC AMN indicators can be found?

A: all indicators can be found on the IPC website: http://www.ipcinfo.org/
SUMMARY OF SESSIONS: DAY TWO – 30 MARCH 2017

SESSION 1: NEXT STEPS/TIMELINE FOR COSTING AND FINALIZING WORK PLAN AND FUNDRAISING FOR ACTIVITIES – GROUP WORK (SAME GROUPS AS DAY 1)

CHAIRIED BY: VICTORIA SALVEPLANE AND RUTH SITUMA

The Strategic Priorities (SP) and Supporting Objectives (SO) were written on 5 different flipchart boards across the conference room. Agencies were asked to write their names, to show preliminary interest in supporting and being part of the taskforce for the costing process. It was made clear that this is just an exercise for the purposes of gathering ideas on which agencies are interested in which SPs and SOs and costing of the WP, and that this will not necessarily lead to agencies taking responsibility for implementing any of the SPs or SOs.

It is estimated that the costing will involve 1 or 2 calls and should be completed by mid-May 2017. A call should be organized within the next month. For details, please refer to session 10 below.

SESSION 2: REVIEW OF THE COSTING OF PREVIOUS GNC WP

PRESENTED BY: JOSEPHINE IPPE

In this session, Josephine discussed the funding of GNC, summarized the key suggested changes to the GNC 2017-2018 rolling WP as per Day 1 activities, and presented the next steps/timeline for costing and finalizing the WP, as well as fundraising for activities.

Funding Support to the GNC

When the nutrition cluster was established at the global level in 2006, a global appeal was launched by OCHA and all CLAs received funds from various sources to set up their clusters. After the funds were used, the donors continued to support the global nutrition cluster: the Swiss Government, the Office of U.S. Foreign Disaster Assistance (OFDA), ECHO and the Department for International Development (DFID). Internally, the global nutrition cluster also received support from UNICEF. Josephine highlighted the need to:

a. Identify new donors. A comprehensive list of donors exists; the GNC should know how to approach and engage them to fund GNC activities.
b. Strengthen the relationship with current donors. This could be through publications, inviting more donors to meetings, etc.
c. Advocate through UNICEF.
d. Explore new opportunities and how to work with and fundraise through UNICEF regional offices.
e. Explore donors’ base feedback. It is important to define the type of work funded, for example the development of a tool or a document, or consultancy work… This gives room for donors to understand the work. A two-year rolling WP helps prepare a more organized modus operandi and enables the donors to see what is funded and by whom.
f. Identify the gaps in funding. It also guides the partners on the collaborative fundraising.

Key Suggested Changes to the GNC 2017-2018 rolling WP (Recap from Day 1 activity) Highlights of yesterday’s suggestions (Summary of discussion)

Josephine summarized some of the key suggested modifications to the GNC WP from the previous day. These included:

- Where to place the technical trainings, there is no proper place to it
• The flow of the WP
• Some areas could be merged or compiled as they are inter related
• The role of the regional offices need to be clarified
• The dissemination plan in the WP
• The development of M&E - how to monitor progress
• Capacity building definition
• Changes in the order of activities
• Emphasis on some clarity of activity
• Clarity on the role of OCHA in the inter-cluster engagement
• CLA regional office arrangement needs to be clarified
• Questions around consolidation funding overview about advocacy

Timeline for costing and finalizing the GNC 2017-2018 rolling WP – The Way Forward

1. **By end of April 2017** the GNC will:
   a. Provide an updated WP based on the feedback received
   b. Provide the costing matrix and list of activities
   c. Cost the activities. Some activities may not need any funds, as such, the costing would change accordingly.
2. **By middle of May 2017**: Donors will be approach to initiate fundraising by implementing action in the GNC Fundraising strategy.
3. **In June**: the WP will be launched. The previous WP was launched in Geneva and was supported by IOCC and facilitated by ECHO and the Swiss Government.

Josephine finally affirmed that everything is possible with partners, sponsors, and the technical taskforces that are leading initiatives.

**Comments, Questions and Answers**

**Q: What is the estimated cost of the WP?**
A: The cost of the past 2 years was around USD $5.6 million; adding internal funds, the overall budget amounts to USD $6 to 7 million. Some of the permanent positions (e.g. Coordinator) are covered by UNICEF. Funds need to be raised to support the GNC deputy position as this cost is not mainstreamed by the CLA. Some areas can be covered by partners.

**Q: How is the GNC going to support its Work Plan in this critical condition in times where many donors are cutting the funding? What proportion of the previous WP was funded?**
A: 85% of the previous Strategy was funded, mainly by UNICEF and 97% implemented. There was a lot of internal allocation of funds by UNICEF.

**Q: What is the possibility of UNICEF to co-fund or mainstream additional positions?**
A: The mainstreaming of the cluster cost is an ongoing process, and it is already happening. For example, proposals which were written and funded were all done under UNICEFs internal fundraising initiative. Even though some positions are mainstreamed, fundraising to maintain some positions and activities is always needed. This year, the GNC started with 350,000 USD. UNICEF is ready to support.

**Comments:**
The WP could be mainstreamed and simplified. It can include clear budget figures at global level. Creating a new product that has a clear figure would assist in engaging donors.

Creating a database that depicts the situation in each country, the work that is completed, its added value among other things could be appealing for the donors. The demonstration of added values is crucial and necessary, it also promotes the inter-cluster work.
Donors have high expectations. It is important to match what is expected with what can be delivered with the existing capacities at both global and national levels. Stating life saved or key achievement at country level as a result of effective coordination could be useful too.

Mainstreaming positions on support budget is a long process, but as UNICEF is developing a new strategy and a new Office Management structure for the next 4 years, there is an opportunity to propose a few cluster positions in the upcoming office structure to be funded through sustainable funding sources within UNICEF. Currently, Nutrition cluster positions are proposed, but important to keep in mind that not all requests/proposals would be accepted, thus advocacy should continue. Additionally, there is a need to target non-regular donors/non-traditional donors or non-regular funding positions. In the absence of this, the GNC-CT will be forced to reduce the number of staff at global level as there are a number of obstacles with regards to fundraising for global level cluster positions.

SESSION 3: PRESENTATION OF THE NIE LEADERSHIP AND COORDINATION STRUCTURE

PRESENTED BY: RUTH SITUMA

Ruth thanked the GNC partners for their rich input and hoped that the session will lay down the steps towards operationalizing the model to address NIE technical issues.

Session Objectives

The objectives of this session were to:

- Present the progress of the NIE Technical Taskforce Work in which 13 members were involved: covering the updated GNC technical role definitions and the model for addressing NIE technical issues.
- Seek GNC’s endorsement on the overall architecture of the model for addressing NIE technical issues, including the communication and escalation pathways.
- Agree on the next steps to establish and operationalize the model for addressing NIE technical issues.

Background

Over the last 3 years, some actions were undertaken to identify the best and most appropriate role of the GNC in addressing nutrition technical issues and support:

- **March 2015**: Decision to reassess the technical role of the GNC
- **Early 2016**: Reviewing and formulating recommendations (around 20)
- **March 2016**: Prioritization of key recommendations by the GNC and constitution of the NIE Technical Task Force to address the key recommendations.
- **October 2016**: NIE Technical Task Force presented the model options and proposed key terms definitions to the GNC. GNC partners agreed on “Model 5 Plus” and agreed on technical role definitions with feedback.
- **March 2017**: NIE Technical Task Force currently presenting “Model 5 Plus”, updated GNC technical role definitions and agreeing on the next step to establish the model.

Definition of GNC technical role in NIE

A handout that includes the full updated definitions for each of the three technical roles was provided. The terminology has undergone several modifications but the definition was kept the same.
- Technical advice: originally technical support.
- Consensus driven guidance: originally technical guidance, captures technical support for the emerging issues.
- Specialized technical expertise: originally specialized technical capacity.

Key features of the Model 5 Plus

1. It was selected from the review report which proposed models 1 to 5. Model 5 proposes a mechanism within the GNC-CT to provide technical support including setting up Task Forces to provide interim guidance.
2. Establishes a technical body that addresses emergency nutrition technical issues in all humanitarian contexts (countries with and without clusters).
3. Some of the key benefits of Model 5 Plus include:
   - Provision of an overarching consolidated conversation
   - Analysis of the changing NIE landscape in terms of giving high profile to emerging technical issues
   - Facilitation of linkages between sectors, normative and operational bodies
   - Linking with development actors and platforms
   - Engagement with relevant actors in NIE in a more systematic way
   - Contribution to the normative process in a more systematic way

Ruth emphasized that the model is still “under construction”.

Presenting Model 5 Plus

Ruth presented the various steps involved in this model to address technical issues at country level. When a government or a partner or a Nutrition Cluster Coordinator in a country identifies a nutrition technical issue to be addressed, the first step is to find the solution within the country. The aim is to maximize in-country capacity and ensure that only un-resolved issues are escalated to the next level. If the issue is not addressed, there are several systems in place that can be used, which include using Nutrition Technical Working Groups in country, Emergency Nutrition Network (ENN), UNICEF Country Office, partners’ country offices, GNC, and GNC Helpdesk. Using these systems not only ensures that one chooses an option that is convenient and accessible to them but also maximizes the efficiency by using the already existing mechanisms and making the process more predictable and systematic.

If the issue escalated to UNICEF Country office or Partner country office, is not resolved, it is escalated to the UNICEF Regional Offices and partners’ regional offices respectively. In the case where the issue is not resolved by the UNICEF or partner’s regional level or by ENN, GNC, GNC help desk, the problem is then escalated to the Technical Lead Coordinator or Secretariat. At this level if the problem is not resolved the issue is brought to the Nutrition in Humanitarian Context Technical Advisory Body. The Nutrition in Humanitarian Context Technical Advisory Body has three working groups namely; Technical Advice, Operational Standard Setting and Specialized Technical Capacity/Expertise. Depending on the technical problem, the relevant technical working group under the Technical Advisory Body will be tasked to address the issue. Feedback will be disseminated back to the requester.

Tracking is undertaken at every level to ensure that lessons are documented and shared for inter-country learning.

Ruth walked the audience through a practical example of finding the protocol of measuring and treating adult malnutrition using Model 5 Plus.
Members of the Nutrition in Humanitarian Context Technical Advisory Body

Members of this Body would be drawn from the GNC members and expanded to include regional platforms, UN agencies, governments, research institutions, as well as other networks and existing technical bodies. Members of the Advisory Body will function through technical working groups as per the definitions of NIE technical capacity:

1. Technical Advice
2. Operational Standard Setting
3. Specialized Technical Capacity/Expertise

Technical Advisory Body Functions

Illustrative Functions for the Technical Working Groups:

<table>
<thead>
<tr>
<th>Technical Advice</th>
<th>Operational Standard Setting</th>
<th>Specialized Technical Capacity/Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop SOPs to address NIE questions whose guidance exist.</td>
<td>• Identify and prioritize NIE guidance gaps.</td>
<td>• Support in updating NIE competencies</td>
</tr>
<tr>
<td>• Address NIE technical questions.</td>
<td>• Advocate for evidence generation to inform guidance development and link with other sectors, WHO/FAO to develop interim guidance.</td>
<td>• Identify additional opportunities &amp; innovations to increase institutional and human capacity in NIE</td>
</tr>
<tr>
<td>• Establish mechanisms to track NIE technical</td>
<td>• Encourage countries to collect and document good experiences and practices in a more systematic manner.</td>
<td>• Facilitate linkages to access specialized technical expertise for NIE</td>
</tr>
<tr>
<td></td>
<td>• Stimulate and advocate academic research institutions to identify research gaps.</td>
<td></td>
</tr>
</tbody>
</table>

Discussion, Suggestions, Questions and Answers

- GNC endorsed the proposed structure for Nutrition in Humanitarian Context Technical Advisory Body with suggestions and recommendations.
- GNC role in NIE task Force definitions - the definitions were also endorsed as proposed as they had been discussed in detail previously.

Communication channels

- The model is making use and consolidating existing mechanisms to communicate and facilitate the tasks.
- Ensure linkage with other sectors/ expertise at both country and global level
- Have narrative that emphasizes that NIE technical issues should be addressed at country level as much as possible and only escalated if not resolved at country level
• It needs to be clear how countries will access the technical expertise in the Technical Body - Countries will know about the availability of the Nutrition in Humanitarian Context Technical Advisory Body as soon as it is endorsed. This information will be communicated and disseminated to all. The communication path way needs to be aligned with agencies communication channels – avoid creation of new mechanisms – it was emphasized during the meeting that the communication pathway will use and maximize existing communication channels within agencies
• Have a quality assurance mechanism for issues resolved at country and global level
• Communication flow should be two way
• Have narrative accompanying the communication pathway to explain the different levels 1, 2, & 3 and reasons for skipping or not skipping a level
• Unlike Working Groups at Country Level, this Body, which draws on existing capacity, is brought together to address unsolved issues and provide technical guidance.

Technical Advisory Body Composition and Function:
• Financing the Technical Advisory Body will be tackled after the Model is endorsed. The Task Force will take into consideration feasibility. Based on experience from other bodies, members volunteer in terms of time, while the core secretariat is funded.
• The Technical Lead Coordinator position for UNICEF will be a full-time position (not double-hatting). Several nutrition issues are waiting to be addressed for years, but there will be a need to continuously prioritize what needs to be addressed first.
• The link between the Technical Body with the normative process while providing interim guidance on emerging issues was very welcomed
• The Technical Advisory body could provide short term solutions while awaiting for support from research if needed. An established committee that can take on those particular issues is already in place within the working group. It could also provide long term support.
• Consider having communication and advocacy be part of the Technical Advisory Body role to support in the dissemination of new guidance.

Next steps
• NIE Task Force to immediately engage WHO as the normative agency (engage early) to ensure linkages
• Consider starting with formation of Technical Advice Working Group
• The Technical Body should either prioritize addressing the following technical issues: adult malnutrition, cash, transfer, simplified protocol, MUAC OR use itemized list from ENN.

SESSION 4: PRESENTATION OF WHAT IS DIFFERENT ABOUT UPDATED GNC HANDBOOK
PRESENTED BY: NICKI CONNELL

Presentation slides

Nicki Connell provided an update on the GNC Handbook Revision Project. The session was divided into 4 major parts: scope of the work (background and methodology), key modifications, gaps in content, and the next steps.
In line with the transformative agenda, the GNC Handbook – Nutrition Cluster Handbook - A Practical Guide for Field Coordination, Version I – has undergone several modifications. The modifications incorporated the learning and operational experiences from the past five years.
Scope of the Work (Background/Methodology)
Throughout the process there was a consultative group (CG) who advised on key decisions to be made. A documentary review was conducted looking at the materials and tools available that would inform the new version of the Handbook. In addition, interviews were conducted with 22 key stakeholders (+4 for multi-cluster). After that, the new structure, chapter flow and expected content were presented to the GNC-CT and CG and agreed upon. The first draft of chapters were sent last year for revision to the CG and interested others, depending on the chapter content. The consultants are in the process of writing up the second draft of chapters and finalizing according to the feedback received.

Key modifications
The handbook comprises two key sections:

- **Section 1** (5 chapters): NIE/Humanitarian principles, Protocols, Coordination Mechanisms, and Standards (including Cluster Coordinator Reference Module (CCRM)). Chapter 5 is new, and is related to nutrition cluster transition and deactivation.
- **Section 2** (6 chapters): Humanitarian Programme Cycle.

At the current stage, some of the Handbook’s second draft chapters are finalized, while others are in the process of being finalized, some chapters are being drafted, others going through a peer review process or waiting for feedback.

Gaps in Content
The new version is intended to be more condensed and succinct. It will incorporate experience from country clusters and sectors as this will help future cluster coordinators in their work.

- GNC Strategic Priorities section (within Ch1): final draft of GNC Strategy shared in March – consultant incorporating key points currently
- Inter-cluster Coordination section (within Ch2): Now drafted using KII results from January – out for peer review
- Shared Leadership and Coordination models (within Ch2): Feedback was that coordination models from transition study to be incorporated – currently being done
- Transition and Deactivation Chapter (Ch5): currently in process of development based on transition study (released December) and related draft guidance (released in February)
- Multi-cluster Approach Chapter (Ch6): now drafted using KII – out for peer review
- Nutrition Cluster Response Planning (caseload calculation guidance for ~SAM and MAM) (within Ch9): Now received guidance from UNICEF and WFP on this and currently being incorporated
- Implications of WHS on Clusters (within Ch1): how does this all play out in terms of supporting responses and ensuring the mechanisms / structures in place to do this – need to clarify what this means practically for Nut Cluster
- Shared Leadership (within Ch2): is also a bigger conversation around OCHA guidance lacking/not practical – requires a bigger study – but consultant will address as feasible within this scope of work
- Updating of Sphere – will have implications on several sections of the handbook including but not limited to CHS and AAP

Next steps
The version is now being edited. There is a need for more examples of good practices to be shared. Additional material is going to be incorporated once it becomes available (e.g. implication of Sphere revision).
SESSION 5: PRESENTATION OF WHAT IS DIFFERENT ABOUT UPDATED SPHERE

PRESENTED BY: PAUL WASIKE

Revision process
The current edition of the Sphere Handbook was published in 2011. The Handbook is currently being revised and an updated version of the Sphere Handbook is expected to be released in 2018. A Working Group was established, consisting of 9 members/organizations (independent, academia, donors, INGOs, National NGOs, and Governments, UN agencies (UNICEF, WFP, UNHCR, WHO)). Initial drafts are currently sent out for peer review. The second draft of the handbook will be finalized in October 2017.

Modifications
- The new version is very friendly to non-humanitarian or non-traditional users.
- It involves more evidence based standards.
- It continuously engages practitioners. More than 80,000 practitioners from more than 149 countries are using the standards.
- It is expected to be a ‘live’ document used on a regular basis.
- Web-based and app-based and is even more user-friendly.
- The introduction chapter will be stronger and it will incorporate protection principles and Core Humanitarian Standards (CHS).
- In terms of technical chapters, Food Security and Nutrition, Health, shelter and Non-Food Items (NFIs), and WASH are maintained.
- No major modifications in the presentation of the standards.
- Thresholds for indicators (if any) are integrated.
- The nutrition sub-chapter, similarly to the previous handbook, includes two sections: IYCF, and management of acute malnutrition and micronutrient deficiencies. The micronutrient section needs to be reviewed.

Comments, Questions and Answers
- Cash is not a standalone section. It is included under Food Security and Nutrition and has 2 sections.
- Food Security and Nutrition are combined in one chapter. They used to be combined in the past as they were considered related. There is a proposal to separate them but the final decision has not yet been taken.
- The aim is to make the Sphere Standards as compact as possible, which is easier in the online version because of links. The hardcopy will be more expanded. Accountability (reasons, transparency, and accountability of affected population) is included with the CHS. A working group is currently working on the chapter.

SESSION 6: TECHNICAL PRESENTATION: RESEARCH INTO CASH AND NUTRITION – REFANI RESEARCH NIGER, PAKISTAN, SOMALIA

PRESENTED BY: ZVIA SHWIRTZ, CARMEL DOLAN AND ANDREW SEAL

Overview – presented by Zvia Shwirtz:
Research on Food Assistance for Nutritional Impact (REFANI) is a consortium comprised of Action Against Hunger, Concern Worldwide, ENN and University College London (UCL). It is a three-year
research project aiming to strengthen the evidence base on the nutritional impact and cost-effectiveness of cash and voucher-based food assistance programmes, as well as identify the mechanisms through which this impact may be achieved. The project started in March 2014 and is planned to be completed in August 2017.

Project studies were implemented in Pakistan, Niger, and Somalia and detailed findings will be shared in Summer 2017.

REFANI Results -Niger – presented by Andrew Seal (UCL)

The intervention:
Seasonal Unconditional Cash Transfer.

Background: The REFANI study in Niger (specifically in Tahoua) was conducted using a cluster randomized controlled trial with distribution of cash-in-hand to women. Target criteria: during 4 months (June to September – lean season), women from poorest households were targeted to receive 32,500CFA (£36) in order to cover 75% of the total calories needed by an average household of 7 people.

The results of the intervention were assessed after the following 6 months.

Research question:
In Tahoua (Niger) the admissions to acute malnutrition treatment programmes seen to rise from March/April, so the question of this research was: Is starting the intervention two months earlier able to decrease the prevalence of GAM?

Hypothesis:
An earlier starting, equal-value UCT will reduce the prevalence of global acute malnutrition (GAM) in children 6–59 months old in beneficiary households and at population level.

Findings:
- Household food security improved for the group with early intervention.
- By the end of the season (end line), in the prevalence of GAM remained high in both study arms. However, all odd ratios were close to 1, showing no significant impact of the two-month earlier cash distribution on the prevalence of acute malnutrition in children aged 6-59 months.
- Morbidity was very high which may help explain the high prevalence of GAM in both study arms and argues for a stronger approach to improving health care and WASH, which are unlikely to be improved by a household CTP in this context.

REFANI Results – Pakistan – Presented by Carmel Dolan (ENN)

Background:
The REFANI study in Pakistan (specifically in Sindh) was a cluster randomized control trial. Sindh is a vulnerable area with extreme temperatures and wind. It is characterized by a high prevalence of acute malnutrition (the highest compared to the rest of the provinces in Pakistan), wasting, stunting and anaemia. In this study, ACF was the implementing partner.

Design:
Four different interventions were studied over 6 months:
- Standard (control group)
- Standard cash transfer (10 pounds per month)
- Double the amount of cash (20 pounds per month)
- Fresh food vouchers (equivalent to 10 pounds per month)
All the cash interventions (groups 1, 2 and 3) were unconditional.

The study aimed at looking at the long-term effects of cash interventions: 6 months after the intervention has ended (1 year post baseline).

- **Primary outcome:** Children < 5 years: % wasting and mean WH z-score (WHZ)
- **Secondary outcome:**
  - Children: % severe wasting, mean MUAC, % stunting (linear growth), % morbidity, mean haemoglobin concentration (Hb)
  - Mothers: mean Body Mass Index (BMI), mean MUAC, mean Hb

**Findings:**

**Baseline:**
- The prevalence of GAM at baseline was very high in all the arms.
- No significant difference between the arms in the prevalence of wasting.

**Post-intervention** (6 months after intervention ended):
- **Primary outcome** after adjusting for age, sex, cluster: there is a significant decrease in odds ration of a child being wasted (WHZ ≤ -2) and increase in WHZ mean of children under 5 among households who received double the amount of cash and among the fresh voucher group.
- **Secondary outcome:** across all the 4 intervention arms, there was a decrease in odds of a child being stunted (HAZ ≤ -2) and an increase in mean HAZ z-score among children under 5. In the group that received the fresh food voucher: there was a significant increase in BMI of mothers but a decrease in Hb among mothers and children. This was very unexpected and a worrying outcome of the study. In the single cash group, a significant decrease in Hb among mothers could be detected as well.
- The household food diversity increased in all groups. The magnitude of the improvement was the least impressive in the group who received the fresh food voucher.

**Conclusions:**
- The larger amount of cash (double) was more effective in improving weight outcomes on the short term (6 months period, not after).
- The group who received the fresh food voucher had unintended negative impact on Hb status due to the restrictive nature of the voucher; the vouchers were exchanged.
- The type of intervention did not affect the weight-for-height z-score.

**REFANI Results – Somalia - Andrew Seal (UCL)**

**Background:**
The REFANI study in Somalia (specifically in Weydow area, Afgooye Corridor) is a non-randomized cluster control trial. Concern Worldwide is the implementing partner. The study took place in IDP camps in Weydow area near Mogadishu, and are very densely populated.

**Research question:**
Is the distribution of cash able to reduce the prevalence of GAM among these internally displaced children aged 6-59 months?

**Design:**
- **Group 1:** 10 clusters not receiving cash (control group)
- **Group 2:** 10 clusters receiving 84 USD/ month during 5 months (intervention group)

The MUAC of children aged 6-59 months belonging to groups 1 and 2 was taken on a monthly basis. MUAC was used for its convenience and feasibility. Health workers were collecting data in 20 IDP...
camps which made MUAC more practical than WFH. During the baseline survey, it was noted that household income and expenditure levels were higher in the intervention camps than they were in the control camps.

Findings:
- Household expenditure decreased by 4 USD in the control group and increased by 25 USD in the intervention group.
- Diet diversity and the number of meals per day increased in the intervention group; meat, fish and dairy product consumption increased.
- The expenditure on non-food items: clothing, housing and building, also increased in the intervention group.
- Expenditure on drinking water consumption decreased; this could be related to drinking water supply shortage rather than expenditure distribution.
- IYCF indicators did not change.
- There was no difference in the proportion of MUAC ≤ 12.5cm between arms at any time point.
- No difference between groups was found in the incidence rate for low MUAC or the hazard ratio when data adjusted for sex and age.
- Fifty-six children died during the intervention period. The reasons of death were mainly diarrhoea, malaria, severe acute malnutrition, and measles. (Less than 50% of the surveyed children were vaccinated against measles, which is a particular concern given the crisis currently affecting Somalia and the fact that measles is very likely to be a major cause of death in this emergency!

Conclusion:
Good results were found for food security and diet diversity but not for mean MUAC or the incidence of acute malnutrition.
Work is ongoing to use the IDP Nutrition and Mortality Monitoring system that was established during the study to look in more detail at the causes of death and to monitor changes in health and nutrition indicators during the ongoing emergency.

Comments, Questions and Answers
- Clarification was sought on inclusion of education component for the use of cash by the families: The presenter explained that, all intervention arms received unconditional cash; however, with every monthly transfer of cash, people were informed that it was mainly directed to benefit the children and the pregnant or lactating women.
- Why were MUAC measurements chosen over WFH in Somalia, where using MUAC is known to potentially underestimate the prevalence of malnutrition: although the research team would have preferred to use both MUAC and WHZ, the feasibility of using the latter monthly on 1,200 children through health workers was very low.
- Clarification was sought on the source of information regarding causes of death: the presenter explained that, the researcher did not use medical records to investigate the causes of death. They used the established WHO Verbal Autopsy method and interviewed the mothers or caretaker.
- For Pakistan, the study has been accepted for publication. More details will be shared upon publishing.
- The findings of these studies were in line with others on food security; and emphasises that the assumption that cash will improve acute malnutrition in most contexts is not evidence-based.

1 VA uses in depth interviews with carers or relatives to establish the probable cause of death.
**SESSION 7: MUAC AND /OR WH AS ADMISSION AND DISCHARGE CRITERIA ON CMAM PROGRAMME AND USE OF EXPANDED CRITERIA**

**Presented by: Diane Holland, André Briend, and Britta Schumacher**

**Session presented by Diane Holland**

This session provided a snapshot of the ongoing work regarding criteria for admission and discharge on CMAM programme (MUAC and WFH).

**Recommendations currently used by program implementers are 2013 WHO recommendation 1:**

- Community assessment with MUAC and oedema check
- In PHC (Primary Health Care), MUAC or WFH and oedema check
- Discharge based on indicator used for admission, except in the case of admission based on oedema and indicator used in the programme

**Status of using “MUAC only” during programming** (By CMAM Forum, to be released...TBD.)

- Uptake in national protocols (e.g. MUAC and oedema only, or MUAC/oedema and WFH where possible and in PHC)
- Uptake in NGO protocols (used by MSFs, GOAL, World Vision among others)

**Next steps for implementation guidance for WFH and/or MUAC**

- For SAM, incorporation into updated Joint statement on CMAM outlining ideal to work towards and minimums that must be met to save lives (in development, release in Oct 2017)

**Next steps for modifying normative guidance re MUAC cut-off points for admission/discharge**

- Requires systematic evidence review through WHO

A very important implication around the use of MUAC and/or WFH discussion relates to the understanding of the actual burden of children and PLWs that needs to be identified and treated.

Diane highlighted the ongoing research work by UNICEF to update the incidence factor as well as efforts to update Joint Malnutrition Estimates to have country level modelled estimates that account for incidence.

**Session presented by André Briend**

**Objective:**

Both MUAC and WFH measurements aim at reducing the prevalence of acute malnutrition and consequent mortality. Providing treatment for acute malnutrition is necessary and therefore having a proper diagnosis is a pre-requisite. It is important to ensure that only the children who really need the treatment receive it.

These objectives were translated into identifying the most appropriate diagnostic tool with the maximum sensitivity and high specificity levels. Retrieving sensitivity and specificity from statistic calculations required consistent and systematic results; however, replications of studies were unethical as it put subjects at risk of death while treatment was available.

**Studies Review:**
MUAC appeared to be better and to have a higher specificity level compared with WFH in certain conditions. Some studies suggested increasing MUAC cut-offs: 120 mm used by most studies.

A study, using body composition analysis, concluded that 90% of weight gain in short children with MUAC 115-125 mm receiving RUTF was lean tissue. Consequently, there is no rationale for the assumption that using MUAC in short children could lead to a false negative result if the weight gain is fat mass.

**Session presented by Britta Schumacher**

This session provided a quick update on the dissemination of temporary guidance related to CMAM protocols in exceptional circumstances.

Based on evidence from its use in different countries, special attention needs to be given to the dissemination of the CMAM protocols in exceptional circumstances. The use of Ready-to-Use Therapeutic Foods or Ready-to-Use Supplementary Foods (RUSF) is based on practical approach rather than evidence.

There was a need to understand and define the specific circumstances and contexts of acute crisis for the application of these protocols, including the expanded criteria. An agreement between the Cluster and the Government is mandatory to make things clearer at the national level. MAM decision tools were developed by the GNC partners also included flow diagram that identifies the triggers of the protocols, such as delay in financial resources, unanticipated supply issues related to RUTF or RUSF. As soon as the situation reverts to normal, the ordinary/national protocol for CMAM (agreed by the Government) can be used again.

The dissemination of the temporary guidance will take place through the GNC website. Cases and experiences of using these protocols have been documented (for example from South Sudan). UNHCR will be included into a broader discussion with UNICEF and WFP with a focus on roles and responsibilities. The protocols will be revisited and updated with new evidence.

**Comments, Questions and Answers**

- It would be ideal to have clear and straightforward directions. The situation in some places is worrying because RUTF is sometimes not accepted.
- There was a question on whether the change in the formulation of RUSF may affect the suggested protocols. The harmonized specification of the treatment products will be very helpful if a revised protocol is used.
- **On the use of MUAC:**
  - MUAC assessment for mothers is a great idea but there is still more data to be compiled and discussed further.
  - It is worth raising the MUAC cut-off to around 120 mm or more so that more children with WFH less than -3 z-score are admitted. On this point, another comment was raised with regards to the concern in modifying the definitions of SAM and MAM cut-off points again.
  - The conclusion that MUAC is best is still debatable and needs further discussion because research is not conclusive and findings show controversy. More consistent and systematic evidence is still needed.
- One question related to whether André was proposing to use MUAC for children above 6 months and less than 67 cm, he responded that, there is no rationale for not using MUAC among short children.
- There was also a concern around how many children do not reach the 125 mm which is a discharge criteria, and it was suggested that, more investigation is required when children do not reach 125 mm of MUAC in the field.

SESSION 8: TECHNICAL UPDATE ON JUSTIFICATION FOR INCLUSION OF RUTF IN ESSENTIAL DRUG LIST

PRESENTED BY YARA SFEIR

Background
There is a large SAM caseload around the world that still cannot be reached with treatment. ACF’s approach to strengthen the health systems strives to integrate the treatment of SAM children within the health systems, to make it sustainable. Discussions show that RUTF is one of the key barrier that could be worked on for the scale up of quality SAM management. It has been suggested to include RUTF to the WHO Essential Medicines List (EML) since 2009; however, there was a lack of evidence-based consensus around this, and on the impact it would have on the availability of RUTF.

Research
Background research on countries that have included RUTF on their essential medical list was done along with interviews with key informants to explore its usefulness and added value.

Synthesis of Findings
In Haiti, Zimbabwe, and other countries, RUTF was on their respective national essential medical list. RUTF in some other countries was registered as a medicine and in others as food.

Putting RUTF on the essential medical list of a country would improve the distribution in some setting and would entice the government to budget and buy RUTF. Both WHO and UNICEF advise having RUTF as an essential commodity in the national medical lists.

Opinions
- Some of the researchers affirm that there is not enough evidence on the effectiveness of RUTF.
- Some of the food movement in Asia voted for a food-based approach.
- Local suppliers or producers producing RUTF may be affected if RUTF have similar-to-medicine specifications standards and consequently will lead to sourcing from one group of suppliers or producers.
- On the other hand, if RUTF production does not have clear specifications, its quality could be affected.

Decision and implementation
The decision to include RUTF on WHO’s EML has been taken. It has received substantial positive feedback and support from various governments, NGOs, communities, etc. 16 INGOs and 8 experts endorsed this application. The decision on the Codex Alimentarius (setting specifications for RUTF) is going to be made this week, and this can take up to 5 more years.

Comments, Questions and Answers
• If RUTF and RUSF are to be used as a harmonised product for SAM and MAM treatment, there will be need to talk about harmonising the specifications of each product that is used for different purposes.
• WHO has been asked not to put very strict specifications and to have certain requirements that tell that this product looks like RUTF, listing it as an item and not as a drug (otherwise the specifications would be very strict).

SESSION 9: WORKING GROUPS: DISCUSSIONS AND ENDORSEMENT ON THE NEXT STEPS

FACILITATED BY RUTH SITUMA

Complementary to presentation and discussion done during, Session 3: Presentation of the NIE Leadership and Coordination Structure

Participants were divided into 4 groups and group discussions were presented in plenary. Follow ups on decisions and discussions took place with the presenters of the groups as mentioned below.

- Group 1: Andi Kendle
- Group 2: Yara Sfeir
- Group 3: Britta Schumacher
- Group 4: Megan Gayford

Click here to see the results of the Group Work
SESSION 10: WRAP UP
FACILITATED BY VICTORIA SAUVEPLANE

Following the previous session where agencies expressed interest in contributing to the costing process of the Work Plan, this session focused on moving the work forward. Therefore, Victoria invited agencies who have expressed interest in leading or being engaged in the costing of activities to initiate the exercise by sending an invitation to other partners and setting up a call, to coordinate the process among all interested agencies and to provide inputs for the activities they have chosen to work on. Accordingly, for each of the activities within the strategy, one agency volunteered or was selected to take the lead on the costing process as per the table below:

<table>
<thead>
<tr>
<th>Strategic Priority or Supporting Objectives</th>
<th>Be part of the task force to finalize and cost the activities</th>
<th>Interested in taking lead in implementation (which activities)</th>
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<tr>
<td><strong>Strategic Priority 1</strong></td>
<td>ACF, TRRT, HelpAge, ACF, UNICEF</td>
<td>A- TRRT, IMC, Save, ACF, UNICEF</td>
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<td></td>
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<td>B- RED-R, ACF, IMC, UNICEF, Save, HelpAge, IOCC</td>
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<td>C- UNICEF</td>
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<td>Save the Children, FAO, World Vision, IOCC, HelpAge, Save,</td>
<td>A- HelpAge, IMC, NCC and RRT, Save, UNICEF</td>
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<td></td>
<td>UNICEF, UNHCR</td>
<td>B1- ACF, FAO, IOCC, WFP, TRRT, UNICEF</td>
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<td>B2- FAO (MN), ACF, UNHCR, IOCC, World Vision, TRRT, IMC, WFP, Save, UNICEF</td>
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<tr>
<td><strong>Supporting Objective 1</strong></td>
<td>FAO for intercluster, UNICEF the rest</td>
<td>Inter-cluster: FAO (part of ICWG), IMC, WFP, UNICEF (B in terms of preparedness- HelpAge)</td>
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<tr>
<td></td>
<td>FAO, HelpAge, UNICEF</td>
<td>CLA: UNICEF</td>
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<td></td>
<td>Donor Partnership: IMC, WFP, UNICEF</td>
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<td>Development Actors: IMC, WFP, UNICEF</td>
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<td>ACF</td>
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<td>B- ENN, WFP, UNICEF</td>
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Closing

The GNC meeting ended and the floor was given to Josephine who gave thanks to partners, participants, donors, and SAG members. She also thanked IOCC for hosting the meeting. She finally thanked the GNC team and wished everyone safe travels.
ANNEX A: AGENDA

Agenda for the Global Nutrition Cluster Working Meeting of Partners
Beirut, Lebanon, 28 – 30 March 2017

Working meeting objectives:

- To present and endorse the 2017-2020 GNC Strategy, review and finalize GNC work plan activities (2017-2018)
- To detail and agree a process for costing the work plan
- To finalize discussions and endorse the recommendations and proposed structure for coordination technical NiE work and update participants on changes in the update Cluster Handbook
- To welcome new SAG members and plan for SAG activities in 2017

Pre-meeting reading materials can be found on links below:

- GNC Strategy 2017-2020
- IPC for Acute Malnutrition Addendum Final
- IPC for Acute Malnutrition Concepts and Tools
- GNC Strategy Development Process
- GNC: Definition and Technical Role in NiE
- GNC NiE Task Force Consultation Questions
- Proposed Model for Addressing NiE Technical Capacity
- Weight-for-height and mid-upper-arm circumference should be used independently to diagnose acute malnutrition: policy implications. Grellety and Golden. BMC Nutrition (2016)
- Severe and Moderate Acute Malnutrition Can Be Successfully Managed with an Integrated Protocol in Sierra Leone. Maust et al. 2015
- How to Accuse the Other Guy of Lying With Statistics. Murray, 2005
Tuesday, March 28, 2017 GNC Strategic Advisory Group (SAG) Meeting

14:00 – 17:00  SAG review and handover:

- Review of the agenda for the GNC working meeting of partners
- Welcome to new SAG members
- Review of SAG Terms of Reference
- Review of meeting follow up, commitments and timeline for SAG members

Wednesday, March 29, 2017

Chairs: Carmel Dolan and Caroline Abla

08:30 – 09:00  Welcome and introductions: IOCC Representative – Ms. Ruba Khoury, and UNICEF Deputy Representative – Mr. Luciano Calestini
09:00 – 09:15  Objectives and housekeeping
09:15 – 10:00  Presentation of the Strategic Priorities and Overview of the Draft 2-year Work Plan – Ms. Josephine Ippe, GNC Coordinator
10.00 - 10.15 Instructions on Group Work

10:15 – 10:30  Tea/Coffee Break

10:30 – 13:00  Work plan discussions: Groups divided by Strategic Priorities, Supporting Objectives and internal development objectives (below) will review and discuss activities proposed. Each group will be facilitated by the GNC SAG member:

- Group 1: Strategic Priorities 1 and 2
- Group 2: Strategic Priority 3
- Group 3: Supporting Objective 1 (Inter-cluster and CLA Engagements)
- Group 4: Supporting Objective 1 (Donor-Cluster Partnership)
- Group 5: Supporting Objective 1 (Development Actors) and Supporting Objective 2 (outcomes B and C)

13:00 – 14:00  Lunch

14:00 – 15:30  Presentations by each group on Work Plan activities (3 groups, each 20 minutes plus 10 minutes discussion)
- Group 1: Strategic Priorities 1 and 2
- Group 2: Strategic Priority 3
- Group 3: Supporting Objective 1 (Inter-cluster and CLA Engagements)

15:30 – 14:45  Coffee break

15:00 – 17:00  Presentations by each group on Work Plan activities (2 groups, each 20 minutes plus 10 minutes discussion)
- Group 4: Supporting Objective 1 (Donor-Cluster Partnership)
- Group 5: Supporting Objective 1 (Development Actors) and Supporting Objective 2 (outcomes B and C)

17:00 – 18:00  Presentation and discussion from FAO on IPC Acute – Nutrition, Mr. Douglas Jayasekaran, FAO
19:00 Reception at Layla Restaurant, Zeytuna Bay hosted by IOCC

**Thursday, March 30, 2017**  
*Chairs: Victoria Sauveplane and Ruth Situma*

08:30 – 08:45 Recap of key suggested changes to the GNC WP – Ms. Josephine Ippe, GNC Coordinator

08:45 – 09:00 Review of the costing of previous GNC WP – Ms. Josephine Ippe, GNC Coordinator

09:00 – 10:30 Next steps/timeline for costing and finalizing work plan and fundraising for activities – Group work (same groups as Day 1)

**10:30 – 10:45 Coffee break**

10:45 – 11:15 Presentation of the NiE Leadership and Coordination structure – Ms. Ruth Situma, UNICEF

11:15 – 11:15 Working Groups: Discussions and endorsement on the next steps

13:00 – 14:00 Lunch break

14:00 – 14:45 Presentation of what is different about updated handbook (scope, content and gaps in content due to lack of clarity/guidance, include Updates on SPHERE Revision – Ms. Nichola Connell and Mr. Paul Wasike, Save the Children - USA

14:45 – 15:30 Technical Presentation: Research into cash and nutrition- REFANI research Niger, Pakistan, Somalia – Ms. Zvia Shwirtz, Ms. Carmel Dolan and Dr. Andrew Seal

**15.30 – 15:45 Coffee break**

15:45 – 16:45 MUAC and/or WH as admission and discharge criteria on CMAM programme and use of expanded criteria – Ms. Diane Holland, UNICEF and Dr. Andre Briend

16:45 – 17:15 Technical Update on justification for inclusion of RUTF in Essential Drug List – Ms. Yara Sfeir, ACF-France


17:30 – 18:00 Wrap Up/Vote of thanks/Closing
### ANNEX B: LIST OF PARTICIPANTS

**Global Nutrition Cluster Annual Working Meeting**  
**March 29-30, 2017**

<table>
<thead>
<tr>
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<th>Organization</th>
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ANNEX C: TWO-YEAR GNC WORKPLAN, 2017-2018

GNC 2 Year Costed Workplan 2017_2018.xlsx