

**GLOBAL NUTRITION CLUSTER ANNUAL MEETING NOTES**

BRUSSELS, BELGIUM

2-4 July 2019

 

**GNC ANNUAL MEETING DAY 1**

**Tuesday July 2, 2019**

**Opening Remarks**

Opening remarks by Jean-Louis De Brauwer (Director of the Dictertorate C, DG-ECHO)

* Emphasized importance of resilience building and building local capacity. How do we, as donors, make sure this also happens? This will require everyone’s participation and commitment in the next three days to set targets.

Opening remarks Meritxell Relano (Director, Office of Emergency Operations, UNICEF)

* Yesterday there was a deep dive on DRC and Afghanistan. Yemen did attract quite a lot of attention last year so we are hoping to refocus on these two countries.
* Donors want quality products that are informed by information management
* We need to invest in capacity of cluster, information management
* Prevent of malnutrition should be at the heart of our agenda
* Local capacity strengthening - strengthening of system of not just the humanitarian response is the way to go
* Support to local actors is important - local ngos and local government authority to have capacity of the protocol
* How do we extend the coverage and shrink humanitarian needs
* Intercluster coordination multi-sector approach -spoke to a mother with a child who was severely malnourished. The mother had no money for transport. How do we address those issues?
* Addressing malnutrition needs to look at many perspectives to ensure the children are not malnourished. If they are malnourished they should receive the support that they need. The needs of families should also be supported. We need to look at what works best for families.

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| **Agenda for GNC Annual Meeting Objectives:** (Ruth Situma)  **Day 1:** To examine global level programming initiatives and country level experiences and realities so as to improve NiE preparedness  **Day 2:** To examine country level programming and global level experiences in High impact nutrition interventions  **Day 3:** To examine country level programming and global level experiences in High Impact Nutrition Interventions (HINI) to improve the quality of nutrition in emergencies responses. |

**Session 1: Achievements Against Strategic Priorities (Josephine Session, Global Nutrition Cluster 2018)**

* Purpose: to recap what we did over the 8 couple months
* Last GNC was 8 months ago
* Usually in Sept or October but that is when those CO are developing plans.
* 8 months achievement since Sept/October
* Strategic reports have been guiding the work at GNC
* Need to put it up front that we are not that strong in preparedness
* Nutrition response and transition
* Now more focus on technical capacity
* Much more focus on this now through the RRT. When we started it was coordination and IM. Now more focus is on the technical side.
* Advocating and influencing- linkages what do we need to do advocate better for resource allocation for the cluster.

Operational support to countries

* Ability to provide support to countries when there’s a gap, in L2 and L3 countries or as country offices start to recruit when there is a need to kick-start the coordination while the country office recruits.
* 5 deployments last year.
* Recruited 2 RRT members.
* Established a technical help desk with 2 help desk officers - coordination and technical support.
* 50% of Shabib’s time as IMO is to deploy and provide hands on support.

Rapid Response Mechanism

* Established in 2012
* L3 countries will have 3-5 deployments in a year. This is not the right way as this should be surge support. Now agreed deployments are 2-3 months and then COs need to recruit someone.
* If a country request deployment, there should be some time. This system is not sustainable relying on surge.
* Cluster coordinators are not budget holders, so funding is in the section. It is important for the UNICEF Nutrition Section Chief to make sure that cluster coordinator is in their proposals.

Who is in the Rapid Response Team?

* 6→ 4 RRT team. Should be used for surge and not to fill gaps. Therefore would like a lean response capacity to have a sustainable continuous support

3 types of capacity building

* Information management - 5 day training.
* We need to review what we have done and strategically improve what we have done already. Issue with high turnover - coordinators are on shorter term contracts. This is not sustainable. Through helpdesk, to capitalize on capacity and fill gaps.
* This is in collaboration with Red R.
* When new coordinator comes on board, through helpdesk. Now with Red R able to develop mentoring package where someone who is more experiences is linked with a new coordinator. Very successful program to highlight.

Cash for Nutrition

* A number of sectors are defining on their involvement in cash, but nutrition has not yet.
* So when coordination is in discussion about cash, nutrition is not at the table. So it is important to define what that means.
* System strengthening within the humanitarian response. Each to be unpacked on day 3.
* How do we better link with the development partners?
* NORCAP has a unit that supports different clusters.

Integration

* Intercluster working group to present on day 3
* There is a training package on integration focusing on the main sectors that influence our work in nutrition.
* Multi-agency working group. With funding for OFDA and USAID to have dedicated helpdesk to help co roll out integrated response.
* Plan to develop 4 country case studies that we can learn from and circulate them widely.

Nexus

* Opportunity to discuss HDN within SUN countries: Ongoing discussions with SUN, out of 60 SUN countries, 18 have both the cluster approach and SUN. These are mostly in fragile states. These are the perfect place to talk about HDN.
* What is the approach to review what is happening and what is not happening to understand how to bridge that gap?
* The hope is to create a “how to” for guidance.
* They have developed the TOR and looking at funding from MQSUN.
* Guidance to support countries in the HDN is the intended result.

Influencing programme quality

* Checklist created to help guide country to monitor and evaluation programme quality.
* Through Yara, they have a very good link with the global technical mechanism.

Challenges

* 2 TAs originally We are now in a space where there are 4 full positions which required a lot of advocacy
* Continuous activation and deactivation is not sustainable.
* 14 countries have dedicated NCCs. Many countries have been in the cluster approach for some time - scale up, scale down.
* We cannot continue with the firefighting.
* How do ensure we have a package of intervention which doesn’t only focus on CMAM?
* Government sensitive to clusters -when you activate the cluster they think that it makes it look like they have failed.

Way forward and hopes for the future for GNC

* Innovative way of packaging GNC funding requirements within key donor priorities.
* Re-focusing on systematic support for improving the quality of the response and programme scale-up by the collective partnership.
* Showcase value added and impact of GNC work on NiE response scale up at country level.

What is the value added on the GNC?

* External evaluation of the cluster.

**Comments for Josephine**

* Andi Kendle - correction that there were 9 deployments in 7 countries thanks to donors OFDA, Irish and and Sida.
* Localisation in South Sudan- made commitment last year. And have already made more commitments.

**Comments from Josephine**

* How do organize ourselves better to systematically review what every partner is doing on capacity building. It’s about capitalizing resources that are there for the good of the collective. Discussed on GTAM on Day 3 to have strategy that can capitalize to enhance the quality of their response
* The people who made the GB commitments are not at programming level.
* Not much discussion in UNICEF about what HDN means.
* Countries are doing stuff but we are not good at sharing.
* How do we support countries better in a systematic way?
* Review what is happening in the country and build on what is already existing. 3-6 countries review their experience within their context of the grand bargain - examine differences and similarities

**Session 2: Examining preparedness with Cyclone Idai**

* Objectives: preparedness what worked what didn’t work and what can we learn from them
* 3 Countries were hit by Cyclone idai

***Cyclone Idai Mozambique (Abigael on behalf of Mozambique team)***

Surge Nutrition Cluster Coordinator for 2 months

In Mozambique before cyclone hit

* Tropical depression, before cyclone hit already grappling with flood emergency
* Tropical depression stayed for 6 weeks, stronger winds came and in the middle of March 14, Cyclone Idai hit one of the provinces
* 6 weeks after Cyclone Idai, 2nd cyclone hit north. This was coupled with a flood emergency.
* Humanitarian dimension: Story by Mozambique team - unassisted birth because of the severity of the flood. Mother stayed on top of the mango tree for 4 days
* Mozambique is prone to a range of disasters. From 2015, already grappling with eln in drought up to 2018. With the drought, also insecurity incidences in part of the country that was hit by the cyclone. There was already an HRP in the country before the drought.

What happened after the cyclone

* Destruction of infrastructure: hospitals, schools, roads, nutrition services
* Wide spread floods that came with access constraints. These constraints. Government workers and employees were equally affected
* Disease outbreaks - cholera
* High prevalence of HIV and AIDS, broken infrastructure

Nutrition situation pre-Idai

* Low rates of acute malnutrition, high stunting, sub-optimal feeding practices.
* The response was 5% funded by the time she left

Structures in place

* PRN program (CMAM) - solely by government through government
* Surveillance systems in place
* Contingency plan and stocks

Design of the nutrition response

* When cluster was activated, the response plan for cluster was based on the government nutrition preparedness plan
* Limitation: MOH plan was not comprehensive, especially on infant and young child feeding which meant that nutrition response plan was not as comprehensive as it needed to be.

Challenges and enabling factors *(take from original powerpoint)*

* Government ownership-preparedness
* External technical support
* Existing guidance for nutrition
* IYCF - was development-focused, but unable to deal with the humanitarian aspect
* Access to data is solely through government system and too slow for the emergency
* Joint statement of action in IYCF-E: policies in place. Government refused BMS but still were provided by small well-meaning church groups.

What is this year going to bring?

* Issues of micronutrient deficiencies. Election in Mozambique and a lot of resources put on the election. And the response has moved to early recovery prematurely.

***Cyclone Idai Malawi (Dr. Felix Phiri)***

Climate change since 2002 - one form of emergency constantly, government had to integrate disaster response within the government

* Each and every district is prepared
* Districts had supplies → prepositioned
* They also redeployed nutrition officers
* Rapid SMS is still used regardless of emergencies
* Mobile teams used to support hard to reach areas
* CMAM is an institutionalised program. In each district 4 positions of nutritionists for different programs.
* LWell established structures that would makes responding to emergencies easier

**Cyclone Idai Zimbabwe (Alison Donnelly on behalf of the Zimbabwe team)**

* Government led response - the government initiated its own surge response
* IMAM service was part of the health system but in practice did not always operate routinely.
* Government made a lot of quick decisions and mobilise (provincial, district, ward response)
* Quick decision making including the use of simplified approach
* Decentralized government has strong decision making power in Zimbabwe

**Discussion Session on Cyclone Idai (Presenters + Marjorie)**

**Question 1:** What is the role of Cosaca for the nutrition sector (Megan Gayford)

*Answer (Mozambique)*

* COSACA - Save the Children is part of a group of organisations who are supporting the nutrition response in preparedness. Generally role of NGOs in Mozambique is limited. Government and UN agencies presence. COSACA worked with government to develop IYCF programming. Technical support was supported by NGOS to government. Corsaca was key in developing IYCF-E joint statement for action. But preparedness is also about preparing technical guidance.

**Question 2:** How was real time monitoring improved?

*Answer Felix (Malawi)*:

* Included CMAM indicators within the health management system. Using mobile phones to assist. Quickly inform and provide support. Districts are taking ownership. Able to track and respond quickly. Recommendation: Depending on systems in place, government should be committed and move this ahead. Then other organisations can help support this.

**Question 3:** Drought response and HRP - What scale up can be done? Knowing the slow onsets are not always well funded. What can be scaled up as part of the drought response

*Answer (Mozambique):*

* Supply contingency plan was used to procure essential nutrition supplies. Treatment of acute malnutrition was done through static health facilities. Infrastructure was broken. Modified approaches to make sure access of population. Decentralized service delivery through mobile clinics and teams to get to hard to reach areas.
* Capacity - specifically in Mozambique started to draw out nutrition in emergency training which was cascaded down to subnational level. Gaps in the drought management of comorbidity and displacement. Management of BMS had policy in place but to stopping small donations was a gap. Having IYCF policy and statement rolled out within 1 week of response was helpful.

**Question 4:** For Mozambique, low GAM rate similar situation in CAR? Given the context, what can be different and high food insecurity? When half of the population is displaced. Lack of understanding on the nutrition status in the context of low GAM rate. How did you ensure the international community to understand the critical context?

*Answer (Mozambique):*

* IPC, knew that nutrition emergency was upcoming. One of the surveillance systems and generated this information. Moving away from CMAM there needs to be a way to promote and protect to create an enabling environment for uptake. USAID was very active in the cluster, DFID was also active in the cluster.

**Question 5:** In these countries, there has been pre-existing coordination structure which has been overtaken by the magnitude. What has been missing in those preparedness plans and what can we do as clusters to build these missing pieces?

*Answer (Allison):*

* Emergency preparedness in all 3 including Mozambique but was not planned for that level of response.

*Answer (Marjorei)*

* Gaps- multi hazard preparedness, prepared for election but not cyclone and looking at comprehensive risk factors for the emergencies.

*Answer Felix:*

* emergency is integrated.

**Question 6:** Diane Holland. Within nutrition cluster there is a common ambition that prevention is an important part of nutrition. Any reflections on how did the relationship with nutrition cluster and help/hinder other response.

*Answer (Abby):*

* Uncoordinated in the beginning. Nutrition cluster felt the impact of it because they were deprioritized. A few weeks into the response, we started having joint coordination with other clusters. Joint prioritisation was established. One message for all sectors, was to put nutrition higher up on the priority list. Joint coordination - able to see how we could make sure responses were integrated.

**Question 7:** BMS - In Myanmar, midwife takes care of many tasks including WASH, immunisation and where BMS and IYCF- who should take care of this monitoring the BMS code?

*Answer (Malawi Felix)*

* In Malawi, MOH is responsible.

**Question 8:**In Malawi is RUTF it on the essential medicine for malawi.

*Answer (Felix Malawi)*

* Yes part of the essential health package. Has seem huge improvement to make sure supplies are available

**Comment 9:** Preparedness. Coordination architecture for non-emergency. In Nepal well developed multi-sector, cluster dealing with earthquake but no linkage. Cluster wasn’t using regular coordination, but using regular architecture.

Preparedness plans for Bangladesh can be used as a case study. Humanitarian agencies looking at the worst case scenarios.

**Question 10:** For Abby, what is meant by premature move to the early recovery?

*Answer (Abby):*

* Premature move from emergency to early recovery - consequences 1) funding constraints, cluster is still struggling so have to prioritise what to do with it 2) affects operation of surge staff 3) 100% implemented by government with capacity issues. Therefore scale-up was delayed.

**Question 11:** For Malawi. What steps did you take to control // presevent BMS especially in sub district levels and what did you do for the non-breastfed infants. For those who are not breastfed, they can get a prescription for BMS.

*Answer (Malawi):*

* For those not breastfed, can get prescription for BMS unless covered within national guidelines

**Question 12:** From MOH Somalia - to Malawi. SUN focal point is seated in upper level office of prime ministry office. Transforming strategy updating. Who is doing developmental and humanitarian?

*Answer (Malawi):*

* Even before SUN, coordination was already there. Department of HIV and AIDS was already there. Anything to do with nutrition cannot be implemented without going through the department. Because of politics, now it’s placed under MOH means that reporting lines are seconded to MOH but functions still remains. Focal person and coordinator - by default head of department becomes focal person.
* Having someone in the highest office.

**Question 13:** From MOH Somalia. What is happening at the district level?

*Answer (Malawi):*

* At district level: structure at national level have national committee chaired . All the way to village level. To make sure they take ownership

**Question 14:** From MOH Somalia. Data system is in the government, which information should be kept in the cluster level?

*Answer (Abigael)*

* All information had to go through government system. Took 1-2 months to get data. DHIS still in pilot phase. Had to have discussions with govt to allow them to have a light version to access this data

**Question 15:** Has there been an analysis of cost of preparedness vs no preparedness?

*Answer (Abigael)*

* Preparedness plans for Bangladesh can be used as a case study. Humanitarian agencies looking at the worst case scenarios.
* Premature move from emergency to early recovery - consequences 1) funding constraints, cluster is still struggling so have to prioritise what todo with it 2) operation of surge staff 3) 100% implemented by government with capacity issues. Therefore scale-up was delayed. Government are trying to build up health services.
* WFP and UNICEF supported certain aspects. Cluster wasn’t involved in developing plan.

**Comment 16:** Felix Malawi - Pellegra may be linked to HIV. They are now doing a study with USAID to see the cause in Malawi.

**Session 3: Strengthening and sustaining nutrition security coordination systems at country level (Annalies Borrel)**

* Remark that she used to be quite depressed by these meetings as she felt nothing was changing, but now feels enthused by the level of discussion.
* Advisor to government in 2002- lessons learnt in Afghanistan and Zimbabwe and show lessons learnt
* Has been leading UNICEF’s~Programme Framework for Fragile Contexts
* We don’t engage on climate or political issues. We must.
* Why we have lot take a systems approach and look at inter-connectedness.
* We are working towards , not a linear pattern. Vision is important.

Context of Afghanistan

* Knows we will be facing risks on these context.
* A lot of these locations are complex. Afghanistan much more complex, not just crisis.
* System - state, partners important, but also communities. These relationships are incredibly important. Structural causes can’t be overlooked

Back to 2002 prior to clusters and SUN

* Real work should be in government
* New government, new capacities
* Asked to lead a public nutrition policy with Tufts, UNICEF and government.
* Nutrition was BF and little maternal child health care back then
* Nutrition is not just a MOH issue but also ministry of agriculture
* Later FAO took up the work

Context of Zimbabwe

* Worked through existing structures. triggered what had already been there
* 1999 entry point where nutrition was well ahead
* Multisectoral rich policy framework.
* 2013 launched the FS&N policy which survicied changes in government

Lessons learnt

1. Sustained dedicated advisory role, accompany the process: Need a sustained advisory role speaking from her policy lens/perspective. That allows us to build relationships and build capacity. Potential to undermine existing capacities. How can we enable, empower from a less visible role. Not worth having these 2-3 month advisory roles.
2. Seize entry points for system strengthening: Let’s embrace MoA
3. Understanding and use of political, economic social and cultural analysisIncredibly important in Zim to work across political parties
4. Process is important but also results
5. Cluster has a role in evidence in best practice but that’s only 1 pillar to a stronger foundation we need to build. Nutrition must not sit in one line ministry or one sector need to build their ownership to drive forward nutrition. Emphasised local governance. Ministry of Zimbabwe prioritised really going locally and building community structures.
6. Move beyond policy framework. Needs sustained support. Shift away from capacity development beyond technical training and knowledge sharing. “How can the system function better” not how many trainings we have done. Building capacity of local NGOs. Yet to see the UN put in place sustained capacity development plans for local NGOs over multiple years.
7. Institutional capacities - hook nutrition into national planning frameworks, human rights and ministry of finance. Move beyond 1 year plans. Important to leave behind preparedness response systems. Development with emergency lens - on the micronutrient groups talked about addressing scurvy with micronutrient supplement but also with agriculture. Examples of frameworks that recognized the multi sectoral importance in malnutrition. Conceptual framework was incredibly useful to bring together the different line ministries. Zim recognized that there were shocks and hazards within its framework. Food security and nutrition framework included emergency and aspects like social protection.
8. Space for meaningful engagement. Example of regulation of salt traders for iodine.
9. Focus on decentralised capacity
10. Platform for scaling up and sustaining nutrition efforts Eg production of salt 4% (2013) to 50% (2004) to 100% (2005)

* Important to take perspective and enable the government to lead well to be transparent and build those partnerships.

Programme Framework for Fragile contexts, UNICEF

* Highlighted priorities and
* We can find entry points of humanitarian - more analysis together and integrate it. How to enhance program strategy

Key message

* This is work is systems thinking, beyond technical interventions.
* It is complex but accept the complexity. Shouldn't see development and humanitarian as separate things
* Development to be more flexible and focused on risks that are not anticipated and willing to change.
* Humanitarians to think long term, beyond your emergency, beyond your assignment.
* We all have humanity at the core.
* Aligning and complementing each other and move in the same direction.

**Session 2: Panel Discussion (Moderated by Annalies Borrel)**

* Highlighted the need for integration with government.
* Panel discussion objectives: Points of opportunity but also a challenge

Panelist Q&A

1. Kheyriya Mohamed Mohamud – Federal MOH Somalia
2. Ines Lezama – Chief Nutrition UNICEF, DRC
3. Felix Phiri – SUN Focal Point (MOH), Malawi
4. Stephen Williams - Scaling Up Nutrition Secretariat
5. Purnima Kashyap - Director - UNN/REACH Secretariat
6. Anteneh Dobamo – Former NCC, Afghanistan
7. Said Shamsul Islam Shams – Chief Ex. Technical Coordinator –Afghanistan
8. Cecile Basquin – NCC, Ethiopia

Kheyriya Mohamed Mohamud (Somalia)

* Works for MOH as a nutrition management. Entry points - in Somalia we are now building the systems and writing our strategies.
* Currently writing strategy. Government leading health care practice.
* 13 associations made in the country.
* Sometimes the technical support do not even speak Somali
* SUN focal point is the prime minister’s office
* Clusters are active, but sector coordination needs capacity building of the government
* SUN secretariat meetings. Very little inter cluster coordination. Somalia sector.
* Local government leads the process
* Somalialnd and Puntland the government leass the process
* Good time for Somalia to build the nexus
* Somalia development plan is in its final draft. Share information with - ministry of planning leads the government plan.

*Challenges*

* There are issues to do with awareness. We have been fighting with MOH to give money for nutrition, but actually need to make the Ministry of Finance aware.
* Everyone now based in Mogadishu, not flying in and out of Nairobi.
* Shifted away from a regional model.
* Our country is a country with protocol issues. Federal government.
* Example of linking H & D: Federal government, one state did not carry out assessment.
* People in Somalia they think it’s only MOH
* SUN secretariat needs to build the other sectors.

Ines Lezama DRC

* Humanitarian needs are very high but compared to other humanitarian needs we are very small when you talk about displaced people.
* Triple nexus. Highlight peace - new ways of working together. How can we capitalize?
* Cannot use global nexus framework.
* Process tries to have a convergence approach - how to identify nexus focal point who are able to bridge development and humanitarian. Working On collective results.

Malawi - Felix Phiri

* Make sure nutrition is reflected in the national agenda
* Coordinating office institutionalized within gov’t systems. 1 multi-sectoral policy
* Strategic plan which includes wash, women empowerment, emergency response
* Need to look at behaviour change and communication. Partners use non standardised behaviour change materials.
* M&E framework
* Alignment of global policies. Translate into local context,it’s not one size fits all.
* Challenges: setting priorities. If we don’t set priorities, then partners come in and do different things

Afghanistan. Anteneh Dobamo

* Internal interface and internal collaboration
* Better collaboration for a better outcome”
* UNICEF is there to respond during emergency to make sure development program is in the right path to eventually have a better service for the child.
* Development program continues to do so, but be mindful of the environment.
* Those are in the responsibility of emergency, don’t wait for the emergency to come, collaborate with development team so you don’t lose the gains that you have made. Call for all organisations to look into how they manage to do this.
* Vaccine in emergencies.
* Regular program, then in shocks build on existing system to respond.
* Barrier: processes of humanitarian programming are not well designed to meet the HDN demand and commitment. When we do a needs analysis we tend to.

Afghanistan. Said Shamsul Islam Shams – Ex Chief Technical Coordinator

* Even when it comes to the substructural challenges. Very important that we have these actors.
* Design programs together: food and nutrition strategic plan. Stakeholder plan developed together.
* NPPs push different stakeholders to work together
* Coordination platforms is the foundation - AFSen provides this opportunity
* Challenges: branding of “development” and “humanitarian”
* Challenges; Competing for resources: organisations compete from resources
* Action 1: regular discussions and platforms but have examples of what are the examples and interconnectivities.
* Better community, information sharing between H&D
* Joint planning and programming
* Incentivise partnerships through joint programming and donors by money or funding that it is a condition/incentive to change knowledge, practice.

Cecile Basquin – NCC, Ethiopia

* Common goals. Different mandate, mindsets agendas
* Different organisations with different mindsets. One way to enable that to happen is to ensure that the nutrition sectors is represented in every sector.
* Ensure nutrition is included in all government-led program.
* Move from substitution role to technical support role to empower local government
* CMAM surge is a good entry point.
* NCC to be part of flexible funding: financing piece - pooled funding, more flexible, more coherent funding./ Important for NCC to involved in pooled fund development mechanisms so that we get wasting on the agenda
* EU and ECHO came together to influence govt to take much
* Funding to Niger government is conditional on there being a roadmap on nutrition

Stephen Williams - Scaling Up Nutrition Secretariat

* SUN is not a development agency, it’s a movement. Anyone is welcome.
* In country: philosophy is that nutrition is a multi-stakeholder, multi-sectoral. Philosophy is that nutrition need to be addressed by all angles all actors.
* Government-owned creates an environment where actors can come together.
* Through sharing information/experiences, who is best placed to address the identified issues
* Nexus is the joining up but not a mix. Because everyone has their own expertise and specialities. Everyone has specific roles.
* Govt is the duty-bearer.
* Donors clusters, one UN is a challenge.
* Barriers: Prejudice and ignorance on the other stakeholders especially the private sector.

Purnima Kashyap - Director - UNN/REACH Secretariat

* Principal of having a facilitator in the country creates the trustee's role of being a neutral actor.
* Demystifying nutrition as an outcome.
* “Tend to take nutrition as an intervention rather than an outcome”
* Need to go beyond MOH. Ministry of Labour, industry. Do they know what we are talking about when we talk about nutrition?
* SDG as a nutrition agenda. Nutrition as an outcome not an intervention.
* Interconnectedness already existing.
* Lots of challenges
* RC and HC often the same and even silos within that individual as they see things differently.
* Financing - multi-sectoral in the way things are financed.
* Looking at structures needs to be one structure bringing everything together

Overall panel

* If we are talking about prevention, we must talk about other sectors

**Questions and Answers session for panelist**

**Question 1:**

* HPC - humanitarian programming cycle. Capacity building shifting paradigm within the coordination team itself.
* Coordination, programmatic, financing, and add policy angles. Challenges with coordination.

*Answer (Shams):*

* same people do both humanitarian and devt, but they will only speak about one or the other depending on the meeting. They don’t bring hum knowledge to devt or vice versa
* Policy analysis - no much skills in country.

*Answer (Anteneh):*

* Widen scope of needs analysis & bring on board many people as possible but practically no one on the ground. Rapid onset in a well developed functioning country than in a fragile state

*Answer (Purnima):*

* Assuming that a lot is not happening. Countries have found ways to build this nexus but countries are not documenting the nexus. How do we use the peaks of financing and work with those providing financing to address the development plans.

**Questions:**

* In Myanmar, there is a coordination mechanism, any coordination including humanitarian is part of this. We need to see where humanitarian fits within this mechanism.
* Is it us creating the divide?
* What are the similarities? Many emergencies happen in country as we do development work. Let’s have a look at what we are doing well together.
* How do we get the donors to be more flexible in their funding?

*Answer (Stephen):*

* The government can't always do everything. They should be responsible for all coordination but should be fully prepared that civil societies take over independent role in times there is a surge. Silos are created because there are specific skill sets. Unfortunately, people with similar skill sets group together.

*Answer (Shams)*

* Food Security have more data. Need flexibility, but do need some boundaries to set the behaviour and incentivise.

*Answer (Purnima)*

* Functional nutrition coordination structure at the country level.
* 2017 - Stephen O Brien issued guidance note. Clearly laid out points that has been made in this document as a reminder in the field.

*Answer (Anteneh)*

* Current response is what is normally funded by pooled funds not much on preparedness, but we should use pooled funds for preparedness.

**Comment** (DG ECHO) - question of priority. Have the same amount of money but needs are increasing. Not a question to earmark, it’s an issue of huge needs and the same funding.. We’re trying to work with more donors.

**Comment (Somalia)** Somalia Case Study: sometimes it’s the leadership that makes a difference. Funding for capacity building

When they got the funding they sat in government and looked at the funding had from UNICEF and two other sources. Changed the strategy of incentivising people for training and they used the money to create a district management team.

**Question:** What do you expect the GNC to do on the HDN?

*Answer (Stephen)*

* We want development actors to be inclusive typically in areas where malnutrition is more prevalent where it is less stable. It is outside their comfort zone? Reach out to the development partners

*Answer (Shams)*

* collect success stories to learn from other countries.
* Pick up on with cluster has already been doing. Proactive engagement with food security sector. A meeting like this would be helpful to have other clusters as well.

*Answer*

* Use a national structure - the GNC should be part of that structure. Should be part of it, not invited to it. Going forward a collective cluster to form joint nutrition outcome.
* Conversation should be on how do we support the government?

**Comment Abi Perry- DfID**

* SUN is global movement. We now have integration of acute malnutrition into health systems.
* We are not going to solve every humanitarian need through this movement.
* From a donor perspective. SUN is moving in positive direction and we need to also talk about government financing, not just donor.
* Japanese global nutrition summit this year wants to secure new commitments to nutrition to try to out us on a better track to be in the right place for 2030

**Comment Diane Holland - UNICEF**

* What works in one context is going to be different in others. Might be good to look at case studies such as the EU Nexus pilot studies, World Bank FAM discussions,.
* UNICEF is looking at public financing to children for how to influence this for nutrition. We need be learning those skills
* UNICEF are expanding this to public financing for children in fragile contexts.
* UNICEF to share the materials from this work.

**Comment** (Kheyriya Mohamed Mohamud, Somalia) - looks at a sustainable system-building- at subnational level. GNC looks at that country to 1) make sure the systems are sustainable for early recovery and governance. Other coordination systems that are happening - pillar network group 3) request to be part of government level decision.

**Comment** (Ruth, UNICEF)

* Accountability mechanisms needed to hold us accountable.
* Important to think why we are doing what we are doing.

**Summary pf panel interview from Analise**

* It is about an effective and functional coordination at country level
* But it is not necessarily a cluster
* Enable and support government in every possible way. It is easy to critique government, but pause and think first. Bear with them because ultimately we want that system to work. Find innovative ways that enable governments to work.
* Emergency response is a critical element of that is overarching. Sometimes they'll need more help than other times.
* Must be country-focused, must be multi-sectoral. Look outside nutrition and embrace social protection.
* Call for UN agencies to not create silos
* Platforms need to be inclusive. Private sector - an example is salt traders who eliminated iodine deficiency.
* Outcome - collective framework and process. We are building systems so lets hold ourselves accountable to those systems
* M any entry points: policy, programmes, internal systems
* Barriers : silos, brand, visibility, funding. Not surmountable but we will need to do something differently so we can overcome those. Document success stories and building on those.
* GNC has an important role to document success stories.

**GNC ANNUAL MEETING DAY 2**

**Wednesday July 3 2019**

Summary and Key highlights from Day 1 (Powerpoint From Ruth Situma)

**Additional Actions from day 1**

* Is there a need to look at the needs and size of GNC? Could be more rigorous about how we look at the targets and report them against them milestones (Regina)
* With EVERY emergency response, before and exit of every response, there should be some emergency preparedness within the government. (IRC Casie Tesfai)
* Entry point of GNC is the cluster. We should extend the relationship. (Shams)
* Impact does not come up in what we discuss. For example, for simplified protocols we need to know the impact and what did we achieve with this. We need to have better ways to document successes. An improvement on the prevalence doesn’t necessarily mean it was because of the programming. (Alex R-P)
* How we can take advantage of programme entry points? (Tariq)
* Nutrition for Growth Summit - 8am tomorrow morning on how we think about nutrition in fragile context, please come along. (Abi Perry DFID)

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**Day 2 Morning session on simplified approaches to the treatment of acute malnutrition**

**Intro by Colleen W.**

There’s been a lot of research on how we can change what we’re doing. The SG has tabled it on a meeting he’s having this week. 1st time Nut have been talked about at such a high level with SG and the principals from all the agencies.

*Agenda change - presentation on literature review Nicolas, then Tanya followed by Danka.*

**Session 1: Summary of evidence on simplified approaches (Nicolas Joanic)**

* Simplified approaches has generated some very passionate debates. There is not one simple prescriptive protocol, but a range of simplified approaches and to increase coverage and reduce cost.
* In many circumstances, aim is to increase access and effectiveness of wasted treatment. However, still a small evidence base so far
* 34 studies are focused on the use of MUAC only as admission and discharge criteria.
* Next most researched is reduced dose
* Most used is the use of RUTF for MAM children
* Few randomized control trials - very few controls
* Some results not published, peer reviewed.
* LImitations: Testing so far is only on children and not on PLW and other vulnerable groups.
* Simplification 1: Integrated treatment for uncomplicated SAM/MAM with one product. Has not shown any impact on coverage. Results on cost-effectiveness are inconclusive.
* Simplification 2: One product. Can be used for both SAM and MAM. RUTF is about 30% more expensive than RUSF
* Simplification 3: Reduced dosage. Important simplification, Idea of this is to improve cost effectiveness. Energy needs decrease over the course of recovery. Reduced dosage can have a negative impact on the recovery of the most severely malnourished.
* Gaps in evidence: We need to determine the optimal dosage of RUTF and whether the actual dose regime can be reduced.
* Make sure that we don’t do any harm to the most vulnerable in the meantime.
* Simplification 4: MUAC only as admission and discharge criteria: WHFH Highly correctly MUAC; Ongoing debate as they identify different groups; MUAC more practical; MUAC selects younger and more stunted children; WFH older taller children with longer legs; MUAC is a better predictor of mortality and this is what it’s about. More recent publications challenge these findings. Important to keep these in mind on our recommendation for simplified protocols.
* Simplification 5 Adaptation Family MUAC: Caregivers can perform sensitive and specific classifications of nut status using MUAC. Improve early identification of children
* Cost considerations - Inconclusive
* Programming cost: Need to consider multiple factors including: (1) programme implementation is critical but not often costed well (2) need better costing models to cost actual expenditure and not on estimation of time (3) Product losses are not factored in

**Session 2 - Mapping & Continuum of Care (Tanya ENN)**

* Have been working on a special issue in FX. Previously on CMAM and various ones. Most recent one is on continuum of care
* We keep hearing the term “prevention”: What I think we’re talking about his prevention of undernutrition. (1) Prevention of becoming undernourished (2) Prevention of deterioration (3) Prevention of death
* Continuum of care looks at this to get a better picture of how SAM and MAM treatment is linked and aligned.
* Currently, working with UNICEF and WFP, we tried to collect data from Jan to June on how SAM and MAM services at country level and regional are aligned in terms of locations and in terms of communication and protocols, and how children are being referred between them.
* Selected countries in East (7 countries) and West Africa (9 countries) were based on high levels of acute malnutrition
* 2 reports to be published on the highlights of this mapping
* New forum launching on EN-NET on continuum of care.

**Session 3: Potential drawbacks of MUAC only (Danka Pantchova, ACF)**

* Presented on drawbacks on SAM and MAM targeting in programmatic aspects, history/evolution of acute malnutrition care
* Objective is to find the best solution but solutions need to be adapted to the context
* ACF has a position paper a few years ago and acknowledged that MUAC is good for coverage.
* In response to one of the gaps mentioned in the review of literature. Commissioned through CDC. Retrieved SAM and MAM data from 550 surveys in 22 countries
* Potential Drawbacks include:
* Drawback 1: Ignored risk of excluded children. Proportion of SAM children will be excluded (27%), 50% of SAM caseload will be excluded or undertreated. Drawback is the ignored risk - the excluded children
* Drawback 2: Proportion of MAM would be excluded
* Findings indicate large restriction of SAM and MAM target and will not receive treatment as per WHO under MUAC-only and expanded MUAC protocols.
* Our findings suggest that programs target increase while programmatic costs are likely to be directed towards the less severely affected children.
* Do we explore all possible solutions?
  + Using digitalization: Photo & 3D imaging diagnosis
  + Targeting beyond anthropometry only: Anthropometry + recent history (morbidity, weight loss, IYCF practices), Bio-markers
  + Targeting integrated in existing service packages: Health delivery platforms: IMCI (AleDia), reproductive health, neonatal care; Revisiting Growth monitoring and promotion?
  + Linking with other sectors activities: Maximizing targeting at each contact point (WASH, food aid, cash etc. together with health) ex. WASH’NUTRITION
  + Comprehensive piloting to adapt Acute malnutrition targeting and treatment to what current health services can bear and deliver upon: Pilots in West Africa

**Session 4: Regional coordination of Evidence Generation on Simplified Approaches: (Sophie Woodhead, UNICEF)**

* Since 2008, focus has been on scaling up within health systems. This has given us some key lessons on issues
* Thorough coverage surveys and bottleneck analysis learnings include:
  + Lots of limitations on HR
  + Specific barriers in terms of health staff capacity to be able to implement at high quality
  + Pre service training - in many west africa models on pre services training on acute malnutrition not sufficient.
  + Issues around quality and difficulty community outreach
  + Issues to initial and continued utilisation of services
  + A lot of programme inputs still heavily dependent on humanitarian financing
* Lots of terminology, but will use “simplified approaches” as the term for the different approaches
* Simplification can be at different stages:
  + diagnosis - screening of Acute Malnutrition by the Family at community level
  + *Admission: Targeting:* Services implemented in the same delivery point, Delivery of AM management by Community Health Workers, Harmonisation of client registers/tools and monitoring, Admission for all children MUAC <125mm and/or oedema
  + *Treatment:* Use of one LNS product for treatment, Treatment dosage of LNS product reduced over course of recovery, Reduced visits to health facility during treatment
  + *Discharge:* Based on MUAC > 125mm only
* Some of these it’s important to note are already operational, validated by normative guidelines
* Evidence Generation to Respond to Identified Gaps: 3 studies highlighted.
  + Individual Pooled Data Analysis on children dosage reduction ALIMA. *Objectives: how does this differ from standard protocol*
  + An Exploratory Analysis Study Comparing Acute Malnutrition Prevalence based on Weight for Height Z Scores, Absolute Mid Upper Arm Circumference (MUAC) and MUAC for Age Indicators. *Objectives: targeting question, additional risk factors and age*
  + Costing and Financing of Wasting (including financial modelling on reduced dosage, expanded admission) UNICEF + +. *Objectives: How this impacts cost effectiveness not only now but over time.* *As it could be a big upfront cost but over time*
* Opportunities and coordination is happening
* Next Steps:

1. Support WHO in the collection and generation of evidence to support existing guideline reviews
2. Support roll-out of certain simplifications where they are proven to be safe and effective (ie family MUAC)
3. Conduct key learning and dissemination moments, including a regional workshop in the last quarter of 2019
4. Continue to provide technical support and coordination to partners on the implementation of and simplified approaches (to build evidence based and moving towards effective change)

**Session 5: Presentation of the UNICEF/WHO/UNHCR/WFP communique on the innovative approach for management of CMAM (Zita Weise Prinzo, WHO)**

* Findings limited in scope and context specific, and relatively small scale- ultimately impact on population based outcomes and cost are not yet known
* Support simplified approaches in exceptional circumstances where warranted monitoring needs to be conducted and reported on (eg, recovery, mortality relapse
* Preliminary findings are promising but limited in scope, very context specific. No south asian context.
* Implications on large scale outcomes are not known
* Evidence we have available to date does not warrant a change in WHO global guidelines
* Next steps:
  1. Would be good to see what the outcomes were and exit strategy - was it short term?
  2. Better documentation of these specific examples and data collection
  3. WHO to look at questions that remains
  4. Support national coordination platforms to lead the use and documentation of simplified approaches in exceptional circumstances, where warranted
  5. Continue to support and encourage further opportunities

**Questions for clarification from Day 2 Morning Session**

Question 1: For ACF (Cox’s Bazar NCC)

* We have done a couple of SMART survey and realised that we miss the children.
* Considering to change screening. Cannot use scales and height boards
* 23% of MAM children are above 140mm MUAC
* Have you looked into the range of MUAC? How high do we have to go to cover a minimum % of cases?

*Answer 1 (Danka ACF): Looked at this in Gambella but haven’t done the analysis yet. Bangladesh and Cox’s Bazar has the biggest discrepancy in the SMART surveys. Longitudinal data: Reduced dose Mango study, will need to analysis on functional outcomes.*

Question 2: Tanya for Sophie

* Community based Innovation was for the treatment of SAM
* Vision was always that it should be through the health system
* Loads of good examples - these simplifications have been done since 2008
* Is it helpful to put MAM and SAM together rather than delineate from the simplification around therapeutic care?

Question 3: Question is that RUTF is based on weight of child. Any impact on LOS on this simplified protocol?

*Answer (Nico):*

* No conclusive evidence on LOS. We have seen frrom a couple of unpublished studies that weight gain and height gain velocity was a little bit inferior to regular dosage. To share data collected.
* To treat acutely malnourished children across all spectrums.
* Evidence base is still be small - just a work in progress.

*Answer (Sophie)*

* What we do have is a certain amount of individual trials

Comment 4: Allison OMan- WFP Regional

* This has been a bit of a battleground. Often don’t have a choice.
* firm line on do no harm and know where we are crossing the line of do no harm.
* East Africa region multiple approaches - we forget maternal nutrition. We Need to not forget maternal nutrition
* Key point: Need to remember the prevention piece
* Lets using the opportunity to have it on the agenda to not oversimplify

**Day 2 Part 2 IYCF**

**Session 6: IYCF-E in DRC (Annie)**

Additional notes to presentation:

* Main challenge in the Ebola context is when either mother or child is tested and found to be with EVD, they have to be separated.
* When the choice was to separate - Ready to use infant formula is provided
* No integration of IYCF-E in previous 9 Ebola outbreaks, but with the IYCF-E training TWG was created.
* training provided n IYCF-E in Ebola affected areas
* Additional challenges include difficulty with calculating RUIF since we don’t know how many people will be infected.
* Large numbers of children requiring UHT - government gives approval to buy the milk through a procedure with UNICEF and government

Key asks:

* Reaching out to IYCF-E TWG on IYCF-E documents especially in Ebola context that could be shared with Yara or Annie directly
* Improve monitoring and response systems for BMS code
* Explore opportunities to better integrate IYCF-E into other sectors. Where there are already opportunities - protection sector to manage children who need creche
* GNC to review the global guidelines on EVD to ensure that IYCF is integrated effectively

**Session 7: IFE Core Group. Protecting all infants dependent on artificial feeding (Linda Shaker)**

Additional Notes:

* We need to switch we report on breastfeeding to those who are not breastfed to remind ourselves who we are missing
* Have we been able to follow and implement the guidance? In the GNC meeting in 2018, IYCF-E was given much visibility and reviewed presentations and discussions. These highlighted the gaps in IYCF-E & children who are not breastfed. In the Ebola context, there is no doubt that BMS needs to be used but in other contexts there are fears -Lack of leadership
* There are severe gaps in addressing gaps in infants dependent on artificial feeding.
* Why little progress? What are the bottlenecks? How do we operationalise it? What about accountability?
* Need to think about immediate and long term actions
* Operational guidance exists, but in practice not much is being done to address infants who require BMS and artificial feeding.

**Session 8: High impact Nutrition interventions (HINI) (Yara, UNICEF)**

Additional notes:

* Lancet 2008 priorities are still relevant. By 2013, another series that looked at maternal and child nutrition but also looked at double burden in women and children, adolescent girls and childhood. Also examined evidence at nutrition specific and nutrition sensitive to improve the interventions.
* Purpose of mapping of the HINI to see how much are we doing on this comprehensive package of interventions and how do we improve the response.
* Repackaging of UNICEF framework which highlights nutrition -specific and nutrition-sensitive interventions. 13 studies
* High impact nutrition interventions is controversial - is it the same impact everywhere? No. But to look at the package to see if we're only focusing on SAM or at a broader intervention that we may have missed.

How did HINI come to be? Ruth Situma

* Inspired by 13 intervention and implemented in Kenya
* 2 things happened in kenya. 1) global momentum from 3 different documents and 2) high malnutrition rates at 30%.
* In Kenya, stunting rates were stagnant for 10 years, so reviewed Key drivers, key bottlenecks, human capacity level, supply level and reviewed each challenge 1 by 1. Worked with agriculture and WASH.
* Many processes and government systems were put in place
* Based on the interventions implemented in Kenya, we asked countries if these interventions were implemented to map the various interventions. Goal is to review how we can improve response.
* High impact also depends on where we are. But good to see how much we are including other interventions on top of SAM treatment. How much are we broadening the scope?
* To trigger thinking about what we are doing, are we agreeing in what we are doing?

Question for discussion

* Should we be looking at a broader package in HINI?
* How can we further improve the response beyond HINI?
* Is the quality of the response up to the mark?

Asks:

* Would it help to have a checklist? For the checklist to be a collective. W
* Would like to review and pilot the checklist. South Sudan is interested
* Would be interesting to see if a few partners or all partners have implemented.

**Discussion on Topic 2 IYCF:**

**Question 1:** Alex for Yara *Impact of HINI*. For the checklist, can we try to look at the impact of the high impact interventions. tHis is the first step. We need to go deeper? IE in areas where salt is iodized, have iodine deficiency improved?

*Answer (Yara):*

* Agree with suggestion - this was a gap. We did not look collectively at the quality of our nutrition response.
* Suggest to review checklist.

*Answer (Josephine):*

* This is a conversation starter. In group work is where we need to unpack

**Comment 2:** (Colleen). We did a mapping, but we don’t necessarily have global guidance. Gap is that there isn’t global guidance for the HINI.

**Question 3:** (Felix). If we are doing this, is it included in the health system and identify existing gaps within the health system?

*Answer (Yara):*

* This was a conversation starter to get people to look at this package

**Comment 4:** Have to include deworming.

**Question 5:** Operational guidelines suggest never to give cows milk. Why was UHT was provided?

*Answer (Annie):*

* Because water was contaminated and risk of EVD it was better to have something to use. Below 6 months - RUIF

**Comment 6:** Update on nutridash - external users are able to sign in and use the data which has been collected from up to 114 countries since 2013.

**Question 7:** For Linda-in every context there are many non-breastfed children. In settings where there are few non-breastfed children, it is unlikely this will happen. There is a gap in guidance of this- what’s being done?

*Answer (Linda)*

* We are not ignoring the 1-2 babies. Depends on the context and RUIF can be discussed.
* What do we need to do how can we push this forward to find preparedness measures?

**Question 8:** There are 3-4 countries in the ESARO who are priority 1 for Ebola. EVD is within the health management, how can we enhance our coordination?

*Answer/Comment:*

* Example of Syria salt iodization. Iodine wasn’t a problem in 2013. But now iodine is not allowed in Syria. How do we link linking conversation between preparedness and development.

**Question 9:** BMS - in Bangladesh, have BMS 2015 punishable act in any circumstances to provide BMS. What should we do when there are policy constraints?

**Question 10:** For Annie - What is the protocol on IYCF in the community? How are we linking with development colleagues? Impact on BF would be tremendous. How do we get back to the practices that we had before?

*Answer (Annie):*

* Manual has been produced and focuses on promotion and protection
* Aim to link with community groups for development and promotion before the Ebola epidemic.
* Promote with those who do not need to change. At the centre level there is a nutritionist to support.

**Question 11:** For Annie: How do you monitor use of RUIF since it is managed through the government?

*Answer (Annie)*

* Supply is monitored closely throughout the different levels
* Plans are submitted to the government.
* Tools have been developed for health centres where they have to fill out documents and report on stock.
* Stock is closly monitored at community level as well. At the community, a notebook was developed for mothers and need to take containers back from community.

**Comment 12:** Advise GNC to reach out to the MOH to look at integration

From the field experiences there will be facilities providing different services. One providing SAM, another SAM and MAM

**Question 13:** How do we better link the right interventions are there regardless of whether it is in the HRP and development funding?

**Comment 14:** Reaffirm that changing the system takes time.

**Question 15:** How do we learn the operational “how to” from all of this?

**Comment 16 from Josephine**

1. When looking at linkages, we also have look at systems. What are the system building issues that we need to look at?
2. More and more, we are integrating IYCF-E. We need to address non-breastfed and breastfed as a whole. What is the problem and what is that we are not doing? In areas where it is really needed, we need to be more practical in the discussion in the afternoon.

**Comment 17** from Linda

* We know we have a problem with addressing the needs of the most vulnerable in terms of addressing the needs and IYCF is there is a gap in BMS.
* Non-breastfed - it is a frustration from many countries. Try to have concrete actions. Addressing the needs of the most vulnerable including the non-breast fed. Need to prioritise and how do we complete the IYCF-E interventions.

**Comment 18**

* Abigael - policy level constraints. IYCF-E policy level constraints, they have been a challenge in doing what we need to do in Bangladesh.

**Comment 19** from Isaac. Danka’s presentation good to see how many children will not access service. Generally huge preference for using MUAC. Recommend GNC take action on passing messages on WFH & MUAC debate.

**Comment 20** from Andi Kendle re ACF presentation

Missing discussions on how we realistically treat MAM in a way that’s possible for governments to do in a big scale. Are we going to treat them all with RUSF? Unrealistic, need to start discussion on above. Everywhere there is MAM.

**Comment 21:** Casie Tesfai IRC

Where are the challenges in this current system, how can we improve? But we are risking splintering in many camps on where we sit on the position and lose the big picture in the process. It took more than a decade to come to a consensus about allowing CHWs to treat pneumonia. What are the issues that we can all agree on? And come together to address it.

**Comment 22:** Anteneh -

Simplified protocol is rich information. Was waiting to hear the final conclusion, for people working in the field. Mentioned 7 million funding shortfall. Do you recommend us to go ahead and apply?

**Comment 23** Allison Oman

* If you look at MAM globally and look at the high burden countries who cannot afford to provide a product for every child.
* We do need to be flexible in different approaches.
* Major evidence gap in this area. How much is enough? What is treatment? Not distinguishing a MAM child who has had SAM? Was there an identifiable shock that
* One size fits all not going to work for MAM. We need to look at what is the best model in certain contexts.
* WFP would love to do is to look for allies for operational research. Sustainable model that doesn’t require every child to have RUSF. Locally produced food and change behaviours. How can we make sure that children are really recovering?

**Comment 24** Wilfred - NCC Malawi

* Highlighted overweight. U
* Underweight and wasting and not forget the fight against overweight
* Not lose sight of the window of opportunity right now.

**Comment 25** Carrie MSF

* From an inpatient perspective, it is very difficult for MAM - often to manage unless she’s seen the child.
* Is this a MAM that should go on the full nutrition protocol or can we start them on the family meals. If we move towards high risk low risk. Then we would need 1) what’s happening at the physiological level, maybe animal modely 2) follow-up of patients

**Comment 26:**

* When we simplify, it might make it more complicated. Teams often wanted to add height as they were already weighing the kids for dosage.
* For MUAC only, we were keeping the child too long and they plateaued at 120mm and they had to keep coming back.

**Question 27.** In a simplified protocol of providing 2 sachet per day for each SAM child, this would be find for a child under 5kg. But for those who are above, there is risk of being undertreated. What would be the performance of the regimen for children admitted with more than 5Kg. If performance low compared to the standard protocol, to which extent would this simplified protocol affect the performance of program at large?

*Answer*: Highlights Mango study- model to reduce dosage of RUTF - poster is the room. Keep first 2 weeks standard dose, reduction is for the following weeks of treatment. Children with higher weight receive a little more. Found no difference in weight gain velocity.

**Question**: Iris Bollenger- IMC. What are the discussions on the mandate of WFP and UNICEF in terms of MAM? Would there be discussions on shifting MAM to UNICEF?

*Answer (Nico):* Not only the 2 but also involves WHO, UNHCR. Will need a roadmap on how we contribute. It’s not only about treatment. Continuum of care is prevention, treatment, back to prevention.

**Comment:** Community outreach to make CMAM effective, is very important questions. Have we made efforts that’s been done to make CMAM work. What about communities don’t have access to health systems? How do they access health services? How do we bring access closer? Are we sure we have made everything possible to make CMAM work?

**Comment:** Zita and a point on the CMAM approach - management of moderate wasting

Intention is not to scale up CMAM approach everywhere

**Comment: (Danka)** Inflation of targets versus pipeline breaks.

* How far is importation sustainable?
* llocalization of production of RUTF. For example, local producers today 20 are validated by unicef, MSF, WFP.
* This group is working actively in looking at how to produce more

**Comments**

1. Updated joint statement where we had the ambition to reset the policy environment.
   1. Political economy issues it still needs to address
   2. Strategic objectives first then operational issues Technical and operational issue and thena political economy issue.
2. Is it safe, is it effective?
3. Important to put them in the right boxes and unpack them in the right places. **Operational, technical and political.**

UNICEF has 20 supplies. 50% of RUTF are at local and national production.

**Session Group work Presentations Day 2**

**Topic 1: Wasting**

**Question 1: What are some other ways that quality and scale of treatment of wasting can be improved?**

Opportunities

* Changing awareness about the concept of child health including nutrition
* Meaningful integrate nutrition into existing health systems and facilities - possibility of one-stop shop?
* Be creative about entry points - vaccination campaigns
* Investments in health system strengthening and community platforms
* Be creative with entry points in other sectors
* Back to basics - just making sure that IMCI

(add from photos)

* Map coverage of health facilities and mobile teams for out of reach
* List alternative structures which can be used for expansion in informal settlements
* Rationalisation plan of minimum care capacity geographic ad difficulty of access
* multi-sectoral/ multi programem convergence health WASH FSEc for active case findings and monitoring quality
* Sustained and close field presence for quality monitoring and correction actions
* Remove spatial analysis of programme performance
* Mtul-sectoral convergence for supporting supply chain management system
* IPC acute malnutrition analysis - systematic way to analyse contributing factors - useful way to look beyond treatment

Challenges

* Lack of trained medical personnel
* Expensive to train and hire such medical personnel
* Lack of inter-cluster coordination at the beginning of any emergency
* Donor preferences and restrictions
* Pipeline breaks related to therapeutic foods- supply chain
* Access issue
* Training, knowledge and skills lacking in our personnel
* Data collection -who does it, how is it done, which indicators
* (finish from photos)
* Insufficient capacity (technical-surge) of wasting management at both national and international
* Difficulty of integration of wasting care into routine health care
* Inadequate context specific guidance on sustainable scale up of MAM care especially in food secure settings
* Inconsistency of geographic prioritisation and ranking of priorities
* Clearer guidance on practical ways of identification of wasted populations. Admission-discharge MUAC.WFH
* Insufficient capacity (technical-surge) if wasting management at both national and international
* Difficulty of integration of wasting care into routine health care
* Inadequate context specific guidance on sustainable scale up of MAM care, especially in food secure settings
* Inconsistency of geographic prioritisation and ranking of priorities
* Clearer guidance on practical ways for identification of wasted population. Admission-discharge, MUACH-W/H

GNC Asks: prioritising area of population with highest needs of assistance.

**Question 2: How can GNC partners engage in a strategic way to improve the quality and scale of the treatment of wasting?**

* Contribute to context analysis, especially in rapidly deteriorating or rapid onset crises (where and to what extent; RAM, ENA? )
* Technical and operational evidence
* GNC feeding into WHO guidance process
* Improve knowledge management and diffusion into easy access platforms
* Camp setting - agreement between different clusters from the onset - make this a policy
* Mechanisms such as Tech RRt to be continued and supported by GNC
* Adding in the components that would work for your context
* Agree, define and stick to tools that can be used to produce an intervention which are based on context analysis and needs
* Specific meetings with donors all together to understand the views of all the partners
* Where camps have to be set up for a long period of time,
* Guidance needs to be available when people need it . improve on the knowledge management platforms
* Greater need to capacity building on various topics
* Ask: GTAM - Assessing issue of referrals
* Ask: GNC to feed into the WHO guidance process

How do we simply train our staff on everything?

We talked about the nuance between coverage and prioritisation in a world of limited resources

The specialised food tables need to be harmonised - there are currently 3.

**Group Work Topic 2: IYCF-E**

**Question 1: What is the level of capacities and resources available to scale up IYCF-E and the care of the non breastfed infants?**

* Guidance:
  + Operational guidance
  + Country specific guidance and policies
  + SOPs for refugee camp setting on BMS
  + Guidance on counselling
  + Guidance on assessment
* There are no context specific/country specific guidance /plans
  + Need country action plan./strategy to scale-up
  + Some exists but are not in line with existing guidance
  + Some are not implemented
  + Lack of deciion maker genagement
  + Needs to be more pragmatic
* Some level of expert capacity but no expertise in BMS programming
* Ot clear whose role it is to address non-breastfed (midwife/nurse) - health
* Advocacy on exclusive breastfeeding-fear of using BMS
* Sometimes we have data
* UNICEF

**Question 2: What resources and capacities are needed to support the care of the non-breastfed infants?**

* Global:
  + Clear position from UNICEF on the mandate
  + Need risk analysis/global and country level - what if we don’t respond? What are the risks?
  + Advocacy/briefing paper on care for infants and young children (breastfed and non-breastfed)
  + SOPs on BMS - global decision tree for non-breastfed
  + IYCF-E technical expertise lacking globally 0 need technical capacity
* Country:
  + Context specific guidance/country specific policies/operational guidance/strategy/ contextualised SOPs in line with recommendations
  + Leadership from UNICEF in terms of advocacy to ensure contextualisation (targetd advocacythat is in line with the code= not a result of lobbying from BMS)
  + IYCF-Ee technical expertise lacking globally - need technical capacity
* Other:
  + Gender Cash programming
  + Funding to maintain pipeline
  + Monitoring systems for IYCF-E
  + MApping of sources of BMS
  + Integrated intervention IYCF into CMAM programming
  + Human resources/ capacity building
  + Fianacial resources

**Question 3:** **How do we measure the impact of IYCF-E programming? What needs to change? How shall we start the change? Who should lead?**

* Challenges in communicating what success looks like in IYCF programming?
* Improve methods for collecting IYCF indicators (monitoring and impact)
* Communicate the results of poor IYCF programming e.g. # increased cases of diarrhea
* Do no harm indicators

Unicef has been working on standardize routine program guide. Standardising element,s visualisation and indicators. Which will be going into dhis2.

**Question 4: What opportunities exist for improving the implementation of IYCF-E programming?**

* Policy from emergency perspective.
* Routine level
* Improving IYCF-E implementation needs to take place in the preparedness work, that takes place within the development Sphere
  + Review of policy – making sure that policy work includes a IYCF-E lens
  + Need to engage with national IYCF partners (e.g those that are completing the breastfeeding trends score cards etc)
  + Embedding IYCF services monitoring with the health services monitoring (e.g not all contexts have nutritionist – so need to strengthen monitoring within the health system) – at both clinic and community level. At community level, does CHW reporting include IYCF monitoring?
* IYCF needs to be **framed as ‘Public Health issue**’ - not a Nutrition/Food issue. The idea of shared responsibility – not keeping it as ‘nutrition’ e.g. early initiation of breastfeeding falls under the responsibility of reproductive health. “Needs to get out of our camp” Frame IYCF-E more broadly
* Need to frame this around the ‘Nurturing Care Framework’ – supporting children to reach their development potential, narrative needs to change beyond nutrition. **Empowering of caregivers.**
* Accountability of WHO member states to WHO guidance – middle and high income countries don’t feel that IFE guidelines apply to them. Policies currently in place don’t reflect norms we want to see in iycf
* Use of Global stock-take of IYCF - HMIS IYCF data or DHIS data - galvanize
* Strengthen WBTi analysis of IYCF-E - self report.
* Schools – adolescents – sexual/reproductive health education - talking about breastfeeding within school.
* Faith leaders

**What is the role of coordination mechanisms and donors?**

* There are current opportunities to capitalize upon – we are starting to talk about this more
* Accountability to IFE-OG – are we holding ourselves to account e.g. a bench/mark score card?
* Does every cluster – systematically have IYCF-E working group?
* IYCF needs to be reflected in preparedness documents (not routinely done now)
* Donor – acknowledgement and acceptance that IYCF has to be embedded in whatever your funding stream is (& not just confined to the nutrition box).
* Embed IYCF into all assessments. Key indiciatrs
* Budget guidance on what IYCF response (what needs to be funded on iycf response)

**Group work 3: Comprehensive Nutrition intervention (CNI) Group Work**

**Question 1: What are the key challenges to implementing a comprehensive package of nutrition interventions in humanitarian settings?**

* To many to remember
* Need to be contextualised depending on needs assessment in each context
* Donors have their own agenda
* Definition of minimum package of CS for each country/context/emergency
* Communication/ consensus with other sectors/clusters SUN etc
* Common understanding for NS
* Unit of measure for tracking certain intervention
* Supply chain management is an issue. Supply chain management for different interventions
* Guidelines and operational guidance is sometimes missing
* Impact is not measured

**Question 2: What are the next steps to better define a comprehensive set of interventions in humanitarian settings?What opportunities exist to provide a comprehensive set of interventions beyond CMAM and IYCF-E?**

* Map the gap
* Further analysis to identify operational gaps
* Reach out to other sectors to understand opportunities and capacities
* Change the narrative to the donors, comprehensive package is life laving and cost-effective
* Define HINI/CNI in emergencies
* Analyse government policies and see how we can align BNS, monitor etc
* Opportunities with Nutridash
* Recommend CNS whilst donors are reviewing policies, strategies. Advocacy with the right info/data
* Have actual thresholds for progress/performance → analyse and classify
* Further analysis to identify operational gaps beyond the quantitative info/data
* Factor in extreme and fragile contexts operational guidance
* Reach out to other sectors to understand opportunities, capacities and advocacy
* Change the narrative of the package and when discussing with donors

**Question 3: If you were asked to review the quality of the nutrition in emergency collective response in a country how would you go about it?**

* Show the cost-effectiveness of comprehensive nutrition package
* Measure outcome and impact beyond measuring process
* Have contextualised country level nutritional surveillance system
* Measure process & outcome → Quality → Defined for acute malnutrition & need to define for other indicators

→ longer term → strengthen HDN

* Improve preparedness with governments. But how do we measure preparedness?
* Better to have vulnerability analysis beyond IPC

Josephine’s closing remarks

1. To look structures coordinate TWG -leadership role is same (seen how difficult it is). Current structure. How do we organize ourselves so that actions can be taken forward.

Key Asks:

* Potential meeting for technical discussions
* Document experiences and success stories on
* Reaching out to IYCF-E TWG on IYCF-E documents especially in Ebola context that could be shared with Yara or Annie directly
* Advocate for the development a review the global guidelines on EVD to ensure that IYCF is integrated effectively
* Continue generating evidence on alternative to imported RUTF
* GNC: promote use of local foods- formulated or not- for the treatment of AM wherever possible

**GNC ANNUAL MEETING DAY 3**

**Thursday July 4, 2019**

Thank you to Josephine from GNC (Anna) and UNICEF (Diane Holland) for Josephine’s service for 6 years

Thank you to Ruth Situma

**Day 3 Part 1: Global Technical Assistance Mechanism (GTAM) for Nutrition**

Purpose is to demystify GTAM

**Session 1: Why Global Technical Assistance MEchanism for Nutrition (Julianne WVI)**

Additional notes

* Reviewed history on the GTAM
* A lot of technical needs and the GNC not always ready top respond to those needs.
* Suggestions to address these gaps put forward following a review.
* With all partners together, technical mechanisms was going to be implemented
* Why GTAM: Will only be used if the technical gaps were not addressed with in country. Help practitioners to reduce time. Facilitate learning from country to country and at regional level
* What is GTAM: GTAm is a little more than Tech RRT. 1st pillar is the technical advice pillar. Consensus driven guidance pillar, technical. 2nd pillar is where tech RRT is integrated.
* Core team consists of UNICEF, GNC, ENN etc
* Baseline survey was online finalised really recently. Finalised by ENN
* Global thematic working groups. Wants to build on what is already there and if there is an issue that the core team is unable to address.
* IFE core group involved for IYCF-E
* NIS group to handle assessments. Currently no cash for nutrition but will be an update later.
* Develop generic TOR that can be shared with those groups. Coordination partnership
* Technical expertise pillar Tech RRT and consultancy roster.\Currently developing IT system/platform to address GTAM once in place. Different areas such as self serve area. Hoping to be launched in 1-2 months
* Can be linked to different platforms such as EN-Net
* Examples of early work - request and what are we doing answer country needs
* Different priority areas including Cash in emergencies case studies & position paper, guidance on estimation of children with SAM, Guidance on Ebola and nutrition.
* Requests for deployment for training SMART survey support through GTM
* Request for protugese speaking consultant.
* Formation of consultant roster
* Long term agreement to enable - can be assessed by all UN agencies. Would like to get other UN agencies WFP
* UNICEF NIE online course update of basic training but includes NWOW and GB
* GTAM Challenges: Learning and adapt as we go. Journey/vision began in 2015.
* It has changed a lot since the initial vision
* High workload for core team and contractual issues - IT platform

**Session 2: Baseline Technical Needs Assessment Report (Isabelle Modigell)**

Additional Notes:

* Understand the types of technical requests
* Multi step process which sought multiple inputs
* Review of EN-NET and survey to NCC and review of the country technical working group.
* EN-NET is an existing resource
* Combed through questions
* Aim to look for question which hadn’t been answered or no consensus
* Out of this there were 20 technical gaps. Can read report to go thorugh the methods and limitations in detail
* Purpose is a start point.
* Reviewed 4 more commonly used forums
* Priority Gaps in Assessment: This is just a snapshot, which gives us a direction and something to work with. But aware that in this rapidly changing environment with many issues arising all the time.
* Top priority: (1) Influence of body shape on anthropometric status (2) sampling among pastoral populations (3) estimating dietary intake in households eating from a common plate (4) estimating feeding practices in children over 2 years old
* Priority technical gaps CMAM: (1) Alternative MAM management (2) Programming in the absence of therapeutic products (3) clarity/guidance on simplified protocols (+other terms) (4) Better integration of SAM screening for infants <6 months by community volunteers (5) SAM and MAM caseload
* Priority technical gaps IYCF-E: (1) Monitoring and evaluation (2) Management of non-breastfed infants in emergencies - recognize there is a lot of guidance but focus on the practical (3) Impact of cash-based programmes on IYCF practices. (4) Direct Impact of IYCF programmes on stunting and wasting (5) IYCF Corners and mother baby areas - review and streamlining of current guidance

Next Steps

1. GTGWs to provide recommended actions
2. Feedback from NCC to ensure that they are practical solutions
3. Who is doing what. Straight forward actions can be addressed by core team.

**Session 3: NIS working group (Louise)**

* Main function of the group is to focus on issues that are unresolved
* Process of nomination to lead the group.
* Chairs are ACF and UNICEF

Progress so far

1. Looking beyond the standard IYCF indicators and using the guidance that is out there
2. Guidance for anthro measurements for pre-adolescents and adolescent girls and bos to determine their nutrition status
3. Develop evidence based MUAC measurement cut offs for measuring malnutrition in women and PLWs
4. Consolidated available info and create guidance on how to set up a nutrition information system as part of preparedness
5. Make sure data from surveys are easily accessible with a global database and dashboar
6. Document to explain how to calculate the number of beneficiaries expected in a CMAM program (SAM/MAM) - incidence research study
7. Guidance on sampling for moving population - pastoralists is one part but also huge displacements in Mozambique.

**Session 4: GTAM IYCF-E (Linda)**

* Importance of linking the TWGs.
* Need to have a passion and belief in IFE to be part of this, sectoral memory
* New TOR has guidelines for conflict of interest.
* IFE core group is addressing some of the priority gaps
* Gaps different in scope (who should take on addressing these gaps)
* Update: IFE core group is conducting 2 studies - complementary feeding in emergencies looking at the extent the response is adopting the guidelines
* Qualitative study the use of BMS and adopting operational guidance in relation to Non Breastfed Infants in the 4 countries to feed into evidence around challenges in NBF

**Session 5: GTAM Nutrition Sensitive t interventions (GTWG) (Dora & Antony)**

* Co-chaired by FAO
* Many questions on whether if they should act as the nutrition-sensitive
* Priorities to be further informed by helpdesk.
* 4 products that have been developed with trainings, concept note and case studies on integrating nutrition by end of the year (dec 2019)
* Conducted trainings on integrating nutrition in Nigeria, and translated training to French and conducted in DRC
* One donor is interested in supporting.

**Session 6: Technical Expertise Pillar (TEP) WG (Coleen & Andi)**

Additional notes

* What is Tep? 3 areas: technical expertise (deployment & remote), competency and capacity strengthening, consultancy rosters
* review ed TEP membership structures.
* Steering committee- purpose is to approve deployments going to be funded in common pot
* If a country or agency requests GTAM expertise and they can’t pay, there needs to be a process to vet this.
* Tech RRT - serves as the role of coordination x 2 years. AFter, will discuss and look at the way forward. Roles in GTAM will rotate ex role of co lead will rotate. Does it make sense for tech coordination role that rotates as well? Tech will be coordinated by the Tech RRT.
* Consultancy rosters - shortlist of applications have been done
* Working modality document has been shared for comments. Outlines process. Outlines the whole process of how you make the request.
* Action Item : Flowchart Sheet for feedback
* Can be for small agencies as well to request . with or without funds. If agency has own funds. - can request specific agency from the TEP members. Can see matrix of suppliers and choose which one they want to put a request to.
* If agency doesn’t have funds it goes out for resourcing.
* Added value: Benefit of backing of 18 technical support. Quality control of the consultancy.
* Continuity of the work is something they have struggled with - 6 week deployments they often don’t know what happened afterwards. With the 18 agencies including UNICEF there will be more continuity.
* GNC & UNICEF have the ability to make sure that the resources are being taken advantage of
* We hope countries have the ability to pay or contribute to deployment will do so, but if not, this is a great community for global community to make sure it doesn't prohibit support.
* Rosters - active rosters. When you put in a request, they will be available.
* There will be a roster manager 6 months down the line.

**Session 7: Cash and Voucher Assistance for Nutrition (Donna)**

* Update on what could be done since mid March and what will be done in the coming years
* Recap of points from 2018 GNC Annual Meeting
* Cash is used at all levels - what do we mean by that?
* More evidence is needed -indeed, many cash in nutrition documents with review of impact which are a bit early given state of development of cash for nutrition
* Can agree that there are a number of gaps in cash in nutrition and the impact.
* Need of nutrition sector to clarify its position on the use of cash - agreed that GNC would work on a position paper. Does the nutrition sector have what is needed to develop one? Or should other things be done before a position paper be developed?
* How to strike the right balance between the need to get a bit more evidence and the need to get a position paper out quickly.
* Need to find a framework - already have conceptual framework for nutrition everyone know this.
* Can be used at all levels. - social and family care practices cannot be done with cash.
* Analysis framework 1) emergency cVA to support treatment and maternal and child undernutrition for access, transport, complement
* Existing resources/initiatives and ongoing work: important to incorporate ongoing work in the following to bring them on board.
* *Global Health cluster* : research question for cash in health, can be nutrition sensitive
* *R4ACT:* most recent review of impacts of cash on nutrition outcomes. But also looked at certain design features of cash can influence nutrition outcomes. None found super strong evidence with a scale of 1-4. None of the areas was rated 3 in a few areas only.
* *REFANI project:* now over, cash for nutrition outcomes from a food security perspective
* They would like to hear of other initiatives let us know.
* Field is very vast, most intervention is outside of the sector - in health, food security and wash.
* It is important that you have the means to advocate and influence the design of cash in other sectors so they can be nutrition sensitive
* CashCAP - specialised roster (40 people) to develop desk review, case studies, guidance, position paper.
* One colleague from CashCap will work purely on cash in nutrition from mid-August.
* One question is to find out the best governance structure. How are we going to form this governance structure and who is going to be there?
* Still need to define scope of case studies. Because not useful to look more into impact but need to know more about practices. We have to think which context are of particular interest because each emergency context has its own emergency features. Conflict? Displacement? Drought? Where do we want to stop in the thematic nutrition related? SAM only? MAM only? Both? These questions need to be discussed.
* Which context is of interest, what kind of emergency?
* Need to start collecting resources cash and nutrition in systematic way. A lot of things exists.Define and create
* Lots exist and people are aware of resources, but there is not a central point and difficult for new people to know how to access.

Way forward

* Determine most appropriate governa
* nce structure to provide oversight for the work to be done in the GNC; ensure linkages of governance structure with existing initiatives
* Agree on the type of desk review, case studies and guidance to be developed by the GNC CashCap, and also by partners based on the work already done, and in coordination with key existing initiatives
* Agree on common approach on advocacy with other sectors on the use of CVA for nutrition outcomes
* Start building a repository of CVA for nutrition resources - link to general knowledge management strategy of the cluster
* With the help of the CashCap dedicated to the GNC, develop desk review, case studies, guidance, position paper. Partners in the governance structure to provide technical support and quality assurance
* Need to pull together a task force of members and will be reaching out to interested partners. Reaching out in August.

**Session Group Work: GTAM Questions & Answers**

Objectives:

1. To answer participants’ most common questions about the functionality of the GTAM
2. To stimulate discussion and hear different perspectives
3. To general frequency asked questions for the GTA website
4. Prioritisation of questions

Action - Frequently asked questions will be put on GTAM website.

Prioritised questions

**Question 1:**

**Can governments request support of the GTAM and can requested support build capacity?**

*Answer 1:*

* Government can request support and this is desired. The idea is to improve the capacity of local actors and national actors.
* Government is the central point. One of the requests in the past was from the South Sudanese Director of Nutrition. She supervised the deployments.
* In principal, there should be capacity strengthening of government.
* Hosting aspect is different as it can be difficult if an international is hosted by government as security management could be challenging

**Question 2:**

**Does GTAM have defined mechanisms for addressing conflicts of interest?**

*Answer 2:*

* Partners have requested that we ensure that we are impartial and not fronting an agency-specific interest.
* There is a selection of GTAM NGO co-lead.
* They are learning from other networks such as people declaring their interests.

**Question 3: What is the role of the GTAM in strengthening the HDN**

*Answer 3:*

* They see capacity building as a core of GTAM. Guidance development and ensuring the utilization of it.
* When disseminating guidance is not just an email to send out but also walking it through with the teams. With Q&As. Not just at global level but also at country level.

**Question 4:How does GTAM initiate process of evidence generation with academia?**

*Answer 4:*

* There is the core team, but everyone can be involved and there are new global thematic groups.
* Each thematic group has list of technical priorities and linking academic institutions in order to have a proper partnerships to generate evidence. For example, incidence and how do we calculate caseload.

**Question 5: Does GTAM have a long term strategy, workplan and specific targets and deliverables?**

*Answer 5:*

* Yes, is valid for 2 years, now past half a year. Development focusing on building blocks but they updating periodically. Will be able to share it.

**Question 6: When there are multiple requests, how do you prioritise the requests**

*Answer 6.*

* A few components to that question - there is and annex to the GTAM document that outlines how the decisions are made.
* Generally they have periods of high and low demands. There are ways to meet the demands during the high demand times.
* Broader field of suppliers means they can support higher numbers deployments at the same time.
* In terms of technical guidance, this is informed by urgency. Priorities on IYCF-E in different areas but they had to proritise Ebola.
* Urgency, impact and comparative advantage will be taken into account.

**Question 7: Is regional support needed to determine that there is support for this?**

*Answer 7:*

* They make sure that the capacity doesn’t already exist in country or regional level.
* Cost sharing is a consideration - if already funded then no cost to the organization and cost sharing is always factored in.

**Question 8: What is the process of selecting advisor, and what extent can the country influence the process.**

* They have full time advisors. This is explained in the presentations in detail.

**Question 9: If the tech support is not able to deliver, what does the country need to do next?**

*Answer 9*

* We have had deployments that haven’t gone so well. The organizations behind deployment take steps to rectify this. They try to make sure that the deployments are going well.
* One deliverable didn’t come out as desired so they brought in additional resource to make it better.

**Question 10: How will the consultant roster be advertised and how will the consultants be selected?**

*Answer 10*

* There is a new selection process. IYCF, CMAM and micronutrient selection for the roster will be done by a Tech RRT advisor.
* Assessment roster: is hosted with SMART roster, ACF Canada.
* Final selection by GTAM core team. Not planning to have additional steps of having interviews because it is a consultant roster and can be different reasons
* No interviews as there they don’t want to make it too narrow.
* UNICEF hosts as the CLA, but it’s accessible to everyone
* How to access the roster will be available on the GNC website. We are planning to have a person dedicated to managing the roster.

**Question 11: How will GMAM function keep information up to date, comprehensive**

*Answer 11*

* Coordinating is the key word as we won’t be able to house everything ad there are so many existing repositories
* They will be doing some mapping of those repositories and link to them and have links to the more detailed repositories.
* GTAM website to have key resources. Will be aiming to keep them up to date. Underneath, having links to more detailed repository.
* They will support dissemination of documents. For big pieces of guidance to have webinars and Q&A sessions and a post on En-net to have a discussion.
* Create a post on en-net and talk about the experience of implementing this guidance
* They welcome suggestions on how to improve this

**Question 12: How will GTAM collaborate with other technical organisations like NAS, MQSUN?**

This conversation is about to happen - MQSUN and GTAM

**Question 13: What if organisation needs staff? Is the roster out of your scope to help support recruitment.**

* Idea behind roster was more for consultants. If staff, then it is a problem we are all facing.
* Will likely cover the coordination approach and NIE.
* Have been asking the global groups to help find people.
* Are just sharing to the same people? Or is it forwarded on? So it would be good to find out.
* Initiative ACF started - trying to grow young talent
* Capacity building should also include: Trying to grow young talent, people who can be attached the a programme - recent graduates.

**Question 14: Have you looked at other clusters outside of UNICEF?**

**Are there lessons learned already?**

* Looked at health like CDC colleagues on how they handle technical health issues. Experiences shared on requesting support and how they handle prioritisation. Experience on match needs with what's available at global level. How do they manage at supply side.
* GBVE has a helpdesk which was explored. Maybe we need to invest in the roster and competency framework to assess what is available.
* Once that is there, when you surge and come down you have something there.
* 2015 study will research into what other clusters are doing

**Question 15: What is the integration of ENN and GTAM?**

* Will not be housing everything in ENN. Moderators of EN-NET sees that there are unresolved issues can feed into GTAM
* Louise said that they would like to have the subnational surveys on the database.
* Need to make sure that the indicators are standards across the surveys as not necessarily the same.
* Two next steps to form TWGs.

**Session Overview of IPC AMN Louise**

* Presented on what is IPC with its key principles and functions. Acute malnutrition is its newest scale.
* Focus is mainly on food security and if malnutrition as an outcome has been affected by food security. IPC acute malnutrition to have this differentiation.
* Needed to have it clearly included in the analysis in a systematic way.
* With nutrition we would also have other contributing factors including risk of disease. IPC also looks at these issues
* Introduced the IPC conceptual food security and nutrition framework
* Acute malnutrition use WFH and MUAC. They have classifications for both WFH and for MUAC.
* Lots of other indicators on contributing factors. Some key updates and next steps
* Strength of IPC is that is’ not just about SAM and MAM but to also forces you to look at other contributing factors.

IPC version 3

* “Famine likely” classification
* Reviewed ongoing activities and areas of focus.
* Workplan will be shared later today. IPC country analysis roll outs.
* Good opportunity for countries to go through their data.
* Example of GAM and SAM, but often other indicators are a gap.
* Not just about doing a nutrition survey, it’s also technical consensus. What planning processes is it fitting in to?

**Question 1:**

**Ask: Raise issue Potential risk of IPC is that the data is separated. FS and nutrition separate, analyse the data then come back together afterwards. No joint analysis.**

ANswer

* Not the way it's supposed to be. They separate, but then they come back. Yes take they point that it needs to happen.

**Question 2:**

**In West Africa there is Cadre Harmonise - twice per year and they use smart survey data collected in the lean season in July.**

**For the round in March**

Answer 2:

* Working to have IPC protocol included in the West African countries.
* Work in progress to make sure that it happens. There were pilots and now it’s been accepted by the CH committee. There is a clear defined way on how it can be used.

**Question: Isaac - sometimes the SMART indicators you have the anthropometry, but not contextual. Can we work with SMART at the global level include this information?**

* Biggest gap is IYCF as morbidity is often taken and some WASH.

**Question about combined GAM which do we use when there is MUAC and WFH. Risk of creating sectoral silos?**

* Good idea, but would not hold our breath for that.
* Even getting to the MUAC threshold was an issue
* Have other sectors present in the analysis. If we do it right is should break down the silos.
* Health colleagues do not collect the same systematic data.

**What about rapid onset situations - where there might not be up to data info to use**

**Will there be flexibility in the tool for these situations for converging efforts and advocating?**

**Saba WFP**

*Answer*

* IPC is not a response analysis but a set of protocols. We have different indicators and different datasets. Biggest challenge is the availability of data. Once to advocate that put our efforts together to make sure that these data are collected.
* IPC is a protocol we don’t collect data.
* Systematic way of analysing already available information
* Need regular interval data.
* Another challenges is acceptance of use of data by host govt. Huge pressure not to show as negative.

**Abi Perry (DfID)**

* Absence of data is problematic.
* Longer term efforts to strengthen data systems. Gates foundation has been doing looking at strengthening DHS and routine surveillance. UNICEF works on this. DFID also has initiatives with the EU
* We’ll never have enough data in these settings. It’s expansive and access is often limited.
* Can we be more creative. Can we focus on absolutely the data we need to make the decisions and se of more innovative approach to this challenge.
* There is new technology such as MERIAM which us AI to model data to predict acute malnutrition.
* It is a burdensome challenge for everyone to collect this data. Takes a lot of time - is there any discussion on how to automate some of this analysis.

**Remarks from Stefano**

Worked with Josephine for many years and appreciated support she has given when he was in Haitoi. Looks forward to working with everyone.

**Remarks from DG-ECHO**

Revising nutrition policy and still a process. Will take a bit of time.This forum is the best moment to feed into a new EU policy for the future.

You will be consulted to provide input

**Remarks by Josephine & next steps**

* Meeting reports to pull out key actions for GTAM, GNC, SAG and 2020 work plan
* GNC 4- year strategy is until the end of next year.
* Lets try to incorporate inputs into the next 4 year strategy.
* Hope that momentum continues. There is a need for leadership. Should be clear communication from unicef to drive this.
* To report on what has been agreed. To move agenda forward.
* Thanks to ECHO (donor host) for making it happen.
* Thanks to country teams - Afghanistan, DRC and government participants
* Thanks to NCCs and IMOs for participation and being field level experience
* Thanks to various presenters, Joanne & Alison who have helped communicate the stories
* Thanks to donors - especially ECHO, USAID, DFID who are part of us. Allison ESARO regional office participation and pleases that UNICEF regional could make it. Scaling up nutrition - Stephen presecen of SUN focal point. Hope to work together much more.