GLOBAL NUTRITION CLUSTER
ANNUAL MEETING

22-24 OCTOBER 2018
AMMAN, JORDAN

Contents

All presentations are available from the following link: http://nutritioncluster.net/2018-gnc-annual-meeting/

Executive Summary

The Global Nutrition Cluster (GNC) is a collective of 46 partners and 10 observers, providing support to 36 countries affected by humanitarian crisis. Led by UNICEF as Cluster Lead Agency (CLA), the GNC has been coordinating rapid, high-quality and effective response to nutrition emergencies for more than a decade. This coordination protects crisis-affected populations from undernutrition, ensures they receive urgent treatment and care when needed and leaves them better placed to respond to future crises.

From 22–24 October 2018, 110 individuals comprising GNC partners, Country Cluster Coordinators, Information Managers from various countries and some country level and regional level UNICEF nutrition staff participated in the GNC annual meeting in Amman, Jordan with the following objectives:

- To share country experiences on GNC priority topics, including the humanitarian-development nexus (HDN), preparedness and continuum of care in community-based management of acute malnutrition (CMAM) to identify key actions needed from GNC partners for progress and scale-up.
- To examine country level experiences and global level programming initiatives on High Impact Nutrition Interventions (HINI), infant and young child feeding in emergencies (IYCF-E) and Assessment, and explore practical actions for global partners and countries to address challenges to achieve scale.
- To review key updates on the implementation status of GNC projects and other initiatives

A key point of discussion was the humanitarian development nexus (HDN) and its importance given that much of the humanitarian programming has been taking place in protracted long-term crises (86 per cent of humanitarian funding) for many years. Yet HDN has not been defined and we are not clear on what it means for nutrition. The GNC is supporting 28 countries under Humanitarian Response Plans (HRPs) in 2018 and four countries with refugee response plans, with an estimated 44.5 million people in need of humanitarian assistance, amounting to multi-billion-dollar support.

Many countries are struggling with preparedness and the process of transition (except those experiencing sudden onset large scale crises). In countries without a nutrition cluster, it is unclear where the responsibility for preparedness resides from the nutrition perspective. The majority of the focus is currently on response, such as the treatment of children with acute malnutrition, rather than the children at risk of malnutrition due to a deteriorating nutrition situation. The high prevalence and number of stunted children is a concern in these fragile and conflict affected states contexts; at the same time, wasting is also a concern in stable, non-emergency contexts. Bridging the gap between treatment and prevention is critical to ensuring a continuum of care to those most affected. There is a need to better articulate the role of the humanitarian response system in preventing child malnutrition. To do this, the nutrition in emergencies community will need to include the prevention of stunting and other forms of undernutrition e.g. anaemia as part of its efforts.

The group discussed the extent to which it was the responsibility of humanitarians to forge stronger partnerships with the development community around policies, frameworks, financing and programme implementation. There was recognition that the technical language used by the nutrition community can be a barrier to collaboration with development partners. This language should be considered carefully in order to coordinate effectively and influence other actors, including other sectors.

In terms of the role of cash programming in nutrition, it was agreed that, in certain contexts, no matter how much cash is provided, if the health services are inadequate or clean water and sanitation are unavailable, the nutrition situation of the population will not improve. The humanitarian nutrition community needs to clarify its position around cash programming and explain more clearly how services such as IYCF-e counselling, while still imperfect and requiring improvements, can save children's lives.

Participants discussed how to seize the opportunity of an emergency response to introduce sustainable programmes that would help alleviate the next cycle of nutrition crises in country. Creative strategies have been implemented by

Kenya and other countries to deliver High Impact Nutrition Interventions (HINI) and champion health system strengthening and it will be important to share these lessons.

Day 1

Presentations and discussion

In his opening remarks, **Victor Aguayo**, UNICEF, stated that the number of stunted children is declining in all regions except in Africa. Victor noted that stunting and wasting are prevalent in both emergency and non-emergency contexts, confirming the importance of responding to a continuum of care for malnutrition everywhere.

In the Middle East and North Africa region, nine countries are affected by an emergency crisis. Emergency response is central to UNICEF's programming and the organization is committed to delivering emergency nutrition to children and women in humanitarian contexts, in line with UNICEF's Core Commitment for Children in Humanitarian Action (CCCs) and its role as Cluster Lead Agency (CLA) for nutrition.

Victor gave three examples of how UNICEF's commitment is translating into action: 1- UNICEF has invited WHO to review the UNICEF-WHO partnership in emergency response; 2- UNICEF is a partner in the No Wasted Lives coalition, with the goal of scaling-up care for children with acute malnutrition wherever they are; and 3- UNICEF has led the establishment of a Global Technical Mechanism to strengthen the GNC's ability to respond to the technical nutrition in emergencies issues.

Victor emphasized that 'prevention and preparedness is a must; and when prevention fails, treatment is a must and response is a must'. Victor asked the audience to reflect and act in seizing the opportunity of nutrition in emergencies to test innovations and foster sustainability.

Key highlights of the GNC 2017–2020 strategy

Josephine Ippe, GNC coordinator, presented the key highlights and achievements by GNC strategic priorities. She discussed the link between GNC work and country cluster activities, including achievements to date.

Strategic Priority 1 – Operational Support Before, During and After Crisis

The GNC coordination team (GNC-CT) provided remote support to 16 country/cluster/sector coordination platforms through the coordination team and help desk, including reviewing response plans, provision of guidance and operational support. The GNC-CT also carried out three field missions to Bangladesh, Ethiopia and North-Eastern Nigeria during 2018.

The GNC helpdesk started a review of the functioning of country cluster Technical Working Groups (TWGs). The preliminary results shed light on how to better support country TWGs and confirmed the need for the Global Technical Mechanism (GTM).

There have been several discussions on HDN; however, there remains a need to define HDN from the nutrition perspective and provide guidance to countries on taking the concept forward. Transitioning from the cluster approach to sector coordination mechanisms that embed the coordination of nutrition in emergency (NiE) response has only been possible in rapid onset emergencies such as Nepal, Pakistan and Philippines, and thus the need to support transition as part of HDN was emphasized, as well as better support for preparedness.

Strategic Priority 2 – Capacitate Nutrition Stakeholders

At global level, there was no rapid response team (RRT) deployment of Cluster Coordinators/IMOs undertaken in 2018. The Tech-RRT team, a surge mechanism hosted and managed by the NGO Consortium, was deployed ten times in 2018 to support technical capacity in IYCF-e, CMAM, assessment, social and behaviour change (SBC), water, sanitation and hygiene (WASH) in seven countries. Due to budget constraints, there was no training for either Cluster Coordinators, IMOs or country cluster partners conducted in 2018. However, some funds have recently been allocated by the CLA for RedR UK to lead two regional and three country-level trainings in 2019.

Strategic Priority 3 – Influence and Advocate

Advocacy has resulted in the establishment of a standalone Nutrition Cluster in Cameroon. Advocacy is needed to ensure that nutrition sensitive objectives are systematically implemented, monitored and evaluated in relevant cluster

plans (WASH, Food Security and Health Clusters). Similarly, there is a need to advocate for the improvement of IYCF-e and micronutrient interventions, which were enhanced through the Humanitarian Response Plan (HRP) tips, but still lack systematic incorporation across all HRPs.

Josephine also discussed the GNC supporting objectives and the achievements under these objectives.

Supporting objective 1a- External engagement objective- inter-cluster engagement objectives
Following the finalization of the inter-cluster training, the piloting of the integrated package was done in Addis Ababa, Ethiopia and in Maiduguri, Nigeria. A meeting planned in Rome in November 2018 has been planned to further review the content of the integrated package.

Supporting objective 1b- External engagement objective- CLA engagement objectives
The CLA has fulfilled part of its responsibility with regards to ensuring predictable funding remains for the GNC Coordinator, including funding for the Deputy and two RRT positions. There is room for improvement for the CLA to provided more predictable funding to maintain coordination and information management (IM) capacities for the cluster at both global and country levels.

The objective to increase mainstreaming of coordination and IM capacities in UNICEF was reached as two RRT positions are now mainstreamed within the UNICEF Office of Emergency Programmes (EMOPS) office plan. The number of dedicated national Cluster Coordinator/IMO positions at country office level also increased from eight in 2017 to 14 in 2018. Challenges remain in securing fixed term contracts for Cluster Coordinators.

No actions were taken in 2018 by the CLA at HQ level to address preparedness for coordination for NiE responses and this will need to be ensured through the regular UNICEF programmes in countries where de-activation and transitioning is possible to be linked to HDN.

In terms of UNICEF playing a leadership role in technical support, guidance and capacity in 2018, the Global Technical Mechanism led by the UNICEF Programme Division and World Vision International has been officially launched and has developed its first plan of action.

Supporting objective 1c- External engagement objective- Donor partnership objectives

There is a need to define what actions can be taken by the GNC at global level to increase predictable and multi-year funding for programming and coordination, and what alliances must be formed.

In order to demonstrate the value added to donors and that the GNC is meeting the commitments in the Grand Bargain, there is a need to define the engagement of partners in Grand Bargain commitments and identify how they can be tracked.

The Nutrition cluster advocacy toolkit has not yet been rolled out to national platforms as planned due to funding constraints; however, the toolkit was used by Yemen to develop an advocacy strategy. The next step would be prioritizing countries that need this advocacy.

Supporting objective 1d- External engagement objective- development actors' engagement objectives

Collaboration with the Scaling Up Nutrition (SUN) movement has stalled due to changes in staff in the SUN secretariat. To revive the collaboration, it will be necessary to review structures and HND linkages between SUN and the cluster in at least six countries in 2019

Supporting objective 2- internal development objectives

The objective of strengthening partnership and communication was achieved in 2018 by hosting donor webinars, reviewing and prioritizing GNC activities, developing a GNC advocacy document, issuing a letter to the CLA on GNC funding, institutionalizing the mid- and annual year report, and maintaining an effective Strategic Advisory Group (SAG).

In terms of improving knowledge and information management, the GNC-CT is revamping the GNC website, reviewing the use of the GNC IM toolkit, seeking guidance on definitions and tools for gap analysis, and working with Action Against Hunger Canada to support the mainstreaming of gender-based violence (GBV) issues/approaches in GNC tools.

Summary of key outcomes of the side event meeting on Yemen and Sudan

Ruth Situma and **Josephine Ippe** summarized the outcomes of the side event on Yemen and Sudan. Hosted by the UNICEF Regional Office for the Middle East and North Africa (MENARO) in Amman on 21 October 2018, the side event aimed to shine a light on the particular challenges faced in those two countries and to move forward on a call to action to end malnutrition in Yemen and a nutrition investment case for Sudan. Eighty participants representing the Governments of Sudan and Yemen, donors, international NGOs, SUN Facilitator, UN agencies, Academia and Research institutions attended the event. Teams from Yemen and Sudan presented the nutrition situation, the progress and the challenges faced in the nutrition cluster response.

Today in Yemen, an estimated 22 million people are in need of humanitarian assistance, while the population is facing disease outbreaks and currency devaluation due to an economic crisis. The Sudan team also described the nutrition situation in Sudan where an estimated 5.5 million people need humanitarian assistance, with the HRP being only funded at 24 per cent, and similar challenges of currency devaluation and disease outbreaks. Both countries are highly dependent on humanitarian financing for the nutrition response and both have weak access to long-term and flexible funding to strengthen government systems. There is a lack of progress in scaling-up multi-sectoral programs; however, in Yemen, the Integrated Cluster Programming following the Rome meeting which was organized to develop actions to prevent famine in four countries threatened by famine in April 201. Integration is now mainstreamed in a number of districts in Yemen, while in Sudan, although integration is part of the government strategy, this approach has not been scaled up yet. In both countries, representative national level data is outdated, while localized data cannot be extrapolated to the entire country, thus the teams are working in a data vacuum.

Working groups were established during the side event to discuss key challenges facing each country in more depth. In the case of Sudan, the working groups addressed three main thematic areas: ***Long-term financing, multi-sectoral nutrition programming and coordination.*** It was agreed that to implement the continuum of care for malnutrition – from prevention to treatment – there is a need to do much more on the prevention side by promoting the implementation of a package of HINIs, strengthen health systems and improve multi-sectoral approaches. The working groups highlighted the need to have a common narrative including both humanitarian and development objectives for nutrition. The humanitarian nutrition community should pro-actively engage with development actors such as the World Bank, the European Union, USAID, and the Global Financing Facility and make them aware of the difficulties faced when transitioning to development programmes in fragile states and protracted emergencies like the Sudan. To this end, the GNC and CLA will be looking to ensure representation of development donors at the next GNC.

The working groups also expressed the need for the GNC and SUN to move quickly and clearly on the formulation of guidance for strengthening the HDN in countries. Sudan has agreed to be a pilot country as there is an opportunity to link with the United Nations Development Assistance Framework (UNDAF) as well as promote the link with SUN movement initiatives in country.

In the case of Yemen, the working groups addressed three thematic areas***: Donor commitments, UN agency commitments, and NGO commitments***. They discussed the possibility of creating a pooled fund for the government health workforce and the need to explore funding from the private sector. On the commitments of UN agencies, the working groups discussed building a common strategic approach among UN agencies on the provision of services as well as looking into ways to process joint agreements between agencies and partners. In terms of NGO commitments, the groups discussed how international NGOs can build the capacities of local NGOs through trainings and on the job coaching.

There was agreement that the GNC should explore opportunities with OCHA for multi-year funding for HRPs; and, if there is a room for maneuver within the HRPs in the protracted crisis context, to incorporate systems strengthening. Greater clarity is also needed on the transition triggers in these contexts, including discussions on what it takes to agree on milestones, indicators, and cluster de-activation, especially as this work has already been partly done by the UNICEF Programme Division. In addition, the GNC/CLA need to identify how to systematically support countries to generate data for planning and evidence generation. It was also agreed that GNC/CLA and SUN will engage immediately to further clarify roles, responsibilities and coordination mechanisms/advice for countries linked to HDN discussions.

Actions: The group agreed that the GNC-CT would write a two-page summary of the meeting for EMOPS, regional and country offices, while Emergency Nutrition Network (ENN) would produce a short report for this one-day meeting. Once the short report is out, Yemen and Sudan teams will take time to reflect on their priorities for the next steps and come up with implementation and monitoring plans at country level.

Country Presentations

Cecile Basquin of UNICEF Niger presented considerations around HDN in **Niger**'s longstanding humanitarian context, including around policy context, coordination, health system strengthening, and transition in the face of a high malnutrition burden and a fragile health system. While attempting to map key considerations for influencing better linkages between nutrition in emergencies and longer-term nutrition programming, more questions were raised: how can we transition humanitarian programming when the foundations of transition are weak? How can we foster political will for nutrition in a fragile state like Niger, especially when this translates into increasing the national budget for nutrition? How can we build government capacity in coordination and be able to navigate the difference between technical assistance and capacity building versus substituting the government role? What are the opportunities for an HDN approach at sub-national level (in a context of decentralization)? What are the risks to the population of driving transition in the face of a fragile government system that lacks capacity?

Discussion

The group discussed ways to involve the SUN movement at country level. One entry point is the inter-cluster integration package that was developed by the Nutrition Cluster and the Food Security Cluster, which will help bring more clarity on what nutrition sensitive programming means, especially as integration with other sectors to prevent stunting is key to the SUN misson.

Cecile highlighted that governments need to budget the policy and guidance update and include it in their costed plans. UNICEF is using the NutriDash platform to map which countries are incorporating nutrition in emergencies in their plans. Overall, there was concerned expressed about the next emergency in Niger, as humanitarian donors are transitioning out.

Abigael Nyukuri of UNICEF Bangladesh presented experiences in supporting preparedness actions in **Bangladesh** to ensure better response to cyclic emergencies at national and sub-national level. Some of the lessons learned from Bangladesh include: the importance of a robust risk analysis and monitoring mechanisms that inform the scope of contingency planning for both government and humanitarian actors; the need for government consultation and engagement at all levels in the development process of the inter-cluster contingency plans; and the role of the Inter-Cluster Working Group (ICWG) in fostering standardization and harmonization of cross-cutting themes and practices across clusters.

In addition, Abigael highlighted the importance of a dedicated humanitarian coordination mechanism focusing on preparedness and complementing government efforts. She continued to explain that an in-depth analysis of the scope and functionality of the existing government coordination mechanism during the pre-disaster period is useful in identifying gaps and ensure adequate support for the development of NiE related guidelines and the building of technical capacity in NiE.

Discussion

A question was asked regarding the sustainability of such a system and Abigael further explained that sustainability is a work in progress. Humanitarian Coordination Country Team (HCCT) is the forum that the sector works with in Bangladesh, as well as the Local Consultative Groups for Disaster and Emergency Response (LCGDER). Bangladesh has a strong Disaster Risk Management framework, with plans on preparedness done jointly with the government.

The country presentation was concluded by **Ingo Neu**, who shared experiences of CMAM scale-up during the Rohingya response in **Cox's Bazar, Bangladesh**. He explained the coordination structure in Cox's Bazar and discussed the com-

plex coordination of nutrition services since the nutrition sector was established in August 2017, co-lead by the government and UNICEF. The UN High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) are 'camp coordinating agencies' managing the camp planning with different modus operandi.

During the CMAM scale-up at the onset of the emergency, the design was not coordinated and this led to a fragmented response and inadequate continuity between programmes and service delivery channels (facility, community and household). The design of the different components was based on the national CMAM guideline, which does not allow use of ready-to-use therapeutic food (RUTF) or ready-to-use supplementary food (RUSF) and has a weak community outreach component. The relocation during the monsoon season was used as an opportunity to ensure better linkages between programmes to achieve some level of continuum of care.

The ongoing challenges include: the government remaining in an 'emergency' mode, making certain changes currently almost impossible; the lengthy and complicated government process for approvals of international NGO projects; and the fragmentation of CMAM services.

Ingo highlighted lessons learned and recommended actions, including the importance of ensuring that:

- The provision of integrated services for CMAM starts at the onset of the response and is maintained for the entire project life cycle;
- Global memoranda of understanding (MoUs) among UN agencies takes effect and are respected in new emergencies in the absence of country level MoUs.
- Country Level MoUs among key UN agencies are developed prior to emergencies for disaster/emergency prone countries and are activated from the onset of emergencies.
- Dedicated staff for sector coordination and key UN agencies are available from the beginning of the response. Double hatting role of the Cluster/Sector Coordinator in large scale responses negatively affects neutrality and should be avoided at all costs, while dedicated technical capacity for the entire cluster in the areas of CMAM, IYFC-e, and surveys etc., should be encouraged.

Discussion

The group discussed ways to include the Rohingya population in training and disaster preparedness actions in case they need to return to Myanmar. Challenges in providing coordination from the outset of the emergency and the difficulties encountered while estimating the number of SAM cases and coordinating subsequent RUTF supply purchase among agencies were also highlighted.

Samson Desie of UNICEF Somalia shared the rationale, and early experiences in the implementation of the expanded protocol for SAM/MAM treatment in **Somalia**, including the expanded admission criteria for MAM in the outpatient therapeutic programme. The objectives of the protocol were to prevent excess mortality and morbidity and reduce the incidence of SAM. In summary, this approach allowed a greater number of acutely malnourished children to be reached as partners implemented it in their respective areas. Despite the volatile security situation and the access constraints, the pre-existing good partnership between UNICEF and WFP, the existence of global guidance and the presence of implementing partners have allowed this pilot to move forward. Samson advocated for this approach to be implemented more often to give children access to both SAM and MAM treatments.

Discussion

Participants raised concerns that stock outs could be encountered while implementing this type of approach as a result of funding constraints, meaning that SAM treatment may need to be prioritized with the stock of RUTF. Samson explained that, for this programme to succeed, supply management needs to be organized properly and jointly with stakeholders from the outset.

Samson further explained that both mid-upper arm circumference (MUAC) and Weight for Height (WH)should be used if and when possible, as new evidence is showing that both criteria need to be used. He also acknowledged that the country protocol, albeit outdated, would take precedence on international protocols in a given country, thus advocacy

with the Ministry of Health is required to make this work.

Global scene on continuum of care

Diane Holland of UNICEF HQ presented updates on **global** initiatives relevant to the CMAM continuum of care, including a call to action, the UN joint statement, products improvement, and expanded criteria, research and the No Wasted Lives initiative. **Alison Fleet**, UNICEF, UNICEF, presented new initiatives on local RUTF and innovative digitalized height boards. Alison highlighted the benefits of developing locally produced RUTF with local legumes, cereals and grains that can also provide economic benefits to the community.

Discussion

During the subsequent discussions, Zita Weise Prinzo from WHO highlighted the importance of translating the data into evidence to be in a better position to update the guidance while retaining standards and delivering in a feasible manner. Diane clarified that the priority for RUTF supplies should go to SAM children when there is shortage of supplies in a country.

Group work and presentations

Preparedness

How can coordination mechanisms on preparedness be established, strengthened and sustained at the national and sub-national level in the absence of a formal cluster mechanism?

- **Policy framework/governance/coordination**

The groups recommended the need to look beyond the sector cluster coordination body into ways of integrating policy on preparedness within the government coordination mechanisms in the country and the need for linking with SUN at country level to support preparedness measures.

Most groups noted the need to integrate humanitarian response within the national nutrition policy and ensure that national development policies address preparedness and emergency response. These policies would need to be translated into plans with clear roles and responsibilities and triggers to start the process at national and sub-national level. The plans would need to be rolled out through localized coordination bodies. Early warning data should be used to help inform triggers.

Groups recommended the need to train government focal points on taking the lead in emergency response and provide them with guidelines on disaster risk management. Groups highlighted the importance of making policies, plans, roles and responsibilities known and accessible to all.

- **Financing arrangements**

From the group presentations, it was clear that costing the preparedness plan is the first step to ensuring it is funded. An open dialogue with development actors would also allow them to factor preparedness in their plans and cost these measures accordingly. At times, a clear funding plan and framework exists for traditional donors, but not for the private sector. Working to better tap into the private sector's corporate social responsibility schemes is one way to address some of the funding challenges.

The groups recommended garnering a better understanding of how governments prioritize and allocate national nutrition budgets. This would involve gathering evidence to facilitate advocacy to government on budget allocation for preparedness, plans and trainings.

The group further recommended the need to fundraise ahead of the emergency, including by designating responsible actors to fundraise for each of the preparedness and response components. Resource mobilization for preparedness should be as important as the fundraising efforts dedicated for the response.

- ***Programmes – especially those that strengthen integration into existing systems, that lead to nutrition resilience, that maximize nutrition impact***

During restitution, the groups recommended that preparedness actions need to be agreed with the official government authorities. They also emphasized the importance of having systems for monitoring the level at which comprehensive nutrition specific interventions are being implemented, and for identifying how nutrition sensitive programming is being integrated within existing systems to provide early warning and to better orient the response. Nutrition specific and sensitive policies and protocols would need to indicate the threshold for triggering a response and by whom. Protocols would also need to include information on how to adjust the modus operandi facing different types of challenges.

The groups emphasized the importance of supply preparation, whether contingency stock plans in-country or a supply mechanism that can be mobilized in the region. The need to explore flexibile legislation on nutrition supplies to enable quick mobilization of supply importations was also recommended.

Systematic capacity building actions were recommended by the groups as one of the core pillars of preparedness and this action should be better oriented following a capacity mapping exercise. The analysis can be done with other sectors to ensure integration for cross cutting themes, while ensuring that mapping is also done for nutrition specific activities. Groups recommended the establishment of a Rapid Response Team Roster that could be created for each country, either within the government or within the UN or NGOs. This roster of people should be previously trained and able to be deployed to train others. The roster could be linked to preparedness actions at the global level: staff could be in existing positions in-country, in other countries or at regional level within their institution, yet willing to be deployed for the nutrition cluster.

Allowing space for community participation in an attempt to build resilience at all levels was also highlighted as an important component to take into consideration in preparedness programmes.

Discussion

During the discussion, it was noted that advocacy for preparedness is linked to individual initiatives rather than being mandated as part of the role of the CLA. Designating a focal point or institution accountable for preparedness at country level could help move away from a person dependent to a system dependent model. In addition, the capacity required needs to be accounted for and costed.

In Bangladesh, a pre-qualification for national NGOs was done, which helped alleviate some of the delays in project Cooperation Agreement negotiations were made easier as NGOs selected were already vetted and pre-qualified by all partners.

Humanitarian Development Nexus

What have you done in your country to strengthen linkages around HDN?

- ***Policy framework/governance/coordination***

The working groups highlighted the need to review national policies and plans in countries to include a section on emergency response and preparedness. The groups pointed out to the need to have clear plans for emergency response at national and sub-national level. These plans would need to be clear in terms of the roles and responsibilities of each actor.

National nutrition policies need to include IYCF guidelines during emergency and non-emergency times. This work is in progress in both Malawi and Sudan. National nutrition guidelines would also need to be reviewed and updated for the different nutrition programmes, such as CMAM, micronutrients, IYCF-e etc.

Through existing coordination platforms, countries need to develop a multisector country operational plan. The plans need to take into account the importance of Behavioral Change Communication Strategy. Linking with the SUN movement and functioning SUN network could help support some of the initiatives.

- ***Financing arrangements***

The groups recommended that long-term advocacy would be required to get nutrition on the agendas of donors and governments and countries need to be supported in this area. Currently, the HRP exists but its financing depends more on donor mandates and strategies, which are mostly humanitarian, and do not provide space and funding for systems strengthening.

- ***Programmes – especially those that strengthen integration into existing systems, that lead to nutrition resilience, and that maximize nutrition impact***

The integration of Community Based Management of Acute Malnutrition (MAM), Stabilization Centre (SC), Out Patient Therapeutic Programme (OTP), Supplementary Feeding Programme (SFP), and community), Infant and Young Child Feeding (IYCF), and micronutrient deficiency control programs into the country's health system was highlighted as a step towards strengthening the HDN. The integrated actions to be undertaken by Food Security, Health and WASH Cluster to support nutrition action while integration of basic health and wash actions in nutrition was also recommended by the group.

What support do you need from the global cluster?

The GNC can support in rolling out the multi-sector approach, in establishing a pool financing mechanism for HDN by advocating to donors, in strengthening government capacity and in providing guidance to support countries with real examples and case studies on bridging the nexus.

Discussion

The discussion revolved around the need to be more creative in getting the emergency funding to support more sustainable systems building activities.

Continuum of Care

- ***How can countries manage when national guidance is not consistent with international recommendations/approach on CMAM as seen here?***

From the group presentations, some of the major recommendations included communicating with government counterparts with consistent advocacy and messaging from international community on the new guidance and the need to update national nutrition policies to include preparedness actions that are costed and implemented before crisis hits. Advocacy efforts would need to be sustained in-country as well by leveraging existing relationships in diverse ministries and sectors. The groups recommended that pre-negotiating adaptations of national guidance in case of shocks could be useful. It would be important to present government with the benefits of working on guidance beforehand, including preserving human resources and saving lives. The exceptional circumstances/expanded admission criteria protocols could be part of the pre-negotiation agreements. On supplies, it was recommended that the importation of products should be pursued concurrently with local production, local importation and sustainability and the opportunity to discuss the government investment in future local production.

- ***Are there other internationally recognized alternatives for SAM/MAM treatment in emergency contexts where use of RUTF/RUSF is not allowed?***

For children suffering from SAM, day care and F100 was an alternative recommended. Other alternatives included different local recipes or a non-peanut-based RUTF, e.g. chickpea-based (India) or fish-based (Viet Nam).

For children suffering from MAM, the groups presented the use of fortified blended foods that reach WHO Technical Note (2012) as one alternative to RUSF. Another alternative presented was the mother-child cash programming with a nutrition objective, but this might not be effective for treatment programmes unless adequate evidence is generated. Other complementary methods used for prevention were: 1- the Positive Deviance Hearth method and 2- an IYCF behavior change prevention package.

- ***How can we minimize disruption in continuum of care due to separate institutional responsibilities/approaches?***

The groups highlighted a number of methods, including health systems strengthening, creating joint harmonized data,

plans and supply management, and using technology such as m-health apps to support SAM, MAM and the integrated management of childhood illness (IMCI) service provision at health facility level.

The group also highlighted the experience from Mali, where having RUTF on the Essential Medicines List has helped with supply management.

Discussion

The RUTF funding in Mali comes from development funds and there were some interesting discussions on whether there was an avenue for creating local production. The global community would need to advocate and support the development of local solutions when possible.

Wrap Up

Bonus session

Shannon Doocy, Johns Hopkins University, presented the cash and nutrition study from **Somalia**. Shannon explained that despite decreases in household food security over the study period, pregnant and lactating women receiving cash transfers had improved dietary quality and mean MUAC; however, transfers were not as effective for improving children's dietary quality. Child nutrition improved in both intervention groups in terms of mean MUAC (significant) and acute malnutrition prevalence (not significant) while a decline in nutrition status was seen in the non-intervention group. Results show promise but do not indicate a clear benefit for mixed transfers as compared to food vouchers. More research or programme evaluations with larger sample sizes and longer intervention periods are needed.

Discussion

Cash is being used at all levels; however there is a need for more evidence to inform the next steps. The nutrition sector also needs to clarify its position on cash in nutrition.

Action: The group agreed to work on a position paper on cash and nutrition and this is already in the GNC 2019 WP to be implemented by of the GNC partners with expertise in Cash lead by the GNC-CT.

Day 2

Presentations and discussion

Senan Alajel, UNICEF Yemen, presented progress and challenges in IYCF-e scale up in **Yemen**, including coordination, working with government, programming models and assessment. The challenges specific to IYCF-e are many in Yemen, including weak implementation of national legislation, repeated violations of the Breastmilk Substitutes (BMS) Code by health workers and officials, limited partner engagement and capacity, the unavailability of national evaluation data, and the poor coverage of community programs. Senan then asked how partners could engage local partners sufficiently to build their capacity on IYCF; how monitoring and impact assessment of IYCF interventions could be improved; and how needs assessments for non-breastfed infants could be improved. Senan also asked what could be done to better support non-breastfed infants in Yemen; and how the complementary feeding response could be scaled-up to improve diet quality for children.

Alessandro Iellamo, Save the Children, presented a **global** overview of the IYCF-E response.

Alessandro set the scene by reminding partners about the importance of optimal IYCF-e and the wealth of existing global guidance. Quoting the WHO Global Nutrition Policy review draft report 2016–2017, Alessandro highlighted that about 30 per cent of the 163 countries included actions related to improving IYCF-e and complementary feeding in their national policy. He also presented the results of a review of 21Joint Refugee Plans and Humanitarian Response Plans (HRPs) and found that, although IYCF-e is reflected in the HRP/JRPs, there were important challenges. These include: major gaps in IYCF-e leadership, no activities to target non-breastfed infants, no attempts being made to improve complementary feeding practices, key IYCF-e indicators are not used, IYCF-e interventions are not costed or integrated with other programmes and sectors.

Discussion

The discussion following the two presentations revolved around the improvement IYCF-e programing at country level. Programmatic actions around IYCF have evolved in the last ten years, yet a number of issues remain unresolved and artificial feeding remains a subject that needs to be tackled.

Victoria Mwenda, Nutrition Sector Coordinator in Kenya, shared the enabling factors and challenges in scaling up the HINI package and integrated nutrition specific/sensitive programming in an emergency in **Kenya**. The key enabling factors for scaling up HINI in Kenya were facilitative policies at national level, reviewed nutrition information systems, reviewed coordination and partnership arrangements, identified capacity building needs for implementation, costing and financing the roll out, and the development of an implementation road map.

Victoria highlighted what the GNC can learn from Kenya to enable nutrition interventions beyond CMAM in emergencies.

Discussion

There was discussion about the need to move away from overly technical or alienating language in the nutrition community.

Ismail Kassim of UNICEF shared progress and challenges in establishing the nutrition information system (NIS) in **South Sudan**. The South Sudan nutrition cluster and UNICEF as a CLA took action to reinforce the nutrition information system in country. Some of the actions taken were to ensure dedicated capacity in UNICEF attached to the cluster to support NIS, followed by the integration of nutrition indicators within food security assessments, identification of sites for nutrition surveys, financial and technical support to partners to undertake SMART surveys and introduction of the Integrated Phase Classification (IPC) Acute Malnutrition analysis. The main challenges highlighted are linked to the lack of nationally led and weak government capacity. The humanitarian sector is trying to address the gap in data with the many challenges specific to this sector such as short-term funding and turnover.

Discussion

The questions asked were: how to ensure that the data is used by programs and how to address survey fatigue in South Sudan. The group reflected on how can humanitarian agencies build capacity/strengthen and government NIS within humanitarian programming in complex contexts like South Sudan.

Round Table Panel Discussion on IYCF-E, HINI, Assessments

The panel was composed of Yves Nzigndo, Nutrition Cluster Coordinator in Central African Republic, Tariq Mekkawi, Nutrition Cluster Coordination in Turkey, Jecinter Oketch, Nutrition Specialist UNICEF Myanmar, Maria Chidumu, Ministry of Health Malawi, Claude Banywesize Chigangu, Nutrition Cluster Coordinator in Mali, and Javier Rodriguez Corrales, Nutrition Cluster Coordinator in Mozambique.

Panelists noted the need for IYCF-e interventions in Central African Republic and Malawi and the fact that donors do not fund IYCF-e or NiE interventions when global acute malnutrition (GAM) levels are not alarming. The panelists asked, 'how can we make the case that IYCF-e programmes are also lifesaving?'

In Mali, IYCF-e challenges include the lack of baseline indicators, the lack of a harmonized package of interventions, and the fact that the national guidelines do not look at emergency settings. Mali needs support for materials in French, technical support for trainings and a database for consolidating data collection. The fact that IYCF-E is not part of the national policies was also an issue raised by Mozambique. Making a case for donors to fund preparedness for IYCF-e and working together to build the capacity of local actors were highlighted as the two points needing most urgent attention.

Group Work and Presentations

HINI in Emergencies

- ***Have other countries been successful to HINI scale-up in emergency response? What have been the enablers and barriers?***

A clear situation analysis, guidelines for HINI, proper coordination mechanisms and a government committed to nutrition were some of the enablers put forward for HINI scale-up in emergency. The main barriers included push-back from donors and governments on HINI and nutrition sensitive programming, the limited staff capacity and staff turnover.

- ***What practical actions (including in preparedness) can NCCs, partners and government take to include HINI in response plans?***

The first step in making HINI happen is a mapping of the geographical areas affected and the coverage of the HINI interventions taking place. Such a gap analysis can help engage donors to fund a more comprehensive package of nutrition interventions. It would be useful to adapt on a standard minimum package including supply and a full package of nutrition specific and sensitive interventions. Much advocacy is still needed with government, donors and other sectors level to move this forward.

Discussion

An example was provided from Kenya on expanding human resources capacities for HINI implementation. Development partners negotiated and agreed with the government that they would support additional nutrition workers who would implement the whole package and the government agreed to gradually absorb the cost and mainstream those positions. This is an example of a making a programme more sustainable via emergency financing. The group agreed there was a need to share these strategies and experiences.

IYCF-e

1. ***What are the barriers (national & global) to putting policy into practice***?

- ***Non-breastfed infants***

There has been limited attention paid to non-breastfed infants and complementary feeding. Supporting non-breastfed infants (including with artificial feeding) is not a typical programme in development contexts and is highly discouraged. Countries are therefore not prepared and there are no programming models for them to follow immediately after an emergency for the feeding of non-breastfed infants. Countries may also be fearful of the use of infant formula and concerned about unintended consequences (i.e. the impact of formula use on the feeding practices of breastfed infants).

As a consequence, there is a lack of accessible programming guidance on support for non-breastfed children, while existing tools are not consolidated. Although UNICEF has guidance for countries on how to make decisions on the procurement of formula and the care of non-breast fed infants, partners still feel that there is a lack of leadership by UNICEF in upholding the CCCs with respect to non-breastfed infants and planning essential IYCF interventions.

At a national level, conflict of interest can be a major barrier amongst health staff, such as doctors who receive incentives/payment and promote infant formula use, which carries over during an acute emergency. The International Code of Marketing of Breastmilk Substitutes (the Code) is poorly implemented at country level, and there are challenges accessing adequate BMS supplies in-country (such as in the case of the European migration response). There were also problems accessing supplies via UNICEF/UNHCR.

UNICEF reported that they have approval for procurement of BMS as a provider of last resort, but this guidance seems not to have been adequately communicated at country levels. Human donor milk banks are logistically challenging in emergencies, while the supply chain as well as the cost of Ready to Use Infant Formula (RUIF) remains a challenge. When the nutrition cluster partners need to provide targeted BMS within the frame of a programme, the labelling of BMS can also be challenging. Re-labeling is needed to avoid violation of the Code, but it is expensive, takes time and can be impractical. In addition to the lack of preparedness, partners recommend the need for expertise to properly implement programmes for non-breastfed infants as both expertise and capacity are often absent.

- ***Complementary feeding***

The groups identified the general lack of clarity on what interventions are needed on complementary feeding to be implemented in emergencies as one of the major challenges. There is also a lack of leadership on complementary feeding in emergencies within UN agencies. The intervention often focuses on a product, while there is a lack of connection with the other sectors in order to ensure WASH and Food Security considerations. In addition, there is often a gap between the advice and counseling being provided and what families are able to do or what food they are able to purchase. There also seems to be a lack of contextualization around what food is available for complementary feeding and what is culturally accepted, while local availability of complementary food is often a barrier in emergency settings. The programmes that focus on complementary feeding therefore require investment and community involvement, both of which are lacking in most emergency contexts.

- ***Monitoring & evaluation of impact of interventions***

There is currently no discussion on how to measure the impact of IYCF-e interventions or evaluate the quality of services. This gap in impact assessment could be addressed by linking to research institutions. The group recommended the need to unpack existing standard IYCF-e indicators to sort out those related to measuring impact, those measuring outcome and those measuring the output. Additionally, a number of nutrition in emergency responses do not systematically include IYCF indicators in either rapid assessments or in the database being used for monitoring. There is also a challenge in adding IYCF indicators to SMART surveys.

- ***Planning & costing***

Most groups did not tackle this point; however, the group that did indicated that most of the time IYCF activities and behaviour change communication are not budgeted within the HRP or within partner projects.

2. What do we need to do about it?

There is a need to clarify leadership on IYCF among UN agencies regarding the care of **non-breastfed infants**. UNICEF was also asked to provide leadership in order to uphold its own CCCs.

There is a need for accessible and operational programming guidance on non-breastfed infants and children and discussion on key resources that can be drawn upon to support intervention for non-breastfed children. The guidance should be referred to as 'Support for non-breastfed infants and children' rather than 'support for artificial feeding' as the former is more comprehensive and holistic in terms of the support and care needed.

UNICEF should address the infant formula procurement issue through the supply division and should urgently share standard operating procedures on BMS with all partners. In addition, UNICEF and UNHCR should take the lead in preempting unsolicited BMS donations in refugee camps.

Preparedness can be prioritized by strengthening government IYCF programming in countries and adding preparedness measures in government IYCF strategies and plans. Support to governments to enforce measures for companies who violate the Code is needed. The GNC could encourage UN agencies to have their country teams take up this work.

Supporting non-breastfed infants requires specific technical skills and training, coupled with psychological support. There is therefore a need to build country capacity in IYCF-e as a preparedness measure. It was recommended that a Knowledge, Attitudes and Practices (KAP) study be supported by WHO and UNICEF on the management of non-breastfed infants to inform capacity development initiatives in those countries.

On the issue of complementary feeding in emergencies, the lack of leadership across sectors was highlighted and participants called for UN agencies, namely UNICEF, WFP and FAO, to achieve consensus and develop clear and comprehensive guidance on complementary feeding in emergencies.

In terms of programming that supports the availability of complementary foods, there is a need to promote diet diversity. When markets are functional and food is available, complementary foods can be availed to care givers through nutrition-sensitive cash approaches or social protection schemes. However, these approaches need to be better integrated within the entire IYCF response strategy and should include social and behavioural change communication

(SBCC) . When markets are not functional, the complementary feeding aspect of the IYCF response strategy should be integrated into food assistance programmes, with SBCC remaining a strong component.

On **monitoring and evaluation impact**, there is a need to work with research institutions that assess impact and the quality of IYCF-e interventions. The groups recommended updating indicators for monitoring IYCF-e by working with WHO to explore the inclusion of indicators for non-breastfed infants, including within SMART surveys. It was recommended that all GNC partners promote systematic reporting against all IYCF Sphere indicators, including those indicators on non-breastfed infants and on complementary feeding.

On the issue of planning and costing, proposed solutions included developing a standardization package to support the planning and costing of IYCF-e interventions.

Nutrition Information Systems (NIS)

1. What leadership/capacity is needed by the CLA and partners to improve NIS?

- **What are the predictable arrangements needed at global level for agencies specializing in NIS?**

There is a lack of a mutual understanding amongst partners working on NIS, highlighting the need to define and harmonize key indicators at global level.

Coordination amongst agencies leading NIS support, accountability for NIS at global level and pre-established global partnerships would also help to improve the support for NIS. This kind of coordination could help ensure clarity on roles and predictable leadership at country level for managing the national NIS. There are good examples where WFP/UNICEF/FAO have worked closely together to generate nutrition and food security information, with each agency supporting assessment, while the leadership rests with one organization. The Food Security and Nutrition Analysis Unit (FSNAU) in Somalia was able to coordinate the generation and consolidation of data from different organizations and there is much to learn from this experience.

- **Predictable Arrangements: Monitoring and Evaluation**

At country level, there are many streams of data that are outside the role and responsibility of the CLA. Fostering predictability in available data should therefore not just be about data collection, but also the scope of the data, who is collecting it, and how it can be disseminated to make change.

There is also a need to systematically identify what information needs to be collected. The Ministry of Health should have the ability to look horizontally across the data being collected beyond nutrition, and at a minimum, include information on morbidity for malaria, diarrhoea and other common childhood illnesses, without the limitations of SMART surveys or prevalence surveys. While much programme data is being collected, the analysis and ways of presenting, sharing and using the data are weak. The harmonization of performance indicators and reporting processes is also required.

- **What does the CLA need to put in place at country level?**

In countries, it is important to create understanding of what NIS entails and then adopt a systems strengthening approach to NIS. Bottleneck analysis of programmes can also be adapted to support NIS. Funding for surveys and strengthening NIS remains a challenge; there is a need for advocacy to allocate resources to NIS and strengthen the use of data at all levels. Some countries, such as South Sudan, have systematized support for leadership and quality assurance. However, in other countries, the need to build NIS capacity and strengthen data ownership by government cannot be over emphasized.

Multi-sectorial integration within NIS is minimal, especially within health. Secondly, in many countries where we have the cluster approach, the CLA does not systematically provide back up and leadership for surveys and assessments. For the CLA, thisrole should also include the ability to funnel the different systems, different actors doing data collection and bringing it all together comprehensively.

At global level, the GNC should work with the CLA to establish and manage NIS through the global NIS technical working group, and support the updating of tools and promote the systematic use of those tools at country level.

At country level, the CLA needs to account for supporting costs for data processing and monitoring activities. The CLA should also support the government by building capacity through various workshops.

There are good examples like in South Sudan, while the CLA sponsors an IM manager, a cluster coordinator, NIS specialists, while WFP supports the cluster with all the MAM information, a deputy cluster coordinator etc. which clearly means other partners can also step up to support if there is a clear leadership from the CLA. Currently, in very few country's there is predictability only around SMART surveys. Nutrition Information Systems Technical WG are established to provide support for surveys and they take the role of validating all data/survey report before they are disseminated. There is also agreement with partner on who will conducts surveys where, however, there is no predictability around data collection at global level among the GNC partners and the partner's role, the collective role in NIS is unclear.

In many countries, DHIS2 is being used for information systems, however, there is an issue around the effective use of the systems and capacity requirements, as there is a need for a password and training in order to use the system effectively. Therefore, for the DHS2 to be used effectively, the following questions need to be answered, 1) What would be the global strategy on the roll out and use of DHIS2 in NIS for emergencies, 2) Who owns the DHIS2 globally? One example was cited in Mali where the Nutrition partners gave the optimal indicators to be included into the DHIS2 but got no feedback.

The key asks were: technical support to harmonize tools that are flexible and adaptable at country levels. Even when this is developed, there will be a need for deployment of a dedicated capacity to help adapt tools in each country. Where it is the government who is taking the lead and where a government structure does not exist, then the cluster partner capacity needs to be enhanced.

Currently so much data is being generated and submitted to the cluster by partners but there is no systematic analysis of the data to be re-disseminated giving the full picture from all partners. There is a need for the CLA's support for the analysis of the various programs and assessments data as this can promote better understanding on the overall situation and how the response is progressing.

2. **How can humanitarian agencies build capacity/strengthen government systems within humanitarian programming in complex contexts like South Sudan?**

    - **Are there further examples of this?**

In Nigeria, the nutrition surveillance is done by the government bureau of statistics. There is a need to work with the data collectors from the bureau of statistics and train them. Different agencies provide trainings on interventions for Multiple Indicator Cluster Surveys (MICS), for example. Most of the reports on any assessment can be disseminated as long as they are validated by the bureau of statistics, such as District Health Information System (DHIS), Semi-Quantitative Evaluation of Access and Coverage (SQUEAC), KAP, etc.

For South Sudan, there are no issues with sharing the data, but there are challenges in accessing information from the government. Once a survey has been approved by the technical working group, an authorization letter is required from government for the report to be shared widely. In South Sudan, there is a strong DHIS2 system, yet time lags are a challenge, and collaboration with cluster partners is needed to get real-time information. Discussions with the government are needed on why and how data is used, in order to speed up the validation process and transparency. This is equally important for early warning systems and sensitive information.

In Yemen, the reporting moves from the lowest level to the highest national level through partners, in line with the government reporting system. In Syria, partners refuse to share the information from the health facility due to fear that that facility will be targeted. There is a need to liaise with the central bureau of statistics and build their capacity.

- **Where does funding for this come from? E.g. pool fund, Central Emergency Response Fund (CERF), bilateral donor funds**

Most of the funding seems to come from UN agencies, NGOs, the World Bank, USAID and pooled funds.

Discussion

A joint statement issued from WHO is required to clarify which indicators need to be included in the NIS. This will help countries embrace the guidelines and will strengthen NIS in the country.

GNC has an MoU with ACF-Canada where systematic support has been provided by ACF and CDC in L3 emergencies systematically, but on demand Therefore, through the Global technical Mechanism, this support needs to be made more operational and predictable. Participants discussed how this MoU could be made more operational when ACF or CDC has no presence in country?

Mija Ververs, Centers for Disease Control (CDC) and Johns Hopkins University, presented the new joint GNC-CDC **project on mapping** humanitarian needs and response. Based on interviews conducted by CDC, GNC partners identified the following mapping needs: 1) where the current needs are; 2) whether partners are responding to those need; 3) whether partners are at the right location with the right programmes and the right capacity; 4) quantity and location of people in need of assistance; 5) quantity and location of people assisted compared with those that need assistance; 6) population movement impacting programmes; 7) real-time and projected services of partners; and 8) scenario of crisis projected for the next three months. Outstanding issues on terminology where highlighted, namely the people in need, the caseload and the catchment area. The definition of each of the terms would need to be clarified before moving forward with the project.

Action: A working group was created during the GNC annual meeting to take this terminology work forward collaboratively.

Discussion

The group discussed the importance of clarifying the definitions to understand what is being mapped. For example, maps do not distinguish under which discharge criteria children are considered recovered. At times, politics interferes with the different calculations, for instance when calculating people in need. For example, there may be a request for the sector or cluster to justify why the number of people in need of nutrition services is increasing despite the ongoing interventions. Mija questioned the way the number of people in need is calculated and advocated for a breakdown of this group in terms of nutrition intervention types to better understand the calculations.

Day 3

Presentations and discussion

Douglas Jayasekaran of IPC explained how **Integrated Phase Classification (IPC)** acute malnutrition (AM) works where there are areas that are classified based on the acute malnutrition outcomes (i.e. prevalence of acute malnutrition) using GAM by weight-for-height z score (WHZ) and GAM by MUAC as the final outcome. The analysis also identifies the major contributing factors to acute malnutrition based on the IPC Acute Malnutrition Analytical Framework, and the severity and magnitude of acute malnutrition along with possible contributing factors.

Douglas discussed the latest development and immediate plans in IPC AM, which included a new manual (IPC Technical Manual version 3.0) and the harmonization of the three IPC scales. Trainings on the new manual and rollout of IPC AM based on the new manual are currently underway. The focus is on regional and country capacity development in IPC version 3.0, so countries are able to conduct analyses themselves with support from regional experts.

Some of the key issues remaining for discussion include: the integration of IPC AMN in national plans so that it becomes part of the nutrition situation analysis; how to address the data availability and quality; and how to make sure that the IPC analysis findings and recommendations are taken into account in the response.

Discussion

There was a strong recommendation from participants for the IPC group to add the numbers of those children suffering from both wasting and stunting, as these children are most at risk. Chronic malnutrition and the situation of non-breastfed infants were also recommended as indicators to be included in the IPC. It was also recommended that this exercise be jointly done with the WASH and health sectors.

Douglas explained that the a standalone IPC AM was included as a classification recently. Otherwise, before IPC food security was only used GAM rates and morality data to classify IPC Acute foods security situation. The need for a standalone IPC AM that uses food security data as one of the drivers of malnutrition was recommended due to the fact that, food insecurity and malnutrition outcomes do not always behave the same way, partly because health and WASH and care practices are very important drivers as well. So, the advocacy to include different indicators is still in progress. For the first time this year, UNICEF is part of the IPC committee, with Louise Mwirigi dedicated to provide support to countries and colleagues. The GNC has been part of the IPC AM technical working group and has recently need asked to be part of the Steering Committee.

Caroline Abla, ICWG Consultant, shared that the Inter Cluster Nutrition Working group identified limited capacities of humanitarian partners and clusters for multi-sectoral nutrition sensitive programming as one of the main barriers to effectively achieving nutrition outcomes in humanitarian settings. The working group developed an **inter-cluster integrated training package t**o achieve nutrition outcomes, through the implementation of other sectoral nutrition sensitive interventions. The training materials were tested in Ethiopia and Nigeria. The pilot aimed to test the usefulness and appropriateness of the materials, and the time allocated for the training, to receive critical feedback on the modules. The target audience for both pilots was the cluster coordinators and cluster partners of Nutrition, Health, WASH, Education, Protection (including GBV and Child Protection), and Food Security Clusters.

The major lessons learned from the piloting:

- Cluster/sector coordinators were able to commit for the duration of the training, and 20 were capable and willing to take the integrated action plans forward.
- The Engagement of protection coordinator during the training in North Eastern Nigeria was critical
- The attendance and engagement of the UN Office for the Coordination of Humanitarian Affairs (OCHA) is critical for coordinating and sustaining the integrated approach.
- There is a need to develop materials on the coordination and logistics of integration, including those related to emergency shelter and NFI, and Camp Coordination and Camp Management sectors
- The training presentation was “too word heavy”
- There is a need to develop a framework to support coordination and the delivery of integrated programming.

Actions: Improve training presentation; develop a facilitator’s manual; and host a session on the coordination of integrated programming.

Discussion

The timing of the training in Nigeria was ideal as planning for 2019 was ongoing and most partners were present. It was helpful having partners agree on a framework to analyze the needs together and conduct joint humanitarian planning for 2019. The advantage of OCHA being part of the training is that they took it as their own initiative.

There was discussion about the extent to which the integrated package provides opportunity to strengthen what the governments is putting in place and the opportunities to incorporate preparedness.

On the issue of measuring progress, the ICWG collected a few indicators on how to measure outcomes and impact of the training.

It was recommended that the package be made available in other languages in the field and that OCHA be encouraged to make it more systematic. Bangladesh has expressed interest in undergoing an intergration training for its partners.

Round table panel discussion update from countries threatened by famine in 2016

The panel was composed of **Anna Ziolkovska**, ex-Nutrition Cluster Coordinator for Yemen and current Deputy GNC, **Kirathi Mungai**, Sector Coordinator Nigeria, **Samson Desie**, Nutrition Cluster Coordinator for Somalia, and **Orla O'Neil**, Nutrition Cluster Coordinator for Ethiopia.

Panel members explained how and what initiated the integration with other sectors in their respective countries. In Yemen, the first step towards integration was the global advocacy lead by the GNC and the Food Security Cluster, including during the Rome High-Level Advocacy meeting in April 2016. The commitment from other clusters at global and country level pushed the work forward. For Nigeria, informal discussions played an important role in initiating integration. In Ethiopia, integration with the Health Cluster has been a natural fit for Nutrition.

The participants were asked how sectors were prioritized in the famine response plans. In Yemen, prioritization was relatively straightforward because indicators for integration were based on the three famine indicators used by IPC (elevated GAM rate, elevated mortality and severe food insecurity), as well as information from the field and other indicators from WASH and health. Technical government staff were also brought on board, as well as the other sectors, and non-technical government staff joined quickly with the realization that it could help bring more resources into the country. In Nigeria, many negotiations took place to achieve consensus. In Somalia, it was simple to reach consensus within the humanitarian team but not with the government ministries, as each line ministry advocated for resources to support its own sectoral work. In this case, the Ministry of Humanitarian response tried to facilitate consensus building between the ministries.

A question was asked about the difference between the 2011 and 2015 famine response in Somalia, and whether partners were better equipped to respond in 2015. Samson responded that the 2011 famine left a scar on the humanitarian, government, donors, and the community, inciting these actors to be better prepared with a more comprehensive response package in 2015. Most importantly, there was data provided for an early response, meaning that the number of people who died in 2015 was limited, while in 2011, the number of deaths attributed to the famine was as high as 250,000.

In terms scaling up preventative services, in Nigeria, it has been challenging to shift the singular focus on treatment. In Ethiopia, however, IYCF-e is a part of the response, with tools provided to partners, though investments in an effective surge model for response are needed in areas prone to reoccurring crisis. There is also a need to systematically combine IYCF with CMAM as much as possible. Another challenge highlighted was the weak capacity of NGOs in implementing nutrition interventions and the need to build capacities of implementing partners.

Yara Sfeir, GNC Helpdesk for Technical NiE Support, presented the **review of the Technical Working Groups** (TWGs) that was done in August, September and October 2018. The main challenges of the TWGs were highlighted, including staff turnover, the lack of commitment from the TWG's members, the lack of time, and competing priorities. TWGs spend most of their time working on updating national nutrition guidelines. The challenge of having person-dependent technical support rather than a predictable agency was also raised. The Global Technical Mechanism should address this by providing a systems approach to technical support. Detailed information can be found in the presentation on the GNC website and in the review of the TWGs report that will be published in the next months.

Action: Country actors, with UNICEF's leadership, will work on updating national nutrition guidelines as a preparedness measure.

On the **Global Technical Mechanism**, Ruth Situma of UNICEF explained the journey that led to the establishment of the Global Technical Mechanism, and its structure and leadership. World Vision International was nominated to be the co-lead for the Global Technical Mechanism with UNICEF HQ through a vetting process. Ruth presented an outline on the port of calls in nutrition in emergencies, and explained the roles of ENN, the GNC Helpdesk, the Tech RRT, and the co-leads (World Vision International and UNICEF HQ), including how the systems will be coordinated and will triage the issues arising from field teams. This triage will lead to either the deployment of a staff member or a call for nominations for a global thematic working independent expert group to address the issue. The global thematic working

group (GTWG) would need to find and formalize consensus on a certain predetermined technical issue as per set guidelines that ensure respect for commonly agreed ground rules. For certain technical issues, there would be a need to contact WHO for interim guidance or for the longer two year process of guidance development. The Global Technical Mechanism will start small and be receptive to how things evolve.

Discussion

Regarding the process for accessing the first port of call for technical support, Ruth clarified that the five entities (GNC-Help Desk; UNICEF HQ; World Vision International; Tech RRT; ENN) do not need to be contacted at the same time. Rather, representatives of the global team, namely Andi Kendle (Tech RRT), Juliane Gross (WVI), Ruth Situma (UNICEF HQ), Tanya Khara (ENN), and Yara Sfeir (GNC Helpdesk Technical Support) would need to coordinate with one another to triage the issues. An IT system will also be developed where technical issues can be inputted to automatically consolidate and generate the data.

Group Work and Presentations

Global Technical Mechanism

The main technical issues highlighted as priority for the Global Technical Mechanism to focus on were:

- Clear guidance on monitoring and evaluation tools for IYCF-E;
- Guidance on how to effectively run an IYCF support group discussion;
- The impacts of cash-based interventions on IYCF practices;
- Feeding non-breastfeed infants in emergencies, including questions around sourcing RUIF;
- The impact of IYCF interventions on stunting and wasting;
- Effective interventions for preventing stunting at scale.

Technical issues that need to be addressed for **CMAM** include:

- Procedures in the absence of a therapeutic product;
- Improving the integration of infants less than 6 months into CMAM;
- Guidance on the treatment of SAM and cholera;
- Calculating the SAM and MAM caseload;
- Guidance on CMAM coverage surveys;
- Evidence on the implementation of the simplified protocol, including guidance on stock management;
- The process for CMAM national protocol revision.

The main technical issues highlighted as priority for NIS were:

- Sampling among pastoral areas and the influence of body shape;
- Estimating dietary intake among households eating from a common plate;
- Measuring dietary diversity in surveys;
- Estimating feeding practices among children older than two.

Next steps

The GNC-CT will host a SAG meeting to further review the recommended actions from the October 2018 GNC meeting. Prioritized key actions will be included in the 2019–2020 costed work plan, followed by an outreach from the GNC-CT to partners for leadership and fundraising. An advocacy piece would also need to be developed around those priorities.

Annex 1. Agenda of the GNC Meeting

Day 1:	**Monday 22 October 2018**
Chairs:	**Ruth Situma and Anna Ziolkovska**
Objective:	**To set the scene for the GNC three-day meeting in terms of GNC strategy, objectives and focus; and to examine global level programming initiatives and country level experience and realities.**
08.00 - 09.00	Registration of participants
09.00 - 09.15	Introductions
09.15 - 09.30	Opening Remarks by Victor Aguayo, Associate Director, Nutrition Section, Programme Division, UNICEF
09.30 - 09.45	Overview of the 2018 GNC Annual Meeting objectives and focus (including introduction of market place) – Ruth Situma, UNICEF
09.45 - 10.30	Presentation of key highlights of the GNC 2017–2020 strategy; key activities and the link between GNC work and country clusters activities; summary of the outcome of the March 2018 GNC partners meeting; action and achievements to-date – Josephine Ippe, GNC Coordinator
10.30 – 10.45	Summary of key outcomes of side event meeting on Yemen and Sudan (21 October) – Ruth Situma, UNICEF and Josephine Ippe, GNC Coordinator
10.45 - 11.00	**Break**
Objective:	**To share country experiences in GNC priority topics of the humanitarian-development nexus (HDN), preparedness, and continuum of care in CMAM; and to identify key actions needed from GNC partners for progress and scale-up.**
11.00 – 11.30	**Niger (HDN) –** Considerations around HDN in a longstanding humanitarian context, including issues around policy context, coordination, health system strengthening, and transition in the face of high malnutrition burden and a fragile health system. What are the key considerations for influencing better linkages between nutrition in emergencies and longer-term nutrition programming? – Cecile Basquin, NCC Niger.
11.30 -12.00	**Bangladesh (preparedness) –** Experience in supporting preparedness actions to ensure better response to cyclic emergencies at national and sub-national level. What can the GNC learn from this experience and what are the prerequisites for making this work in similar settings? – Abigael Nyukuri, NCC, Bangladesh
12.00 – 12.30	**Bangladesh (continuum of care)** – Experiences of CMAM scale-up during the Rohingya response in Cox's Bazar, including institutional, programming and technical challenges, progress and consequences. What can we learn from this experience regarding coordination arrangements and technical support in complex coordination environments? – Ingo Neu, NCC, Bangladesh (on behalf of Sector Coordination Team in Cox's Bazar)
12.30-13.00	**Somalia (continuum of care)** – Rationale and early experiences of expanded protocol for SAM/MAM treatment in Somalia. – Samson Desie, NCC, Somalia
13.00 - 14.00	**Lunch**

14.00 – 14.30	**Global scene on continuum of care** – Update of global initiatives relevant to CMAM continuum of care (call to action, UN joint statement, products improvement, expanded criteria, research and No Wasted Lives initiative). Diane Holland, UNICEF and Alison Fleet, Supply Division, UNICEF
14.30 – 16.00	**Group Work**
	HDN, preparedness, continuum of care (CMAM)
15.30 – 15.45	**Break (included in the above time allotment)**
16.00 – 17.30	**Group Presentations**
17.30 – 18.00	**Cash and nutrition study from Somalia,** Shannon Doocy, John Hopkins University
18.00 – 18.30	**Wrap Up** – chairs of the day
18.30 – 20.30	**Reception**

Day 2:	Tuesday, 23rd October 2018
Chairs:	**Colleen Emary and Alex Rutishauser-Perera**
Objective:	**To examine country level experiences and global level programming initiatives on High Impact Nutrition Interventions (HINI), IYCF-E and Assessment, and explore practical actions for global partners and countries to address challenges to achieve scale.**
08.45 – 09.15	Summary and key highlights of Day 1 – chairs of the day 1
09.15 – 09.30	**Break**
09.30 - 10.00	**Kenya (High Impact Nutrition Interventions)** – Enabling factors and challenges in scaling-up a HINI package and integrated nutrition specific/sensitive programming in an emergency. What can the GNC learn from Kenya to enable nutrition interventions beyond CMAM in emergencies? – Victoria Mwenda, Nutrition Sector Coordinator, Kenya (remotely)
10.00- 10.30	**Yemen (IYCF-E)** – Progress and challenges in IYCF-E scale up in Yemen, including coordination, working with government, programming models and assessment. What are the challenges specific to IYCF-E and what national and international actions are needed to overcome them? – Senan Alajel, UNICEF, Co-chair, Yemen IYCF-E Working Group
10.30 -11.00	**Global overview of IYCF-E response (IYCF-E)** – Key successes and challenges in translating the Ops Guidance on IYCF-E into effective and at scale programming (HRP analysis, system requirements for IYCF-E response). – Alessandro Iellamo, Save the Children
11.00 – 11.30	**South Sudan (Nutrition Information System)** – Experiences on assessment, both progress and challenges. – Ismail Kassim, UNICEF
11.30 – 12.30	Market Place
12.30 – 13.30	**Lunch**
13.30 – 14.30	Round Table Panel Discussion I (facilitated by Ruth Situma and Carmel Dolan) – on IYCF-E, HINI, Nutrition Information systems (Central African Republic, Malawi, Mali, Mozambique, Myanmar, Whole of Syria)
14.30 – 16.00	**Group Work** HINI in emergencies, IYCF-E, Nutrition Information systems
15.30 - 15.45	**Break (included in the time allotment above)**
16.00 - 17.15	**Group Presentations**
17.15 – 17.45	**Update on Mapping: Joint GNC- CDC project,** Mija Ververs, CDC & Johns Hopkins University
17.45 - 18.00	**Wrap-up** – chairs of the day

Day 3:	Wednesday, 24th October 2018
Chairs:	**Nicolas Joannic and Caroline Wilkinson**
Objective:	**To review key updates on the implementation status of the GNC projects and other initiatives**
08.30 - 09.00	Summary and key highlights of Day 2 – Chairs of the day 2

09.00 – 10.00	Brief Global Updates on IPC AM, DHIS II Indicators - Douglas Jayasekaran, IPC-FAO Rome and Ruth Situma, UNICEF
10.00 – 10.30	Update on the Inter Cluster Working Group, feedback from the piloting of the integration training package and next steps – Caroline Abla, ICNWG Consultant
10.30 – 11.00	**Break**
11.00 - 12.00	Update on Famine Action Mechanism and Round Table Panel Discussion II (facilitated by Ruth Situma and Carmel Dolan) – update from four countries threatened by famine in 2016 (Yemen, Somalia, South Sudan and North-Eastern Nigeria)
12.00 – 13.00	Global Technical Mechanism progress update and 2019 priorities - Ruth Situma, UNICEF, Yara Sfeir, GNC Technical help desk and Andi Kendle, International Medical Corps
13.00 – 14.00	**Lunch**
14.00 – 15.00	Global Technical Mechanism progress update and 2019 priorities continued (including group work)
15.00 – 15.30	Discussion on fundraising initiatives and key actions needed moving forward – Josephine Ippe, GNC Coordinator
15.30 - 15.45	**Break**
15.45 – 16.30	**GNC looking ahead**– Key actions – Josephine Ippe, GNC Coordinator
16.30 - 17.00	Wrap Up and Closing Remarks – Josephine Ippe, GNC Coordinator

Annex 2. List of Participants

Surname	First Name	Organisation	Position	Country	E-mail
1. Abdelhafeez	Mohammed	UNICEF	Information Management Officer	Sudan	mabdelhafeez@unicef.org
2. Abdullah	Murad	UNICEF-Yemen	Health & Nutrition-Officer	Yemen	muabdullah@unicef.org
3. Abdulwaheed Moharram	Adulkawi Abdulrahman	CTG	Information Officer-Nutrition Cluster	Yemen	abdulkawi@ctg.org
4. Abla	Caroline	UNICEF-GENEVA	Consultant	USA	carolineabla@yahoo.com
5. Mungai	Reuel Kirathi	UNICEF-Nigeria	Sector Coordinator	Nigeria	rkmungai@unicef.org
6. Mlambo	Trust Takudzwa	WFP Yemen	Nutritionist	Yemen	Trust.mlambo@wfp.org
7. Abu Taleb	Ruba	International Medical Corps	Nutrition Project Manager	Jordan	rataleb@InternationalMedicalCorps.org
8. Aburto	Nancy Jennings	UN-WFP	Chief,Nutrition Specific Unit,Nutrition Div	Italy	nancy.aburto@wfp.org
9. Adarge	Mustafa Abdalla Adarge	WFP-Sudan	Nutritioin Officer	Sudan	mustafa.adarage@wfp.org
10. Aden	Abdullahi Nur	UNICEF-Somalia	Nutrition Cluster Information Somalia	Somalia	anaden@unicef.org
11. Ahmed	Hassan Ali	Action Contratelafaim	Senior Project Manager-SMART Iniative	Jordan	hahmed@actioncontrelafaim.ca
12. Ahmed Ali	Mr.Abdulakreem Nasser	MoIPC, SUN secretariat	Head of Sun Secretariat	Yemen	krmnasser@gmail.com
13. Al-falahi	Mutahar-Mohammad Ahmed	UNICEF-Yemen	Roving Nutrition Clsuter Coordinator	Yemen	malfalahi@unicef.org
14. Alajel	Senan	UNICEF-Yemen	Nutrition Officer	Yemen	salajel@unicef.org
15. Alam	Khattak	UNICEF	Nutrition Sector Coordinator	Sudan	faalam@unicef.org
16. Alarabi	Ali	Nutrition Sector	Chair CMAM TWG	Sudan	-
17. Ali	Amira	WHO	Nutrition Officer	Sudan	alia@who.int
18. AlQobati	Shabib	GNC	Information Mgt Specialist.	Switzerland	salqobati@unicef.org
19. Baker	Lindsay	Centre for Humanitarian Change Research Assistant	Centre for Humanitarian Change Research Assistant	Jordan	lindsay@checkingin.com
20. Bailey	Jerry	UN-WFP HQ	Senior Policy Advisor-Global food Security S	Italy	jerry.bailey@wfp.org
21. Wilkinson	Caroline	UNHCR Geneva	Senior Nutrition Officer	Swiss	wilkinson@unhcr.org

Surname	First Name	Organisation	Position	Country	E-mail
22. Basquin	Cecile	UNICEF Niger	Nutrition Cluster Coordinator	Niger	cbasquin@unicef.org
23. Shaker Berbari	Linda	IOCC	Regional Technical Advisor / Consultant	Lebanon	lberbari@iocc.org
24. Bontrager	Elizabeth	USAID	Nutriton Advisor	USA	ebontrager@usaid.gov
25. Tabaza	Batool	International Medical Corps	Nutrition Officer	Jordan	btabaza@internationalmedicalcorps.org
26. Butler O' Flynn	Sarah	Save the Children	Emergency Nutrition Director	USA	sbutler@savechildren.org
27. Capalbi	Margherite	Italian cooporation		Sudan	margherite.capalbi@coopitsudan.org
28. Carver	Jon	IMMAP	Representative	Swiss	jcarver@immap.org
29. Castilho De Souza	Darana	UN-FAO	Nutrition& Food system Officer	Italy	darana.souza@fao.org
30. Challier	Mrs Adelaide	Action Against Hunger France	Health and Nutrition Technical Advisor Middle East	France	achallier@actioncontrelafaim.org
31. Chidumu	Maria	MOH Malawi	Principal Nutritionist	Malawi	mariachidumu@yahoo.co.uk
32. Chowdhury	Main M.	Action Against Hunger Canada	Regional Advisor-SMART Iniative, MENA and Asia	Jordan	mchowdhury@actioncontrelafaim.ca
33. Claude	Banywesize Chigangu	UNICEF Mali	NUTRITION CLUSTER Coordinator	Mali	bchigangu@unicef.org
34. Connell	Nicki	Eleanor Crook Foundation	Nutrition Technical Director	UK	nicki@eleanorcrookfoundation.org
35. Dahab	Eman	FMoH	Emergency focal Point	Sudan	emanos56@gmail.com
36. Daher	Jana	Action Against Hunger Canada	Project Officer SMART initiative	Canada	jdaher@actioncontrelafaim.ca
37. Dolan	Carmel	ENN	Technical Director	UK	carmel@ennonline.net
38. Eltahir	Ibrahim	UNICEF	Nutrition Officer	Sudan	ieibrahim@unicef.org
39. Eltayeb	Elmuez	FMoH	Director Primary Health Care	Sudan	elmuez@yahoo.com
40. Emary	Colleen	World Vision	Technical Advisor Health and Nutrition	Canada	colleen_emary@worldvision.ca
41. Esteban	Antoine	RedR UK	Enterprise Programme Manager, RedR UK	UK	Antoine.Esteban@redr.org.uk
42. Fleet	Alison	UNICEF - Supply Division	Technical Specialist (Nutrition)	Denmark	afleet@unicef.org

Surname	First Name	Organisation	Position	Country	E-mail
43. Garelnabi	Hanna	FMoH	National CMAM focal point	Sudan	hanaakusu122@gmail.com
44. Gijsel	Stien	WFP-Yemen	Head of Nutrition	Yemen	stien.gijsel@wfp.org
45. Hanif	Muhammad Shahid	UNICEF-Malawi	Nutrition Cluster Coordinator/Emergency	Malawi	mshanif@unicef.org
46. Hibatulla	Gamila	UNICEF-Yemen	Health and Nutrition Specialist, MPH, MD	Yemen	ghibatullah@unicef.org
47. Hyatt	Loren	IOCC	Country Representative	Jordan	lhyatt@iocc.org
48. Ibrahim	Fatima	HAC	HAC Nutrition Coordinator	Sudan	fatimaibrhim121@gmail.com
49. Iellamo	Alessandro	Save the Children	IYCF-E Global Advisor	UK	a.iellamo@savethechildren.org.uk
50. Ippe	Josephine	UNICEF - EMOPS	GNC Coordinator	Switzerland	jippe@unicef.org
51. Isaack	Manyama	UNICEF-South Sudan	Nutrition cluster coordinator	South Sudan	imanyama@unicef.org
52. Jayasekaran	Douglas	IPC	IPC Nutrition Specialist	Switzerland	douglas.jayasekaran@fao.org
53. Joannic	Nicolas	UN WFP	Chief,Nutrition Nutrition In Emergencies HQ	Italy	nicolas.joannic@wfp.org
54. Jones	Sam	PU AMI-Yemen	Health and Nutrition Coordinator	Yemen	yem.healthco@pu-ami.org
55. Kendle	Andi	International Medical Corps	Tech RRT Program Manager	Spain	akendle@internationalmedicalcorps.org
56. Kerstin	Hanson	MSF-OCP	Nutrition Advisor,MSF OCP	France	Kerstin.HANSON@paris.msf.org
57. Loqman	Afnan	IOCC	Project Assistant	Jordan	atawba@iocc.org
58. Al-Khatib	Mrs Buthayna	UNICEF Jordan	Nutrition Specialist	Jordan	balkhatib@unicef.org
59. Mcgrath	Marie	ENN	Co-Director	Irish	marie@ennonline.net
60. Mekkawi	Tariq Abulgadir	UNICEF-MENARO	Nutrition Cluster Coordinator	Turkey	tmekkawi@unicef.org
61. Melesse	Samson Desie	UNICEF-Somalia	Nutrition Specialist-Cluster-Coordinator	Somalia	sdesie@unicef.org
62. Mohammad	Mezzan	WFP	Nutrition Officer	Sudan	meezan.mohamed@wfp.org
63. Mohammed Sharhan	Sindy Ahmed	BFD Yemen	Project Manager	Yemen	sindy@bfdyemen.org
64. Muqbel Bokeet	Mahfood Ali	Ministry of Health	Physician	Yemen	mahfoodali72@gmail.com
65. Nyukuri	Abigael	UNICEF-Bangladesh	Nutrition Cluster Coordinator	Bangladesh	anyukuri@unicef.org

Surname	First Name	Organisation	Position	Country	E-mail
66. Nzigndo	Yves	UNICEF-CAR	Nutrition Cluster Coordinator	CAR	ynzigndo@unicef.org
67. O'Neil	Ms.Orla	UNICEF	Nutrition Cluster Coordinator	Ethiopia	oorla@unicef.org
68. Oberholzer	Doris Anita	UNICEF-EMOPS	GNC Coordinator Associate	Switzerland	doberholzer@unicef.org
69. Oketch	Jecinter	UNICEF	Nutrition specialist	Myanmar	jaoketch@unicef.org
70. Wigren	Andreas	UNICEF-MENARO	Program Officer	Jordan	awigren@unicef.org
71. Pereira Figueira Periquito	Isabel Maria	WHO Yemen	Nutrition Officer	Yemen	pereiraisabel@who.int
72. Peter	Antony	World Vision	Emergency Nutrition Specialist	Canada	Antony_Peter@worldvision.ca
73. Phiri	Felix Pensulo	MoH, Malawi	Nutrition Cluster Co lead	Malawi	felixphiri8@gmail.com
74. Rachel	Lozano	ICRC	Nutrition advisor	Switzerland	rlozano@icrc.org
75. Kassim	Ismail	UNICEF South Sudan	Nutrition Specialist-Information Mgt.	South Sudan	ikassim@unicef.og
76. Raphael	Darline	WFP-Sudan	Coordinator Nutrition and School meals	Sudan	darline.raphael@wfp.org
77. Rizkallah	Najwa	UNICEF-Syria	Nutrition Cluster Coordinator	Syria	nrizkallah@unicef.org
78. Roy	Khrist Anugrah John	CARE	Technical Advisor Nutrition	USA	Khrist.roy@care.org
79. Ruishauser-Perera	Alexandra	ACF-UK	Head Nutrition	Swiss	A.RutishauserPerera@actionagainsthunger.org.uk
80. Sagno	Kalil	UNICEF-DRC	Nutrition Cluster Coordinator	DRC-Congo	ksagno@unicef.org
81. Sfeir	Yara	UNICEF Geneva	GNC Helpdesk Technical Support	France	ysfeir@unicef.org
82. Shoham	Jeremy	ENN	Co-Director	UK	jeremy@ennonline.net
83. Singh	Dr.Karanveer	UNICEF-Yemen	Nutrition Manager	Yemen	Ksingh@unicef.org
84. Situma	Ruth	UNICEF-HQ	Nutrition specialist	USA	rsituma@unicef.org
85. Sofia	Yahya	DFID-Yemen		Jordan	S-Al-Saydi@DFID.gov.uk
86. Summers	Dr.Aimee	CDC,Diseases Control	Epidemiologist, Emergency Response	USA	ydj1@cdc.gov
87. Tamiru	Mathewos	UNICEF-Ethiopia	Nutrition Specialist, IMO	Ethiopia	mtamiru@unicef.org
88. Tanaka	Julie	SAMARITAN'S PURSE	Senior Nutrition Advisor	USA	jtanaka@samaritan.org

Surname	First Name	Organisation	Position	Country	E-mail
89. Tesfai	Casie	Intern Rescue Committee	Senior Technical Advisor Nutrition	USA	Casie.Tesfai@rescue.org
90. Thurber	Melanie	USAID	Nutrition Advisor-USAID	Ethiopia	mthurber@usaid.gov
91. Tyler	Vilma	UNICEF-MENARO	Senior Nutrition Specialist	Jordan	vtyler@unicef.org
92. Ververs	Mijatesse	Johnd Hopkins/CDC	Senior Associate/Senior Nutritionist	USA	mververs@jhu.edu; mververs@cdc.gov
93. Walia	Sonia	USAID/OFDA	Public Health and Nutrition Advisor	USA	swalia@usaid.gov
94. Wynne	Aileen	Goal	Roving Nutrition Advisor	Ireland	awynne@goal.ie
95. Yassin	Rwada	SMoH, South Darfur	Nutrition Director	Sudan	rawda665@gmail.com
96. Zain Alsakkaf	Ensejam Mohammed	Ministry of Health	Physician, Nutrition Department head at MoPHP	Yemen	ensejamzain@gmail.com
97. ZEITOUNY	Joelle	FEWSNET	NUTRITION COORDINATOR	Global	jzeitouny@fews.net
98. Ziolkovska	Anna	UNICEF	Deputy Global Nutrition Cluster Coordinator	Switzerland	aziolkovska@unicef.org
99. Zita	Weise Prinzo	WHO	Senior Nutritionist	Switzerland	weiserprinzoz@who.int
100. Qutab	Alam	UNICEF	Information Management Specialist	South Sudan	qalam@unicef.org
101. Rodriguez Corrales	Javier Rigoberto	UNICEF	Nutrition Cluster Coordinator	Mozambique	jrodriguez@unicef.org
102. Mohammed Elhassan	Ibtihalat	SCI	Nutrition Specialist	Sudan	Ibtihalat.mohamed@savethechildren.org
103. Gaafer	Nada	FMOH		Sudan	nadajafar@gmail.com
104. Aguayo	Victor	UNICEF - HQ	Associate Director, Nutrition	USA	vaguayo@unicef.org
105. Ali	Javid	IMC, Jordan	Health Coordinator	Jordan	jaali@InternationalMedicalCorps.org
106. Doocy	Dr.Shannon	JHU	Associate Professor – Johns Hopkins School of Public Health	USA	Doocy1@jhu.edu
107. Fernandes	Ms. Christine	SCI Syria	Whole of Syria Nutrition Co-Coordinator	Syria	Christine.fernandes@savethechildren.org
108. Al.Samman	Ms. Sura	Observer	Nutrition Specialist	Jordan	Sura.walid@hotmail.com
109. Shtaiyat	Iyad	UNHCR Jordan	Public Health officer/Zaatari Camp Focal Point	Jordan	shtayiat@unhcr.org
110. Al-Quran	Ms. Samah	UNHCR Jordan	Public Health Associate	Jordan	Alqurans@unhcr.org