**Nutrition Sub-Working Group Meeting 13th May 2014**
**Updates and Action Points**

**Attendees: Hanan Masa'd (MoH); Sura Alsamman, Hannah Kalbouneh (SCJ); Ann Burton, Yara Romariz Maasri (UNHCR); Dr Nada Alward (IMC); Ruba Abu Taleb (JHAS); Suzanne Mboya (UNICEF/SCJ); Peter Voegtli (WFP); Buthayna Al-Khatib, James Kingori (UNICEF); Jo Weir (Medair); Anusara Singhkumarwong (ACF)**

| Discussion point | Action Point |
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| **1. Review of action points of previous meeting**<br>• All organizations doing MUAC screening are now using the same MUAC tapes<br>• ENN shared guidance on calculating additional breastfeeding indicators with the Nutrition Survey consultant<br>• SCJ followed up on a gluten-free product to treat malnutrition; PediaSure, not a local product but available locally, is both gluten- and lactose-free, but expensive, at 8JD for one pack. Can only be used for children under one if prescribed by a doctor.<br>o Many children with malnutrition have underlying problems, need to look at proper paediatric assessment for individual cases.<br>o When sourcing alternative products, need to make sure they are not produced by companies who violate the BMS code.<br>o Need clear guidelines from MoH on what resources and support are available for | **Soft copy of IMAM field cards to be circulated**<br>**UNHCR to put Zaatari anaemia report on portal**<br>**UNHCR will follow up to make sure additional breastfeeding indicator is included in survey findings** |

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| children with metabolic disorders. PKU is included in their guidelines, and screening is being done for it; galactosemia, however, is not included.<br>▪ UNICEF has seen cases in Jordan Valley where people associate galactosemia with breastfeeding and stop breastfeeding completely.<br>▪ Guidelines may need to be updated.<br>▪ At the Health Coordination Meeting, Dr Tarawneh reported a 10% increase in screening of newborns. Screening is done for PKU, G6PD and congenital hypothyroidism. | **MoH to share national guidelines electronically** |
| 2. **Update on the Nutrition Survey**<br>Presentation on preliminary results was done by the consultant at UNHCR on 4th May. Main points:<br>• Level of GAM is very low; 1.2% in Zaatari by weight for height, and 1.5% by MUAC; stunting was 17%.<br>• Outside the camp, GAM was 0.8% by weight for height, and 0.4% by MUAC; stunting was 9%.<br>o Confidence intervals overlap for the stunting.<br>o In Jordanians, according to 2010 survey, stunting was 2.8 %. A new survey is expected in 2015. | **UNHCR to circulate preliminary results presentation** |

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| • High incidence of anaemia<br>  o In Zaatari: children 6–59 months, haemoglobin less than 11 grams/dl: 48.7%; women 15–49 years: 44.7%.<br>  o Outside camp: children 6–59 months, 25.9%; women 15–49 years: 31%.<br>  o Here the confidence intervals do not overlap, difference between those two populations.<br>• Still waiting for complete results.<br>• Comment: comparing weight for height with MUAC, out of camp the incidence of GAM is higher by weight for height, and this is consistent with what we see in the region; but camp results are other way around, why this level of inconsistency? Should be addressed in the results.<br>• The survey is routine surveillance/ situation analysis, not a comparative study. | |
| **3. Vitamin D in pregnant and lactating women, and infants**<br>• There is no strategy for distributing Vitamin D in Jordan because flour here is fortified with ten micronutrients (including iron and Vitamin D), following WHO recommendations. Fifteen mills around Jordan produce 92% of all the flour used in the country, including that which is distributed to bakeries.<br>• Problem with Vitamin D is with children under one year, because they don't eat bakery bread. There is some talk of supplements, after a study showing prevalence of deficiency is | |

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| high because mothers are deficient.<br>  o Women of childbearing age: 60.3% (less than 12 nanogram cut-off point)<br>  o Children over 1 and under 5: 19.8 % (less than 11 nanogram cut-off point)<br>  o Supplements may be distributed with measles vaccine and MMR. Already distributing Vitamin A.<br>• Vitamin D is a problem in the Middle East: pregnant women, non-pregnant and infants, who are born deficient.<br>• In European countries and in the US, it is recommended that 400 international units of Vitamin D a day be consumed until one year (for both breastfed and non-breastfed children).<br>• Is amount of sunshine taken into account? This part of the world has more sunshine. But women are more covered, and children are rarely exposed to the sun.<br>  o Level of Vitamin D comes at certain times during the day, especially noon, when most people stay indoors.<br>  o In the Gulf area, prevalence of deficiency is 80%.<br>• Do we see the consequences of it here, such as rickets in children? Yes. But rickets is the end product of the deficiency, you also have cases that are asymptomatic.<br>• Even the studies, the cut-offs are not the same. Still need to do more control. Cut-off needs | |

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| to be based on a clinical outcome.<br>• In a study done in Egypt, for children found to have Vitamin D deficiency, one theory was timing of exposure to sun, another was a dust layer on the skin which limits infiltration of the rays.<br>• We should not rush into anything for refugees, wait until the Ministry makes a recommendation.<br>• Main issue here is doctors in Zaatari advising mothers against breastfeeding; we should discuss this with the doctors in the camp. In terms of supplementation, will leave that up to MoH. | **UNHCR/SCJ to follow up on doctors in the camp advising mothers to stop breastfeeding** |
| **4. Review of Nutrition Plan of Action (POA) and draft Nutrition Intervention Strategy amongst refugees in Jordan**<br>• Developed in May 2013, sets out rules and responsibilities in NWG to ensure minimum package of interventions, plus timeline. We used it until late 2013, have now updated it. Divided into different categories, with different plans for each category.<br>• As part of the POA, NWG agreed on a few interventions based on age group (children, PLWs, elderly).<br>• Considering having a full-day session to sit together and work on this.<br>• The Nutrition POA sets out responsibilities, interventions, timeline; the Nutrition Interventions document is part of the POA, and intends to be a matrix of activities (who is | **POA, regional strategy and nutrition interventions** |

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| doing what where), and targeting who.<br>  o The Nutrition interventions document other one is part of the POA, to have another document with nutritional interventions, who's doing what, targeting who and in what areas.<br>  o Table also shows us what needs to be done, where we have gaps, where no one is covering an intervention.<br>• We should define which activities constitute a complete intervention; if an organization says they are doing an intervention, need to clarify exactly what is being done.<br>• Regional strategy also comes in here. We want to move away from the emergency response and closer and to what MoH is doing with national POA.<br>• We need to look at NCDs as well.<br>• Before we sit to discuss the POA, we can look at regional strategy and see what we can include from it. We know after Nutrition Survey that we don't have a major malnutrition problem, but maybe iron deficiency.<br>• Currently focused a lot on nutrition-specific activities, a lot of work can be done with other sectors, critical component of the response.<br>• Would be good to have WFP/REACH CFSME results, even if not final. | **document to be circulated**<br><br>**Group to meet on Tuesday 20th May to discuss POA and interventions.** |
| **5. IYCF regional matrix an BMS questionnaire** | |

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| • Matrix was developed to have an idea of who is doing what, where. Was shared with organizations doing IYCF in Jordan. Can be circulated more widely.<br>  o Important to differentiate between what is planned and what is being done.<br>• BMS questionnaire is just to see if these SOPs are being followed, one page questionnaire to be filled by agencies (Food Security, Health and Nutrition).<br>• Any suggestions, clarifications to the question, forward to Suzanne.<br>• This activity is also taking place in other countries – Syria, Lebanon, Iraq and Turkey. Trying to look at the gaps in order to address them.<br>  o Technical gap, especially with high staff turnover.<br>• The vision is to have a package for IYCF. A lot of people are very keen to know what is happening in the Syria response. After this we will come up with a regional and country-specific strategy for IYCF. | **Circulate IYCF matrix, BMS questionnaire to Health and Food Security Sectors, plus NWG**<br><br>**Circulate BMS distribution SOPs to NWG, Health Sector and NFI Sector** (as they deal with donations) |
| **6. Alternative report on CRC with focus on IYCF**<br>• Every five years, the Committee on the Rights of the Child (CRC) produces a report on the position of a country in regards to the Convention on the Rights of the Child, commenting on different aspects related to each article of the convention.<br>• Jordan report will be submitted by MoH, but ENN is writing a shadow report, which NWG has been asked to comment on. Need to agree on an approach. Statistics, facts | |

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| should come from MoH.<br>  ○ Have been asked to comment on both Palestinian and Syrian refugees in Jordan, but can only comment on Syrians.<br>• SCJ and JHAS have also been asked to write about their own experience with IYCF.<br>• There is some confusion about whether or not the shadow report has already been submitted, by Ministry of Foreign Affairs. | **UNHCR and SCJ to follow up with UNICEF on the shadow report** |
| **7. Nutritional surveillance in MoH facilities**<br>• SCJ and UNHCR met with Dr Tarawneh to discuss the plans for nutritional surveillance in MoH facilities, which were partially implemented but not completed due to a few challenges. Report on this was circulated to NWG.<br>  ○ Protocol was developed by WHO regional office.<br>  ○ Health workers were expected to do the surveillance on top of their other duties and the protocol was quite extensive, involved weight for height in children, BMI in women of reproductive age, haemoglobin, among others.<br>• It might be better to recommend surveillance and every two years a survey, rather than doing it in a health facility.<br>• In 2010 a pilot study was done all over the country. Not all health centres have suitable measurement devices, like unit scales; they work with electronic scales, and devices are | **Re-circulate the report from Dr Tarawneh on nutritional surveillance** |

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| not well-calibrated.<br>○ Reports came in from all over the country and have been published on MoH site.<br>○ MoH needs a lot of weighing scales and height scales → why not submit a proposal to the NRP? There is a project on nutritional surveillance.<br>• Two different issues: one is clinical management, what devices and equipment are needed at clinic level; the other is what data you need for decision-making. If there are concerns about quality, better to do a survey every now and then. If you are getting poor quality data from the clinics, people will question it. Rely on national survey, and focus on what equipment is needed for management of patients, rather than nutritional surveillance.<br>• Once you generate the data, what do you do with it? Needs to be thought through. In 2002, with the results of first nutritional survey for Jordanians, iron deficiency programme was addressed. We need reliable data.<br>• Will discuss the issue again next meeting. | |
| **8. Agency updates**<br>• SCJ: tomorrow will be first day in Rabaa Sarhan, MUAC screening will be done at that point for children under 5 and PLWs. Nutritional snack will be provided for mothers in the caravan. Infant formula process will be clarified; will explain there is no distribution of formula in the camps, only prescription for medical cases. SCJ keeps tally sheets (total screened, number of SAM and MAM cases identified) and | |

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| another list with contact info.<br><br>○ 2014 report on mothers in crisis is now out, looking at crises in the US, Syria, Congo and Philippines (download here). Two case studies from Zaatari are included. At the end of the report there is a ranking of countries, Jordan is number 95. Ranking based on maternal health, children's well-being, economic status, political status, and educational status.<br><br>○ SFP: next blanket distribution for SuperCereal Plus in Zaatari will cover children aged 6–59 months, also started distributing to cerebral palsy cases above 2 years, in coordination with NHF.<br><br>• JHAS: during nutrition survey, moved screening south (Tafila, Karak, Queira and Maan), found three SAM cases and three MAM cases. Currently doing distribution on a weekly basis.<br><br>○ Yesterday found one case in Queira (Aqaba governorate) of a SAM child whose mother is also malnourished. Child was given PlumpyNut and mother, SuperCereal. Child had underlying problems, diagnosed with brain atrophy after the incubator he was put in after birth had its power supply cut when the hospital was bombed in Syria. Was referred to Prince Hashem Hospital in Aqaba.<br><br>• IMC: have been in Azraq since day 1, were receiving cases who had not been screened for malnutrition. Treating SAM cases in Azraq, while MAM will be treated by ACTED. Met with them earlier this week to suggest IMC take over MAM until | **SCJ to provide IMC with list of cases after screening in Rabaa** |

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| ACTED has capacity to do so on the ground, but ACTED will start blanket distribution of SuperCereal Plus soon.<br>o For Azraq, screening process to be decided upon need. IYCF counsellors are provided with MUAC tapes. | **Sarhan**<br><br>**Discussion to be had in Azraq regarding targeted and/or blanket distributions of SuperCereal Plus** |
| 9. **AOB**<br>• UNICEF: we need to look at level of investment as far as nutrition responses are concerned, can one organization do it? We need to see how many cases we are talking about, will help a lot in projecting supplies, etc.<br>• RRP6 revision discussed at Health Sector meeting two weeks ago, separate meeting held RRP 4th May. Database instructions were sent around yesterday.<br>o No major changes in the situation, target stays 800,000 total (200,000 in camps, 600,000 out of camps; including 250, 000 new arrivals). No changes to overall objectives of the plan.<br>o Size of appeal needs to come down. Aim is to reduce. Some activities will be moving to the NRP. Guidelines will be sent around.<br>o Nutritional surveillance, for example, would go under NRP.<br>o For projects that are 0% funded, we need to look at whether they're actually going | |

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| to stay in. If you haven't received funds for 12 months, size of appeal must go down, staffing costs, consumables will no longer be over 12 months.<br>○ If you're not sure about whether or not something should go under RRP or NRP, we can discuss. If we don't agree, will go to the ISWG, if there is no decision there, goes to IATF.<br>• SCJ has come across a case in Zaatari with tyrosinemia who refuses to follow up with them. She does, however, go to a doctor outside Zaatari, and they have her on a specific diet.<br>• BMS code has not yet been endorsed by Jordan, but is being reviewed, MoH is taking the lead, had a meeting last week; now it's with the legal advisor. There is a deadline for it to be finalized before Ramadan to be launched in first week of August for breastfeeding week. | |