Nutrition Sub-Working Group Meeting 14th July 2014
Updates and Action Points

Attendees: Ann Burton (UNHCR), Ola Sharif (IMC), Gabriele Fänder (Medair), Henry Sebuliba (WFP), Anusara Singhkumarwag (ACF), Hannah Kalbouneh (SCJ), Dr Amiri (UNICEF), Peter Voegtli (WFP), Reema Al Najjar (WFP), Suzanne Mboya (UNICEF/SCJ), Basma Al Hanbali (SCJ), Sura Al Samman (SCJ), Ruba Abu-Taleb (JHAS), Maysa AlKhateeb (UNFPA), Omar Dihmis (UNHCR), Omar Obeid (IMC)

Discussion point	Action point
1. Review of action points of previous meeting • Draft report of nutrition survey shared with MoH • Received feedback from partners on strategy • All comments compiled into one document, to be discussed today • SCJ to share email on report ?? • SCJ contacted Dr Sawfan on neonatal screening guidelines – he is currently on leave, waiting for him to come back – national guidelines on screening started in 2009 – covers 29 conditions (don't know if its implemented in all hospitals) – introduced by Princess Haya Biotechnology centre in 2009. Problems with guidelines in public hospitals– will try to contact Dr Safwan next week. Main issue is whether they are following the guidelines or not. Is it still valid as from 2009? Information found online. • SJC to meet Dr Bashir and share draft guidelines on iron droplets – met Dr Bassam but Dr Bashir is very busy hasn't found time to go through guidelines. Will try again after Ramadan • WFP to bring supercereal post distribution monitoring results to next meeting – don't have them but it is being sold. When sale started – 65 piasters a bag, dropped to 25 piasters. Now it is 10 piasters/bag. It is a big number but can't quantify it (about 40-50% in camp). Who is end user? It can be sold to feed animals. (bag = 1.5kg). CSB given to animals. Yesterday, people refusing to take it. Not being sold. • Management in Azraq – WFP to provide feedback on measures in Azraq. ACTED supposed to be doing this. IMC would like to take MAM (see agenda item relating to this) • Raba Sarhan – SCJ to check SAM screening – 2533 people – 10 SAM and 51 MAM cases from 14th May to 10th July. GAM rate of 2.9%. End of each month GAM data sent to all partners as identified in Raba sarhan • IOCF focus groups – SCJ from focus groups. It is in finalization stage. Will share findings in first meeting after Eid. • Facts sheets discussed as its on agenda – sent to Yara to circulate. • JHAS check SAM cases have underlying conditions. After meeting – all SAM and MAM cases to be shared. Currently in program in Zaatari, only 7 SAM with underlying conditions. About 14% children have underlying conditions. MAM feedback – underlying conditions – 4 CP cases, 1 tyrosinemia, 1 stoma (referred to JHAS, 1 cleft palate, low birth weight diarrhoea, 2 heart conditions, lack of mother hygiene, lack of appropriate IYCF. Both medical and other causes. Better to split medical and hygiene? For SAM cases can we get paediatric review of all cases as we may be missing other underlying problems. MAM not necessary because there are so many. Should be paediatric follow up regardless	

whether it's SAM or MAM in order to discard any acute conditions. At the moment, looking for standard complications but they're not looking for underlying conditions and it's not paediatric doctor it's a GP doing assessment. Average weight gain of patients shared with Ann. When we look at monitoring of SAM and MAM we will look at this.	
2. Update on the Nutrition Survey/Discuss recommendations • Comments received as of 2 weeks after 30th June meeting from WFP already consolidated comments from different agencies – already sent to consultant – still waiting for final comments from WFP. UNICEF sent comments yesterday – separate meeting for that next week. Immunization coverage also includes routine vaccinations - this need to be clarified. Children over 18 months should have had 4 doses regardless of campaigns – not monitoring effectiveness of campaign it's combined routine and campaigns. Wash also needs to be discussed? • Need to start discussing nutritional products seeing as it took 8 months last year (April to January). We need blanket distribution for children. We need some clarity. • Waiting for WFP food security feedback on survey • WFP to discuss options of which product to use for blanket feeding in 6 to 23 months and MAM next week •	• WFP to provide inputs on food security in survey as soon as possible. • UNHCR and UNICEF to meet to discuss WASH and immunization • WFP to discuss possibility of reducing price of Saha with manufacturer/distributer
3. Review the nutrition response intervention and feedback from partners • All partners feedback except JHAS compiled in document • Could be compressed – much shorter. – Under activities don't need to indicate every message e.g. for the children 6-59 months first two could be combined. We will have to line up activities with interventions. • How are high risk groups that need systematic screening identified? I- pregnant women and children with SAM and MAM. Also children with chronic conditions. Hemocue screening is expensive so it should be focused on those who are at most risk. Children under 2? A lot of children… MAM and SAM good high risk population. Should we screen them if they're already SAM/MAM. Screening for 2anaemia…We are talking about treatment not prevention. Most children who have SAM/MAM have diarrhoea etc they don't absorb iron. If severe need treatment even if on RUTF or Supercereal. Guidelines say you don't give iron in first 2 weeks of SAM management – a lot of recommendations about this. Now we are talking about screening not management. Need to identify children then manage them. Supercereal and Plumpy'nut don't treat 2anaemia. 70% mild anaemia – majority. This is why we're talking about high risk groups – targeted and why we don't want to do blanket screening. Cheaper to target 6-23 months children without doing measurement of anaemia. There are high risk children and women so we're talking about should we do something to identify them? Need to do something for children 6-23 months, Pregnant women. • Many cases of thalassemia found in Syrian population in Lebanon – same situation here? Have there been any reports here? We have looked at extent of anaemia caused by thalassemia minor – about 5% - it is a factor but it doesn't account for the very high levels of anaemia. Pregnant women, SAM/MAM and ?children under 5 with certain chronic diseases are the high risk groups. Any other high risk groups to be identified and screened? • Vit D for PLWs? WHO guidelines for Vit D supplementation in pregnant women. Has some members from Jordan –	• UNICEF to add activities to the strategy relating to micronutrient fortification and Baby Friendly Hospital Initiative. • UNHCR/SCJ to shorten the strategy and recirculate. • Agencies asked to review and put which activity and location.

mentions that VitD supplement not recommended in pregnancy – only through diet – no supplementation recommended. (Harmful or just not recommended? – some conditions can result from VitD deficiency not recommended to try prevent these conditions with VitD supplementations) guidelines from 2012. Names from Jordan? Dr Hiba Bawadi and Wissam Qarqash from MoH. • Rates C-section – exceeds 20%. Educate mothers on early initiation of breastfeeding. Many women approach C-section thinking it's easier. Last year in Zaatari 17% and outside camp around 20%. Its still acceptable levels (ideal = between 5%-15%). Main problem is poor IYCF practices afterwards. Some doctors can't deal with complications so go for planned C-section plus they do it for money. It is unfortunately both commercial and the practice itself. Birth attendant's skills also under question. Problems mainly with doctor – mother's influence is very low. Turning this around is very difficult. We need to deal with doctors by changing behaviour can't do this with one training course. From a nutrition point of view – C-section not the issue, it's the practices relating to baby friendly hospital initiative which are not in place. Add activities anyway to the document (UNICEF). • Could packaging be the problem? In cooking demonstrations everyone eats it so this should encourage refugees. We have cooking lessons in camps and tried to add flavours to the supercereal and we are still facing the same problems. Could be cultural difference – supercereal special to them. They think its cheap etc. They refused Plumpy'nut but when they saw their children improving, they started warming to it. Saha costs $3000, Supercereal $1200 per metric tonne. Anthropological research outside camp shows people overwhelmingly don't like the cereal. Post-distribution monitoring country-wide outside camp would be interesting to see. For blanket distribution- May; 8258. June; 2304. Huge decrease. • Expiry date for Supercearal. Can we fill gap between it and new product (August and another time) with Saha. Can we negotiate Saha price if we're buying in bulk? Problem in changing? We have learnt that we need to do acceptability study – using different products etc before implementing product. We want to use product that can be used for prevention and treatment – Supercereal most appropriate. This was done with Saha – for prevention and treatment of MAM. Product expires in August. Need to give a product in September and October. If Supercereal is cheaper – best option. Even if its cheaper, they were giving to animals. It's not used, this is the bottom line. Waste. Problem is if you want to make age appropriate. Officially – 13,000 children aged 6 to 23 months in Zaatari. • This is very urgent, we have nothing in place for treatment. Logical solution to treat with Saha until another solution is found. For the treatment, number of cases if very small so Saha may be solution and check if we can reduce it – discuss possibility with them. • Regarding children's need for special formula – why not treat those patients (e.g chronic conditions) they have located budget for medication –can we follow ECC approach with these children? E.g PKU patients - can't be breastfed need special formula. Could we treat these cases individually? Are there many children in this situation and what's happening to them now. Don't have figure for how many. These children should just be covered with regular budget. In Jordan they are treated by MoH. Metabolic disorder – under different category to chronic condition (which includes diabetes) • We have 3 cases in Zaatari and 1 case in Azraq (2 year old) who need soy milk (coeliac disease that led to lactose intolerance) – should be managed by health agency. Do we have medical reports that they need lactose free formula? What is process? IMC and JHAS in Zaatari should provide formula if that is what is recommended by health agency.	• Children with nutritional requirements due to medical problems e.g. metabolic disorders should be managed by the health agencies

4. Review nutrition fact sheet • For nutrition working group. Most data comes from nutrition survey – primary result. Some information missing for 2014. Could everyone review it once? – would be helpful. • Main gaps: under response – should we put the where and who In this table? Challenges – left blank. Way forward – put as summary. • Feedback: everyone should send comments and compile it? Asked for this didn't work. 5 minutes now to look at it and discuss. o Nice to have some photos of e.g children being weighed etc. o Acute malnutrition needs to take much less of a focus in "Way forward", emphasis should be on IYCF and micronutrients. o Change target to 6-59 months. o Surveillance: yes but not facility based – more on annual/periodic surveys. o Table regarding key indicators: way data was collected before is not the same. 2012 and 2014 is different. Use 2014 standard indicators as opposed to 2012. o Remove "where" column from response table. o Key challenges section? Pre conflict IYCF practices. o Can everyone send a few points for the key challenges in terms of implementation part of program. o UNFPA to send data on population of WRA. Estimation of 23% and 10% of the 23% are pregnant. o Everyone's logo on it as well.	• Send in some nice photos for the fact sheet • Each agency to send a few points for the Key Challenges in terms of implementation part of the program. • UNFPA to send out population data of women of reproductive age. • Logos of each agency to be added
5. Update on the SFP program (camp and community) • JHAS: As of June 8th started blanked distribution of Supercereal for children < 5 not to PLWs. On-going selective and blanket feeding programs. Children diagnosed as moderately malnourished undergo SFP program. Mothers advised to use within 1 month of buying. Don't use word expiration. Blanket distribution going well in community and within JHAS clinic. • SCJ: Blanket distribution for women started yesterday. Providing tokens in clinic. 170 pregnant women above 1st trimester. For 6-59 months – 3204 people for June. Updates for May o Cure rate: 64% o Defaulter rate: 27%. o Recur rate64% Updates for June o Cure rate: 61%	

○ Defaulter rate: 39%. ○ Recur rate: 61% • Medair – 227 patients enrolled in program for June. End of June started in community. Positive uptake of program. Cooking lessons in evening. Don't have figures as of yet.	• Medair /JHAS to collect standard indicators of default, failure, death etc in SAM and MAM programmes
6. MAM management in Azraq • Contacted WFP regarding this and there is a meeting very soon (with UNICEF as well). IMC willing to take it. WFP contacted by UNICEF; they made it clear that they support age appropriate distribution and that MAM children have access to this. However no monitoring of MAM chidlren UNICEF can possibly support referral of cases to SCJ to put something in place. Meeting very soon to see how this can be coordinated – same way working in Zaatari • Cost implications – WFP funds MAM management. No agreement with IMC but agreement with SCJ. Meeting should deal with this.	• Meeting very soon between UNICEF, WFP, SCJ and IMC to discuss how coordination of MAM management in Azraq
7. BMS in urban settings and BMS on the borders • Issue of donations: lately 150,000 cans of infant formula offered as donation. Take small quantity from this for Azraq and Zaatari but what to do with the rest? Don't distribute in urban settings. Do we want to go through this in JHAS clinic? • Jordan Army asked for breast milk substitutes to be present at border due to refugee crossing. • Really difficult to control in community – formula is everywhere. Maybe to be present in JHAS clinic under prescription to those who really need it. Needs to be strictly controlled – security issue. Once refugees hear that they are distributing, staff in danger. Plus affects UNICEF work. Some Jordanians cant breastfeed and aren't being helped. UNICEF meeting with ICRC next week on this issue. • In community there are Jordanians – they will be excluded if they come to clinic? • Question of sustainability of distribution. • Generally don't think it's a good idea. For those people who can't breastfeed – should have option of providing them with cash assistance. They go to pharmacy and buy it and not seen as being given it. WHO guidelines excludes many women so physical examination was introduced. Best case – refer to these guidelines. It is not common of not being able to breastfeed and some women who have stopped can relocate. Need to come up with a statement as to why we don't provide at the border. • Draft statement that includes criteria.	• SCJ to draft statement as to why it won't be distributed that includes criteria
M&E for nutrition interventions • Due to time constraints, these last agenda items will be left to next meeting	
Agency updates	

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