

REPORT

of

The Third Meeting of the WHO-UNICEF Technical Expert Advisory group on nutrition Monitoring (TEAM)

15-16 September 2016
WHO Headquarters
Geneva, Switzerland

October 2016

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Acronyms

AARR	Average annual rate of reduction
AGRIS	Agricultural and Rural Integrated Survey
ANC	Antenatal care
ANI	Accelerating Nutrition Intervention
BF	Breastfeeding
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
DHS	Demographic and Health Surveys
EBF	Exclusive breastfeeding
FAO	Food and Agriculture Organization of the United Nations
FIES	Food Insecurity Experience Scale
FLW	Frontline worker
GDD	Global dietary database
GIFT	Global individual food consumption data tool
GNMF	Global Nutrition Monitoring Framework
GODAN	Global Open Data for Agriculture and Nutrition
HIC	High-income country
IFA	Iron and folic acid
INDDEX	International Dietary Data Expansion
IYCF	Infant and young child feeding
JME	Joint child malnutrition estimates
LIC	Low-income country
LMIC	Low- and middle-income countries
LSHTM	London School of Hygiene and Tropical Medicine
MAD	Minimum acceptable diet
MDD	Minimum diet diversity
MDG	Millennium Development Goals
MERG	Monitoring & Evaluation Reference Group
MI	Micronutrient Initiative
MICS	Multiple Indicator Cluster Surveys
NCD	Noncommunicable diseases
NIPN	National Information Platform for Nutrition
NLiS	Nutrition Landscape Information System
PARIS21	Partnership in Statistics for Development in the 21st Century
SD	Standard deviation
SDG	Sustainable Development Goals
SMART	Standardized Monitoring & Assessment of Relief & Transitions
SPRING	Strengthening Partnerships, Results and Innovations in Nutrition Globally
SUN	Scaling Up Nutrition
TEAM	Technical Expert Advisory group on nutrition Monitoring
ToR	Terms of reference
UNICEF	United Nations Children's Fund
WG	Working group
WHA	World Health Assembly
WHO	World Health Organization
WPHNA	World Public Health Nutrition Association

List of Boxes

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1. INTRODUCTION

In 2015, WHO and UNICEF established an independent Technical Expert Advisory group on nutrition Monitoring (TEAM) to advise on enhancing nutrition monitoring at all levels. The TEAM is also expected to help identify emerging research questions and needs related to nutrition monitoring and to recommend action to develop or refine indicators and methods for the Global Nutrition Monitoring Framework (GNMF). A specific immediate focus of TEAM is completing development of an extended set of indicators to monitor the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition consistent with the global nutrition targets decided by the World Health Assembly (WHA).

TEAM is a gender- and regionally balanced group of ten technical experts with support provided by a joint WHO-UNICEF Secretariat. TEAM members use their networks to reach out to other experts and agencies for collaboration. Thematic sub-working groups are convened as needed.

The roles and responsibilities, scope and purpose, and operational modalities of TEAM are described in its Terms of Reference.¹

The first TEAM meeting was held in July 2015 in Geneva, Switzerland, and a workplan for the first two years drafted with six main work areas: (i) WHA nutrition target operational guidelines; (ii) prevalence ranges for malnutrition (stunting, wasting and overweight); (iii) Rules for assessing progress towards achieving the six WHA nutrition targets; (iv) anthropometry data quality; (v) a research agenda for global nutrition monitoring; and (vi) engagement with other partners.

The second TEAM meeting, held in New York in February 2016, consisted of an open half-day session with invited partners and a closed session of one and a half days for TEAM members. In the first session, the WHO-UNICEF Secretariat briefed partners on the structure and functions of TEAM and modalities of partner engagement. Partners provided input on priorities as well as modalities for their engagement. In the closed TEAM meeting session, work progress on items pertaining to the drafted two-year work plan was presented and discussed, and the work plan was finalized taking into consideration partners' inputs. The reports on the partner session² and the 2nd TEAM meeting³ were shared with all concerned.

The third TEAM meeting was held in Geneva, Switzerland, September 15-16, 2016. This report includes the summary of discussion from the TEAM meeting sessions (see the agenda in Annex 1 and participants list in Annex 2).

This report and all background documents and PowerPoint presentations of the third TEAM meeting are available at the TEAM SharePoint maintained by WHO's Department of Nutrition for Health and Development (<https://workspace.who.int/sites/nutrition/TEAM/SitePages/Welcome.aspx>). Please contact Ms Jo-Ann Rivera Muriel (murielj@who.int) for access.

2. MEETING SUMMARY

The six main areas of work as outlined in the TEAM's two-year workplan were discussed. The issues discussed on each topic and next steps are summarised below.

¹ Terms of Reference for the WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM), Draft 24 February 2015.

² Report on The Joint session of WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM) with Partners, 4 February 2016, UNICEF House, 3 UN Plaza, NY, USA.

³ Report on the Second Meeting of the WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM), 4-5 February 2016, NY, USA. March 2016.

2.1 Global Nutrition Monitoring Framework (GNMF): 4 deferred indicators

In addition to the six indicators for the World Health Assembly nutrition targets, a set of fourteen additional indicators have been identified in the Global Nutrition Monitoring Framework (GNMF), including five intermediate outcome, six process, and three policy environment and capacity indicators. Reporting on four indicators has been deferred until 2018 to allow for development of additional guidance to support reporting by Member States: (i) iron and folic acid (IFA) supplementation during pregnancy; (ii) number of trained nutrition professionals; (iii) minimum acceptable diet (MAD); and (iv) breastfeeding counselling. For each indicator, a TEAM sub-group was assigned to develop concept notes and terms of references (ToR) for developing comprehensive definitions and operational guidance for countries.

2.1.1 Development/validation of iron and folic acid supplementation indicator

The TEAM with the Secretariat outlined a ToR to develop a comprehensive indicator definition and operationalization of the indicator relating to iron and folic acid (IFA) supplementation during pregnancy. The issues TEAM covered are presented below, and the key discussion points and decisions are summarised in Box 1.

TEAM reviewed the issues discussed at its last meeting and then presented findings from the rapid assessment done by the Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING) and the proposed ToR. Decisions made during the February 2016 TEAM meeting included: (i) use of IFA and not iron-containing supplements; (ii) not to include fortification; (iii) not to use ANC coverage as a proxy for IFA supplementation; and (iv) to investigate the rapid assessment done by SPRING in 22 low- and middle-income countries (LMIC).

The SPRING assessment used DHS survey data from 22 countries to examine four “faltering points” for IFA delivery: (i) women attending at least one ANC visit; (ii) women receiving or purchasing IFA supplements; (iii) consumption of one or more IFA tablets; and (iv) consumption of the recommended minimum of 180 IFA tablets. The most common faltering points were numbers (i) and (iv). Countries with high faltering at point (iv) (e.g. Rwanda and Uganda) showed relatively low anaemia, which may suggest that specifying whether or not 180 IFA tablets were received may not be useful. The SPRING exercise does not address data availability in countries lacking population-based surveys.

The ToR was presented; the scope of work includes identification of a set of Member States to assess the feasibility of reporting on components of suggested indicator. There should be a mix of low-, middle-, and high-income countries, a variation in the anaemia burden, health system infrastructure (public vs private or public-private mix), national IFA policies, primary distribution channels, and different health information systems.

The other presentation was on the household surveys that the Micronutrient Initiative (MI) will be conducting in Bangladesh, Ethiopia, India, Kenya, Pakistan and the United Republic of Tanzania starting November 2016. These surveys will be in the districts/states which are part of the MI programme and will include women of reproductive age where IFA is part of the ANC. These surveys will measure consumption of IFA supplements in 2000-3000 postpartum women asking them about their last pregnancy and additional questions about access to IFA, received/purchased IFA, consumption of IFA, and knowledge of benefits and barriers of IFA. Data will be available by March 2017.

Box 1: Main discussion points and next steps for iron and folic acid supplementation indicator

Discussion
This is a process indicator related to anaemia outcome in women of childbearing age. However, this indicator should not be considered a proxy for anaemia as there are other factors associated with anaemia. As this indicator measures IFA supplementation in women, it should include a minimum

cut-off for the number of IFA tablets consumed. Women can achieve the highest number of tablets (180) consumed if they get to ANC early. So, it will be useful to have information on both coverage of ANC and the number of tablets distributed/ purchased/ consumed. Although DHS includes a question on the number of tablets consumed, there is no validation of women's recall of tablet numbers.

The scope of work in the ToR will provide an opportunity to use the MI survey data in six countries if there is an overlap of the countries selected for this exercise. The scope of work should include investigation of data availability from high-income countries (HIC) and Latin American countries. Almost all countries selected for MI survey are DHS countries, but not all Member States have DHS. It should also include what these countries would be reporting on, especially the countries without DHS.

There was a call for consultants for this ToR and the selection process continues. This ToR requires someone with a good network who can identify and interview key informants independently, ideally has experience with iron/anaemia measurement and understands what we are trying to achieve with the GNMF indicators.

Next steps

- Finalize the ToR and hire a well-connected and experienced consultant.
- Connect consultant with MI team.
- Complete scoping work by December 2016.
- Complete validation of the proposed indicator and finalize indicator by March 2017.

2.1.2 Development/validation of trained nutrition professionals indicator

The indicator for trained nutrition professionals is one of four indicators being deferred for reporting until 2018. The issues covered in the presentation are summarised below, and the main discussion points and decisions are presented in Box 2.

The first presentation reviewed the issues discussed at the last meeting and then presented on follow-up and the proposed ToR. During the February 2016 TEAM meeting it was agreed: (i) not to use existing health workers density indicators as a proxy; (ii) to validate data against some selected health outcomes; (iii) to use indicators more inclusive of front-line workers; (iv) to consider a skill-based approach; and (v) to follow-up with Jessica Fanzo about her review of human resources for nutrition.

R. Heidkamp met with Jessica Fanzo, who agreed with capturing data from frontline workers despite the availability/collection challenges. She also agreed to examine some institutional capacity indicators.

The group discussed the proposed two-step ToR developed with the Secretariat:

- Step 1 includes an exploratory analysis using the three indicators from the Global Nutrition Report (physicians, nurses and midwives, and CHWs) focusing on (a) data availability; and (b) the relationship between the indicator and key nutrition outcomes (stunting, LBW and overweight) across all Member States over the last 10-20 years or so.
- Step 2 includes an intensive scoping/feasibility exercise in five countries based on predefined selection criteria to determine the feasibility of producing the data required to report on the indicators/indicator components and generate a series of specific indicator definitions based on these findings (one each at individual and institutional levels) and rate their relative feasibility across WHO Member States. A similar exercise to that described in Step 1 will determine whether the proposed new indicators are predictive of selected nutrition outcomes (stunting, LBW and overweight, TBD).

Box 2: Main discussion points and decisions on the trained nutrition professionals indicator

Discussion
<p>The proposed indicator is included in the Nutrition Landscape Information System (NLIS). In 2009, a desk review was performed to assess readiness of governments in 19 countries with a high stunting burden to report this indicator. The review revealed that the existing data include the density measures for physicians and nurses. Data on community health workers (CHWs) were not available. None of the countries included measuring individuals with specific nutrition skills. The physician and nurse indicators were correlated with stunting and maternal anaemia. It would be interesting to see an updated analysis including the CHW data under the ToR.</p> <p>The issues related to this indicator were discussed in a recent workshop of the World Public Health Nutrition Association (WPHNA). The Capacity Building Taskforce within the WPHNA has submitted a proposal for this ToR. The work of the Capacity Building Taskforce identified that the curriculum at higher-level institutions mainly focuses on clinical nutrition and dietetics and not public health nutrition. Trained nutritionists usually stay in capital cities working in hospitals/clinics.</p> <p>Two questions about trained nutrition professionals have been included in the Second Global Nutrition Policy Review: (i) number of frontline workers trained in basic nutrition services (kind of training/skills given to the frontline workers); and (ii) number of supervisors at district level that received training in nutrition. A review of global nutrition capacity looks at educational institutions and areas, trained dietitians working in the area, health personnel in the institutions, number of hours dedicated to training, in-service training (including CHWs), and number of workers trained in complementary feeding. All countries in all regions were asked to provide data, and 41 responded.</p> <p>The importance of revisiting academic nutrition training programmes was discussed. Some low-income countries such as Burundi, Burkina Faso, Ethiopia and the United Republic of Tanzania have structured nutrition education programmes. However, there are gaps between the content of academic programmes and service delivery. It is important to identify and assess core training content to define training requirements and skill-based indicators. Although some schools/hospitals have standardized training, competency among workers varies. This is important to consider when assessing indicators for skill-based health workers density.</p>
Next steps
<ul style="list-style-type: none">• Drop exploratory analysis in Step 1 of the ToR and focus on the scoping exercise in step 2.• Collaborate with the Capacity Building Task Force of the WPHNA to implement the ToR for developing this indicator.• Finalize indicator definition and operational guidance for countries by December 2016.

2.1.3 Development/validation of minimum acceptable diet (MAD)

Minimum acceptable diet (MAD) for children 6-23 months of age is one of the four deferred indicators. The presentation covered the follow-up points from the February 2016 TEAM meeting that were needed to help decide on the following: (i) to replace MAD with a minimum dietary diversity (MDD) indicator; (ii) to restrict reporting to countries with high stunting; and (iii) to initiate work on a diet quality indicator sensitive to undernutrition, and food and beverages which should be consumed in moderation. The issues covered are summarized below, and the main discussion points and decisions are presented in Box 3.

A concept note indicating pros and cons proposed replacing MAD with MDD. The rationale for this proposal was the simplicity constructing MDD and data availability (DHS and MICS adopted this indicator, and for countries without DHS or MICS, MDD data are easier to obtain). Moreover, MDD provides a clear programme focus and is more relevant to HIC.

One caveat regarding MDD is that breast-milk substitutes are counted in the dairy group but breast milk is not, giving advantage to formula-fed infants, which is more salient in HIC. It was proposed that the indicator definition be reviewed and possibly revised the better to align breastfed and non-breastfed children. However, MDD would no longer be a complementary feeding indicator if combined with breastfeeding. For MAD, conversely, the way milk feedings and diet diversity are assessed has put non-breastfed children at a disadvantage. This error in the manual needs to be corrected.

Proposed next steps include both short- and long-term activities:

- Short-term activities include: (i) an interagency consultation to achieve consensus on correcting MAD and revising MDD involving, at minimum, the same agencies involved in formulating the 2008 WHO IYCF indicator documents; and (ii) development of (a) a ToR to revise definitions/calculation for MAD/MDD in manuals based on the outcome of the consultation, and (b) guidelines for calculating MDD (or MAD) using different data sources.
- Long-term activities include: (i) a wider review of the IYCF indicator documents as well as a research agenda on healthy eating/unhealthy diets. It is time for the inter-agency team to review and refine existing methods and documents in the light of 10 years of using MDD and MAD. This might be a medium- to long-term initiative and require resources to bring stakeholders and users together to revise the manuals; and (ii) incorporation of unhealthy diets/healthy eating into the indicator documents. This will be a very long-term initiative, but it will be good to have the proposal for funding to cover consultants to develop a scope of work and initial processes. It will be important to make it clear if other groups at WHO are working on this or whether TEAM should pursue this work.

Box 3: Main discussion points and decisions on minimum acceptable diet (MAD) indicator

Discussion
<p>Feasibility of changing the indicator from MAD to MDD was discussed. Whether an indicator in the GNMF can be changed should be discussed at higher level. However, as an expert advisory group, TEAM can make a recommendation to the Secretariat in addition to needing clarity on this in the future. Indicator definitions can be refined as part of operationalization for guidance on country reporting provided that justification for such modifications is clearly articulated.</p> <p>It will be important to analyse the shift in (i) estimates for MAD after correcting the definition; and (ii) options for MDD to better accommodate milk feeds.</p> <p>It was agreed that further analysis of DHS and MICS data can be done as an immediate next step to provide guidance to countries as the political process for this might take longer. CDC has some data and experience that a consultant could draw from to develop guidance. The inter-agency consultation can be considered a short-term activity.</p> <p>Decisions: (i) replace MAD with MDD; (ii) correct the MAD definition in the manual (i.e. 3/6 food groups for non-breastfed infants/children); and (iii) report on all countries.</p>
Next steps
<ul style="list-style-type: none"> • Develop a ToR by TEAM with support from Secretariat. • Identify a consultant to work on the ToR. • Complete this task by January 2017 (depending on data availability). • Secretariat to reach out to original indicator document authors to discuss correction of MAD definition in the manuals and discussion of revision of MDD changes and arrange for a consultation (either e-consultation or face to face meeting) in time for reporting guidelines to be given to countries. • UNICEF to develop a background paper presenting country, regional and global estimates using corrected MAD definition and options for changing MDD.

2.1.4 Development/validation of breastfeeding counselling indicator

The breastfeeding counselling indicator is the last of the four deferred indicators. The presentation covered the proposed indicator definition, the issues around age group, specificity of the indicator to breastfeeding (not complementary feeding), data collection from LIC and HIC, and frequency of country reporting. The issues covered in the presentation are summarized below, and the main discussion points and decisions are presented in Box 4.

The originally proposed indicator does not capture the prenatal intervention component or counselling support delivered by media. The development of this indicator should be based on current knowledge and programmes that reflect different settings globally. Experience from Alive & Thrive projects suggests that, although exposure was higher in intervention areas, information was diffused in non-intervention areas. Therefore, source of information is important.

This indicator does not yet exist. The process for fully developing and field-testing it will take about 12-18 months. If countries require something by March 2017, an interim approach should be applied to ask countries to report on interventions and policies to support breastfeeding. It was proposed that the sub-group would explore data availability from the Alive & Thrive projects and report back in December 2016 with an outline of possible examples and investigating two questions: (i) Is counselling on breastfeeding included national nutrition and programmes? and (ii) What delivery platforms are used?

Box 4: Main discussion points and decisions on breastfeeding counselling indicator

Discussion
<p>The discussion started with the scope of the indicator, whether it should capture the whole spectrum of breastfeeding, i.e., initiation, exclusivity and continuation. This indicator is related to the other two GNMFI indicators, i.e., exclusive breastfeeding and MAD. Therefore, it might be useful to capture information on complementary feeding at the same time as children need support for complementary feeding as they get older. It was agreed that the interim approach should include countries reporting on existing interventions and policies to support breastfeeding interventions.</p> <p>A sub-group will be formed from interested TEAM members and additional individuals engaged in the IYCF indicator process. The sub-group will report back on what are meaningful and feasible interim indicators after speaking with the Alive & Thrive about the programme aspects and platforms used.</p> <p>A ToR has not been developed for the interim phase. It is feasible to use available resources, look at draft questions and seek inputs from expert groups. However, additional funding will be required for a longer-term proposal.</p> <p>The timeline of 12-18 months for fully developing and field-testing this indicator is optimistic to learn what is meaningful and feasible. It would be good to test the new indicator in countries where Alive & Thrive projects have good relations with governments.</p>
Next steps
<ul style="list-style-type: none">• Sub-group to recommend an interim indicator by December 2016 for countries to report on existing interventions and policies to support breastfeeding interventions. No additional funding will be required.• Test questions and platforms for data collection by July 2017. Additional funding will be required.

2.2 Ranges of prevalence levels for stunting, wasting and overweight

The presentation covered the key motivation for revisiting prevalence levels: (i) global reduction of stunting approaching the level currently designated as “low” – 23% (JME 2015) with 43% of

countries having stunting levels below 20%; (ii) release of the WHO Child Growth Standards in 2006; and (iii) the need for prevalence level ranges for overweight, which is one of the six WHA global nutrition targets.

The current prevalence level ranges for stunting were determined in the early 1990s based on an analysis of 79 national surveys from low- and middle-income countries by grouping them into four categories corresponding approximately to the observed quartiles: “low” (<20%), “medium” (20-29%), “high” (30-39%), and “very high” ($\geq 40\%$). For wasting, the prevalence level ranges “acceptable” (<5%), “poor” (5-9%), “serious” (10-14%), and “critical” ($\geq 15\%$), were derived differently, in association with mortality risk.

The prevalence level ranges for stunting have been used mainly for descriptive purposes, in global reports, to map countries according to malnutrition levels and to identify priority countries according to prevalence or numbers of affected children. In contrast, severity levels for wasting in emergency settings have been used for triggering nutrition interventions e.g., establishing therapeutic feeding centres.

Three approaches were presented; all are described in detail in the background document for this agenda item:

- 1) A descriptive approach like that applied previously with ranges based on quartiles using the latest available data;
- 2) An approach based on an association with functional outcomes such as mortality; and
- 3) A novel approach that establishes the ranges based on degrees of deviation from "normality" based on the WHO Child Growth Standards.

Box 5: Main discussion points and decisions on prevalence level ranges for malnutrition – stunting, wasting and overweight

Discussion
<p>There is a need to revisit current prevalence level ranges for stunting and wasting, and to define new ones for overweight. Everyone agreed that any revision should be done cautiously and be well-justified as changes could be disruptive. The pros and cons will need to be carefully considered before any changes are made.</p> <p>The original terminology for stunting used neutral terms such as “classification of prevalence levels” and was never meant to imply that specific levels had any specific “public health significance”. For wasting, the original terminology referring to a “severity index for malnutrition in emergency situations” was more in line with the fact that these cut-offs were derived based on associations with mortality.</p> <p>Participants agreed that, in framing any recommendations for labelling, TEAM should carefully consider how these levels/thresholds/cut-offs should be named and described. The terminology “public health significance” does not seem justified to describe stunting levels. TEAM should clarify that the ranges, at least for stunting and overweight, are merely descriptive (based on distributions) and carry no meaning as to risk levels of morbidity/mortality. Similarly, the labels used for the different levels need to be discussed.</p> <p>Any publication on these ranges should clearly state the justification for doing so, the rationale for the overall method selected, intended uses of the prevalence ranges for each of the three anthropometric indicators, and the proposed actions at different levels.</p> <p>The three approaches for revising the prevalence level ranges were discussed. It was decided to focus on the first and third options. Despite being conceptually more attractive, at present the second option was deemed unfeasible due to data scarcity. For the third option, there was agreement on defining the ranges in relation to standard deviations of the normative WHO child</p>

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<p>growth standards. Not only is this approach conceptually more logical than using quartile-based ranges in low- and middle- income countries, but also it is a longer lasting approach that will not require updating unless the normative data are revised (which is unlikely to happen in near future). Nevertheless, there was general agreement that basing the ranges on association with functional outcome was, ultimately, the ideal approach and this idea should be prominent in any write-up, making clear that this option will require TEAM to establish a process and develop a research agenda to collect required evidence.</p> <p>On the discussion regarding functional outcomes, the point was made that different outcomes would likely be related to different ranges, thereby making linking stunting and overweight with functional outcomes quite challenging. For wasting, it is clear because the outcome is mortality. The Guatemala study clearly shows increased productivity accompanying increased height in one context. Six other countries showed that stunting is related to functional outcomes. However, for the moment, these data are insufficient to proceed with this approach.</p> <p>This is the first time that prevalence levels are being developed for overweight. An advantage of using the model approach is that there will be no need to revisit this again unless the normative data change. For wasting the novel approach is on agreement with the current approach, so there is not much work to be done on this indicator. This is a good news for users who have been applying wasting cut-offs for years without raising concerns.</p> <p>In using the novel approach, overweight and wasting can have four categories, but stunting would need more given the higher levels worldwide. Everyone agrees on the importance of how the categories are labelled.</p>
Next steps
<ul style="list-style-type: none"> • Use the novel approach for all three indicators – stunting, wasting and overweight. • Conduct additional analyses for stunting to include more categories. • Share revised draft with TEAM for feedback. • Prepare a manuscript for submission to a peer-reviewed journal.

2.3 Rules for monitoring progress towards the WHA global nutrition targets

The presentation on the rules for global monitoring of the WHA nutrition targets provided a brief background: (i) WHA targets were specified globally; (ii) countries should set their own realistic and ambitious targets; (iii) a comparable algorithm for classifying countries globally is needed; (iv) global assessment will not replace national analysis and tracking; and (v) on/off track classification has so far been presented in the Global Nutrition Report (GNR). Accepted rules will be one way to describe how countries are progressing towards the WHA nutrition targets.

Key points for defining the algorithm behind the rules were discussed during the 2nd TEAM meeting in February 2016. A proposal was presented based on feedback received from TEAM members on a background document shared before that meeting. The rules were consistent across all indicators except wasting which TEAM requested the possibility of assessing. The alternative for wasting was to use a simple rule with only two categories (<5%, on-track and ≥5%, off-track). For exclusive breastfeeding, TEAM recommended using “reduction in non-exclusive breastfeeding” instead of “increase in exclusive breastfeeding” to align with rules for measuring progress of the other indicators.

A few issues required additional analyses for TEAM to agree on the final rules and thus were pending discussion: 1) level of “acceptable prevalence”; 2) required average annual rate of reduction (AARR); 3) establishing a buffer around zero for “no progress”; 4) establishing time windows for assessing current progress; and 5) testing the rules based on recent data.

The additional analyses provided good guidance for a few but not all issues. For example, on confidence intervals (CI) around testing current AARR equals to zero, data scarcity resulted in very large confidence intervals around zero or any other cut-off. Preliminary discussions between WHO and UNICEF led to a revised pragmatic approach, as for the Millennium Development Goals underweight indicator where monitoring included a 'buffer' around the actual cut-off. Following this rationale, the revised proposal included buffers around the zero cut-off that were proportional to the sizes of the standard errors based on the additional analyses for the confidence intervals, starting from a 0.5 for stunting.

Concerning acceptable prevalence levels, while 5% is currently classified as low for wasting, the decision to propose the same for other indicators was arbitrary, as there is no study to support it. Additional analyses based on recent data provided guidance on the time window for current trend derivation. On the required AARR, global targets were followed for all indicators except exclusive breastfeeding and overweight, for which arbitrary target reductions were proposed.

The revised proposal was presented to TEAM to facilitate discussions:

- 1) An acceptable prevalence of <5% for stunting, anaemia, LBW, overweight, and wasting. Two proposals were presented for EBF: >90% and >70% as acceptable levels.
- 2) To achieve global targets between 2012 and 2025, the required AARR should be 3.9% for stunting (target 40% reduction), 5.2% for anaemia (target 50% reduction), 2.74% for LBW (target 30% reduction) 1.65% and 2.74% for not-EBF (target 20% or 30%), and 3.9% for overweight (target 40% reduction).
- 3) Buffers around zero were proposed: 0.5 for stunting, anaemia and LBW, 0.8 for not exclusive breastfeeding, 1.5 for overweight and 2 for wasting.
- 4) Four categories were proposed: on-track, off-track – some progress, off-track – no progress, and off-track – worsening. For the number of categories, an alternative proposal was presented merging the last two Off-track categories.
- 5) Four time-window options were proposed for assessing current/recent progress: (i) All data from 2005, assess country progress regardless of availability of post-baseline data. (ii) All data from 2005, but assess progress only for countries with at least one post-baseline data point. (iii) All data from 2008, assess country progress regardless of whether there are data post-baseline. (iv) All data from 2008, but assess progress only for countries with at least one post-baseline data point.

Feedback was requested on: (i) time window assessing progress; (ii) approaches for EBF; (iii) buffers around zero, (iv) number of "off-track" categories; and (v) appropriateness of 40% reduction for overweight.

Box 6: Main discussion points and decisions on rules for monitoring progress towards the WHA global nutrition targets

Discussion
<p>Overall, TEAM agreed that countries should report on progress. However, members stressed that additional guidance must be provided to help them understand the purposes of the on/off track classification.</p> <p>Main discussion points:</p> <p>(i) Time window for assessing progress</p> <p>2005 should not be the start for a time window for recent trends and it is important that countries use post-baseline data for monitoring their progress towards targets. UNICEF provided information on Sustainable Development Goals that might have 2005 as baseline, although a final decision was not taken. As for the definition of baseline year, WHO informed TEAM that, for indicators with no</p>

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model-based data, the approach used for determining the country baseline year was the latest survey data within the time window 2005-2012. If no data are available for that period, then the earliest survey year after it is considered as baseline year. TEAM emphasized the importance collecting data every three years.

TEAM members agreed to use 2008 as the time window for current AARR calculation, to represent recent progress for monitoring purposes, as it better represents recent trends. It was also agreed that ON/OFF track assessment should be missing when there are no data available beyond the baseline.

(ii) Not EBF: 20% reduction if <10% vs 30% reduction if <30%

Considering that no countries had baseline EBF rates above 90% (or not EBF less than 10%) and 5 countries had baseline above 70% (or not EBF less than 30%), the group opted for a 30% reduction in Not EBF rates if the baseline rate is less than 30%. Based on the selected option, countries with high rates of Not EBF would have to make a greater effort to bring rates down.

(iii) Buffer around zero

TEAM agreed that having a buffer around zero was the best approach. It emphasizes the need to communicate the methodology well so that the countries can understand. UNICEF expressed concern about the buffer size for Not EBF. After some investigation of available data, the group concluded that there was no visible pattern that would indicate an alternative to the one currently proposed.

(iv) Number of categories

4 categories: 1. On-track 2. Some progress 3. No progress 4. Worsening

3 categories: 1. On-track 2. Some progress 3. No progress or worsening

After discussing the pros and cons for the two options, TEAM recommended using three categories for all indicators (plus a "No data available" designation), consistent with MDG monitoring for underweight, which was easier to understand. The three categories are: on-track; off-track – some progress; and off track – no progress or worsening).

(v) Overweight, is a 40% reduction appropriate?

The proposal for overweight was based on a 40% reduction for countries with a baseline above 5%. While the global target is "no increase in overweight", some countries have high rates.

Main points of discussion:

- TEAM questioned the rationale for choosing a 40% reduction. WHO explained that it was a proposed percentage based on simulation of different departure levels and the implications of different reduction percentages (as described in the PowerPoint presentation and the background document).
- TEAM then proposed that, before making a final recommendation, an exercise be carried out to determine whether countries stayed below 5%, how much the rest of the world needed to reduce for the global target to be achieved, that is a global average in 2025 of 6.2%, as the global baseline, to achieve "no increase"?
- TEAM pointed out the importance of discussing this point with those involved with the GNR, the only report that includes such on/off track rules, about the implications and interpretations of the categories for countries, especially those classified as "no progress or worsening". Since some TEAM members are also members of the GNR, they can take the issue to that group.

One TEAM member suggested publishing a paper on methodology in a peer-review journal. WHO

Discussion
noted that such an endeavour would have to be carried out by a TEAM member.
Next steps
<ul style="list-style-type: none"> • Use 2008 as starting year for the time series used for the current/recent trend progress rate calculation, and provide ON/OFF track assessment only for countries with at least one data point beyond the baseline. • Use 30% reduction of 'Not EBF' for those countries with a baseline less than 30%. • Use buffers around zero that are proposed for indicators. • Use 3 categories (plus a designation of "No data available"): on-track; off-track – some progress; off-track – no progress or worsening. • No decision was made regarding 40% reduction of overweight. Additional analysis of the required reduction for countries above 5% would lead to a global average of 6.2%, that is, no increase compared to the global baseline.⁴

2.4 Anthropometric data quality

The presentation covered methods for harmonized data collection, analysis and reporting of nutrition surveys. There is a working group (WG) of 11 people – four members from TEAM and seven other experts. WG members were introduced and WG achievements were presented. The WG developed a table of contents for a report on anthropometry data quality and TEAM members were invited to participate in sections based on their interest and expertise. The report format will follow a novel approach (for an example, follow this link: <http://whoeducationguidelines.org>). The presentation also included the next steps of the WG: a second WG call to discuss the way forward, finalizing the survey planning section, follow up with CDC work on SDs, and identify a consultant, possibly a demographer or social scientist, to explore ways to improve the age assessment in children 0-5 years.

Box 7: Main discussion points and decisions on anthropometry data quality

Discussion
<p>TEAM members recommended Jeff Leroy and Jere Haas as additional experts given their work on anthropometry standardization. A video from Vietnam on anthropometric standardization could also be shared. The WG should coordinate work with EU-funded NIPN project staff to harmonize recommendations.</p> <p>The UNICEF Supply Innovation Project is doing some exciting work on future technology in measuring devices (Mercedes and Julia are on the advisory committee).</p> <p>The WG will consider the SMART, MICS and DHS approaches to obtaining data quality scores. UNICEF is collaborating with the MICS team to propose assessments that make the most sense. Additional funding would help to accelerate the work.</p>
Next steps
<ul style="list-style-type: none"> • Have a working group call and finalize the survey planning section – an immediate next step. • Follow-up with CDC work on SDs.

⁴ Immediately following the meeting, the proposed analysis was prepared. However, the WHO team responsible for monitoring targets discussed matters further in the light of discussions regarding monitoring rules for overweight. It was decided internally that a proposal would be put to TEAM for rules consistent with the WHA global target for that indicator, at the same time recognizing that all rules will need to be tested in countries before they are finalized. The proposal put forward was accepted by most TEAM members. The rule for overweight consists of only two categories, ON track when current AARR is equal or above the buffer of 1.5, and OFF track otherwise.

- Identify a consultant to outsource the work needed on improving age assessment.
- Organize a working group meeting to finalize report sections and explore eBook approach.

2.5 Operational guidance for the GNMF indicators

The presentation provided perspectives on clinical guidelines as there are not enough examples from the operational guidelines in public health or nutrition. Review suggests that in clinical medicine, explicit guidelines do improve clinical practice, when introduced in the context of rigorous evaluations. However, the size of the improvements in performance varies considerably. Such reviews are not available for operational guidance in public health or nutrition.

The presentation included potential opportunities and practical challenges related to the operational guidance of the GNMF indicators. The operational guidance can be used as a global reference guide for monitoring progress of the GNMF indicators. It is also useful for data collection to ensure meaningful comparability across countries. This guidance will be useful to strengthen national HMIS and can be used as a tool for capacity building in countries. The main challenge is to maintain a balance between details to be included in the guidance and references to other documents for further instructions. Other potential challenges include providing guidance on collecting representative data on low birth weight and timely completion of the development and validation of the four core indicators on which reporting has been postponed until 2018.

There was a description of completed activities and a list of future activities with work-completion deadlines. By December 2016, the draft guidelines will be shared with TEAM members for their feedback. The operational guidance will be finalized by February 2017.

Box 8: Main discussion points and decisions on the operational guidance for GNMF indicators

Discussion

TEAM members wanted to see if there was an example of operational guidance for another WHA indicator that has worked well. This will allow them to see what kind of elements to look for and help provide consistency in their feedback. Some examples are the SDG indicators on HIV and the report on noncommunicable diseases. TEAM will share ideas on additional reference materials that are aligned to what is already available.

It is important to know who the users of this operational guidance will be. The extent of details to be included should depend on the purpose of their use and type of users. The main users are ministries of health and WHO country offices.

It was pointed out that there is a lack of compliance for LBW measurements. For example, the minimum standards for scales, their procurement, and precision level are not enforced. Further guidance on these issues should be useful for countries.

It would be helpful if templates for reporting could be provided.

Next steps

- Share draft guidance on 10 additional core indicators with TEAM for feedback.
- Develop operational guidance on four postponed indicators with TEAM sub-groups.
- Share full revised draft with TEAM for feedback.
- Complete operational guidance by end February 2017 (including the progress made on four postponed indicators).

2.6 Global Data and Accountability Initiative for Nutrition

David Kim of the Global Data and Accountability Initiatives for Nutrition presented the results of a mapping exercise commissioned by the SUN movement. They are summarised below, and the key discussion points are presented in Box 9.

The objectives of this exercise were to: (i) present the landscape and global data and accountability initiatives in nutrition; (ii) increase awareness among users, providers and funders of nutrition data regarding current initiatives; and (iii) contribute to a more coherent and robust nutrition data and accountability landscape.

The report includes publicly available information, analyses on the topic, and interviews with key actors (initiatives, donors, users). Inclusion criteria embraced globally initiated and coordinated nutrition-specific initiatives.

The initiatives are presented in one of the four elements of the data and accountability value chain:

- **Data prioritization:** Initiatives working with normative functions, e.g. TEAM, GNMF on Maternal, Infant and Young Child Nutrition, Compendium of Indicators for Nutrition-Sensitive Agriculture – FAO;
- **Data collection:** Generating and gathering data through surveys or accessing market information such as DHS, MICS, Standardized Monitoring and Assessment of Relief and Transitions (SMART) Survey – hosted by ACF Canada, Food Balance Sheets – FAO, Voices of the Hungry / Food Insecurity Experience Scale (FIES) – FAO, Agricultural and Rural Integrated Survey (AGRIS) – FAO;
- **Data accessibility:** Aggregating, structuring, analysing and providing accessibility for data – Global Database on Child Growth and Malnutrition – WHO, Nutrition Landscape Information System (NLIS) – WHO, Global database on the Implementation of Nutrition Action (GINA) – WHO, other WHO-maintained nutrition databases, UNICEF global databases, NutriDash – UNICEF, Global Individual Food consumption data Tool (GIFT) – FAO/WHO, FAOSTAT – FAO; and
- **Data use:** Synthesizing and presenting data for different uses – including advocacy, accountability, or to inform policies and funding priorities. UNICEF-WHO-WB Joint Child Malnutrition Estimates (JME), Tracking tool for WHA targets, SUN Movement Annual Progress Reports.

Key findings:

- Nutrition has different challenges in data accountability due to its multisectoral and multidimensional spectrum, and that most data are from household surveys.
- *Data availability:* Low frequency of data collection, as well as limited guidance, and limited data on dietary and nutrient intake. New initiatives that could help address this issue such as GIFT, International Dietary Data Expansion (INDDEx), Optifood, and ANI.
- *Data quality:* There is low consistency, lack of capacity, inadequate tools and lack of normative guidance in data collection. However, initiatives are addressing this problem, e.g., LSHTM, INDDEx, and NIPN.
- *Data accessibility:* There has been some progress in data standardization (e.g., JME), but there is still fragmentation across databases. There is some effort to promote data accessibility, but challenges remain concerning “open data” due to country ownership and quality control.
- There is no equivalent of a Monitoring & Evaluation Reference Group (MERG) for nutrition to establish priorities and avert fragmentation in approaches and initiatives (although TEAM is working to achieve this).

- National capacity to analyse and interpret data remains limited. However, there are some promising initiatives such as DHS, NIPN, and the Partnership in Statistics for Development in the 21st Century (PARIS21).
- The Global Nutrition Reports are useful, but they should be complementary and incremental.
- There is no clear leader in nutrition data collection and accountability.
- There is no initiative specific to gender and nutrition, even though many actors work with the data, and there is some overlap.

Box 9: Main discussion points on Global Data and Accountability Initiative for Nutrition

Discussion

The discussion started with the purpose of this mapping exercise. This exercise was intended to provide a snapshot of available data and who is doing what. The SUN donor requested this exercise.

During its February 2016 meeting, TEAM started a discussion about who its partners would be, and who will be reporting. This mapping is helpful in identifying potential partners. There is need for a multi-partner discussion to stimulate ambitious governance and to establish national connections and surveillance. It would be more efficient if the community came together, and if there were opportunities to discuss this in a structured way. Donors are more interested in some nutrition elements than in others. This group is trying to uncover the landscape to understand better recent approaches and protocols.

This is the time to consider the issues of translating data into policies and whether designed interventions are data driven. At present there is no example of using data for developing policies and programmes, and funding priority. There might be isolated cases, when certain countries commission this type of work.

In an earlier meeting on data gaps, there was a discussion about data revolution, although it was unclear what this revolution should look like. It is important to bring people together to understand the goals and activities of other partners. Some TEAM members are already involved in other platforms that are engaged in data harmonization. It will be interesting to see models from different MERGs and to have access to them. There is insufficient knowledge about MERGs. Having a common vision is a good idea, but it requires further coordination.

2.7 Review and update of TEAM workplan

This session was jointly moderated by TEAM Co-chairs. Using the existing TEAM workplan the presentation covered the status and next steps for each activity of the six major outputs. For activities that are not initiated yet or not presented/discussed in the TEAM meeting, responsible entities for those activities were asked to update the status and future plans for those activities.

The existing TEAM workplan will be revised based on the discussion and decisions made in this session and shared with TEAM members by 30 September 2016. The revised TEAM workplan is available on the TEAM SharePoint:

(<https://workspace.who.int/sites/nutrition/TEAM/SitePages/Welcome.aspx>)

2.8 Closing session

On behalf of the WHO-UNICEF Secretariat, the Director of the Department of Nutrition for Health and Development gave his remarks. He acknowledged TEAM's active engagement and excellent work for monitoring of the WHA global nutrition targets and other GNMf indicators. He also reiterated the importance of partners' engagement in this effort to accelerate achievements. There

is enhanced recognition and attention for nutrition among the international agencies and development partners.

The Decade of Action provides ample opportunity for the nutrition community to respond to global nutritional vulnerabilities in a comprehensive manner to accomplish the unfinished agenda. Accountability will include a progress report every second year. Nutrition is central to the G7 agenda, and it has been mentioned in the Kobe Declaration. The N4G has catalysed investment in nutrition, and it should be meticulously followed up given high expectations. There are new investments, new partners, new resources and new ambitions. Although the nutrition targets are in the global agenda and the SDG includes addressing malnutrition in all its forms, there is still much to do. He conveyed his sincere thanks to the TEAM members for the high quality of their work.

The TEAM Chair summarized the outcomes of the meeting. On behalf of TEAM, he thanked the WHO-UNICEF Secretariat for excellent support provided to TEAM during the last six months. He also thanked all TEAM members for their engagement in their respective areas of the TEAM workplan. The achievements so far are encouraging, but some areas need attention to meet the timeline. He also mentioned that the meeting format had been successfully modified to make it more dynamic by ensuring that all members were responsible for at least one session. The TEAM Chair proposed a day-long partner meeting, preferably after the next TEAM meeting. He requested the Secretariat to determine a suitable date for the 4th TEAM meeting in February-March 2017.



3rd WHO-UNICEF Technical Expert Advisory group on nutrition Monitoring (TEAM) Meeting

Salle C (Main Building, 5th floor), WHO Headquarters

Geneva, Switzerland

15-16 September 2016

AGENDA

Thursday, 15 September

9:00 am-9:30 am	Welcome and introductions <ul style="list-style-type: none"> - Opening remarks - Objectives and expected outcomes of the meeting - Introduction of the participants - Administrative issues 	Mercedes de Onis Julia Krasevec
9:30 am-10:00 am	1. Development/validation of iron and folic acid supplementation – current status and next steps	Presentation by: Rebecca Heidkamp Discussion led by: Luz Maria de Regil
10:00 am-10:30 am	Tea/Coffee	
10:30 am-11:00 pm	<i>Continuation of iron and folic acid supplementation</i>	
11:00 am-12:00 pm	2. Development/validation of trained nutrition professionals indicator– current status and next steps	Presentation by: Rebecca Heidkamp Discussion led by: Mary Arimond
12:00 pm-1:00 pm	Lunch	
1:00 pm-2:00 pm	3. Development/validation of minimum acceptable diet (MAD) – current status and next steps	Presentation by: Julia Krasevec Discussion led by: Eline Korenromp
2:00 pm-3:00 pm	4. Development /validation of breastfeeding counselling indicator – current status and next steps	Presentation by: Purnima Menon Discussion led by: Faith Thuita
3:00 pm-3:30 pm	Tea/Coffee	
3:30 pm-5:00 pm	5. Prevalence level ranges of stunting, wasting and overweight – status update and next steps	Presentation by: Elaine Borghi Discussion led by: Mary Arimond
7:30 pm	Group dinner	Specifics to be provided

Friday 16 September

8:30 am-10:00 am	6. Off track/On track rules – status update and next steps	Presentation by: Elaine Borghi/Larry Grummer-Strawn Discussion led by: Rafael Flores-Ayala
10:00 am-10:30 am	Tea/Coffee	
10:30 am-11:30 am	<i>Continuation of Off track/On track rules</i>	
11:30 am-12:30 pm	7. Improving anthropometric data quality working group – status update and next steps	Presentation by: Monika Blössner/Julia Krasevec Discussion led by: Trevor Croft
12:30 pm-1:30 pm	Lunch	
1:30 pm-2:00 pm	8. Operational guidance for the GNMFI indicators – status update and revision	Presentation by: Kuntal Kumar Saha Discussion led by: Mary Arimond
2:00 pm-3:00 pm	9. Global Data and Accountability Initiatives for Nutrition	Presentation by: David Kim
3:00 pm-3:30 pm	Tea/Coffee	
3:30 pm-4:30 pm	10. Review and update the two-year work plan - agree responsibility of team members	Led by: Rafael Flores-Ayala/ Mary Arimond
4:30 pm-5:00 pm	Closing remarks Wrap up	Francesco Branca Rafael Flores-Ayala

Annex 2

3rd meeting of the WHO-UNICEF Technical Expert Advisory group on nutrition Monitoring (TEAM)

15-16 September 2016, WHO/HQ

List of Participants

TEAM Members

- Rafael Flores-Ayala – Chair
- Mary Arimond – Co-Chair
- Trevor Croft – Member
- Luz Maria De-Regil – Member
- Rebecca Heidkamp – Member
- Eline Korenromp – Member
- Purnima Menon – Member
- Faith Thuita – Member

TEAM members could not participate

- Abul Kalam Azad – Member
- Patrick Webb – Member

TEAM Secretariat (WHO)

- Francesco Branca
- Mercedes de Onis
- Kuntal Saha
- Elaine Borghi
- Monika Blössner
- Larry Grummer-Strawn

TEAM Secretariat (UNICEF)

- Julia Krasevec

Meeting minutes written by

- Monica Crissel Flores-Urrutia – WHO consultant

Annex 3

Group photo of the Technical Expert Advisory group on nutrition Monitoring (TEAM) members with WHO-UNICEF Secretariat members, 15 September 2016, WHO Geneva, Switzerland



From left to right: Monika Blössner, Rafael Flores-Ayala, Mercedes de Onis, Trevor Croft, Kuntal Kumar Saha, Rebecca Heidkamp, Purnima Menon, Larry Grummer-Strawn, Mary Arimond, Luz Maria De-Regil, Julia Krasevec, Monica Crissel Flores-Urrutia, Eline Korenromp, Pura Rayco-Solon, Elaine Borghi, Faith Thuita.

Report of the Third Meeting of the WHO-UNICEF Technical Expert Advisory group on nutrition Monitoring (TEAM), 15-16 September 2016, WHO Headquarters, Geneva, Switzerland.
