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

**Meeting Report  
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## Acronyms

ANC	Antenatal care
CORTASAM	Council of research and technical advice on severe acute malnutrition
Data-DENT	Data for decisions to expand nutrition transformation
DHS	Demographic and Health Surveys
FAO	Food and Agriculture Organization of the United Nations
GNPR	Global Nutrition Policy Review
GNMF	Global Nutrition Monitoring Framework
HIC	High-income country
HMIS	Health management information system
IFA	Iron and folic acid
IFPRI	International Food Policy Research Institute
IYCF	Infant and young child feeding
JME	Joint child malnutrition estimates
LIC	Low-income country
LMIC	Lower-middle income country
MAD	Minimum acceptable diet
MDD	Minimum diet diversity
MICS	Multiple Indicator Cluster Surveys
MIYC	Maternal infant and young child
MMF	Minimum meal frequency
M&E	Monitoring and evaluation
NCD	Noncommunicable diseases
NIPN	National information platforms on nutrition
NIS	Nutrition information systems
PMA	Performance monitoring and accountability
SAM	Severe acute malnutrition
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
WHA	World Health Assembly
WHO	World Health Organization
WPHNA	World Public Health Nutrition Association

## 1. Background

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 focus of TEAM during the first two years was 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 twelve technical experts with support provided by a joint WHO-UNICEF Secretariat. 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.<sup>1</sup>

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 session<sup>2</sup> and the 2nd TEAM meeting<sup>3</sup> were shared with all concerned and are available on the TEAM website.

The **third TEAM** meeting was held in September 2016 in Geneva, Switzerland. Updates were provided on all ongoing activities in the TEAM workplan. The concept notes and/or terms of reference on iron and folic acid (IFA), minimum acceptable diet (MAD), trained nutrition professionals and breastfeeding counseling indicators were discussed. It was agreed that the calls for consultants for IFA, MAD and trained nutritional professionals would be finalized and advertised by the TEAM Secretariat. It was decided that the TEAM working group working on breastfeeding counseling indicator would revise the concept note including a recommendation for an interim indicator. Other activities discussed were rules for tracking WHA global nutrition targets, and prevalence level ranges for stunting, wasting and overweight. The timelines for the activities were updated based on the current progress. A report<sup>4</sup> on the 3rd TEAM meeting is available on the TEAM website.

The **fourth TEAM** meeting was held in March 2017 in Geneva, Switzerland. TEAM reviewed progress and next steps towards finalizing interim indicators for IFA, MAD, trained nutrition professionals and breastfeeding counseling, and agreed on prevalence levels for wasting, overweight and stunting. Other activities discussed were operational guidance for GNMF indicators, the anthropometry data quality report, and methods and estimates for low birthweight, stunting and overweight. TEAM was also

updated on the work on modeling exclusive breastfeeding rates using retrospective data. A mapping of ongoing nutrition monitoring activities was presented, and the group discussed other research priorities for TEAM, outside of its work on the GNMf. A draft workplan for 2018-2019 was discussed and it was decided that the workplan would be finalized in the next TEAM meeting.

The **fifth TEAM** meeting was held in New York in November 2017. This report includes the summary of discussions, recommendations and decisions stemming from that meeting. The agenda and list of participants are included in Annex.

## Welcome and introduction to participants

Mark Hereward, Chief of the Data and Analytics Unit at UNICEF, and Victor Aguayo, Chief of Nutrition at UNICEF opened the meeting and welcomed participants. Mark highlighted UNICEF's commitment to using data in advocacy and programming and welcomed TEAM's support as UNICEF embarks on its new Strategic Plan in 2018. Victor emphasized that knowledge, evidence and data are at the heart of UNICEF's work and have a direct impact on programme quality.

On behalf of the TEAM Secretariat Kuntal Saha from WHO welcomed new members Edward Frongillo, Jennifer Coates and Wenhua Zhao, as well as Lynette Neufeld and Omar Dary, who were unable to attend the meeting. He also thanked outgoing members Luz Maria De-Regil, Patrick Webb and Abul Kalam Azad for their valuable contributions to TEAM's work over the past two years.

## 2. Summary of presentations and discussions

During the 5<sup>th</sup> TEAM meeting, participants reviewed progress on activities in the current workplan and identified new actions to be included in the workplan moving forward.

### 2.1 Overview of UNICEF and WHO nutrition work

Francesco Branca, WHO Director of Nutrition for Health and Development, provided an overview of WHO's global priorities for addressing all forms of malnutrition. With the UN Decade of Action on Nutrition 2016-2025, many countries are making ambitious commitments to tackle malnutrition, and identifying action networks to support and accelerate the implementation of these commitments. WHO's 2016-2025 Nutrition Strategy supports this global agenda by working with Member States and partners to ensure universal access to effective nutrition actions and to healthy and sustainable diets. Priorities for WHO include providing global leadership, monitoring and guidance to countries. WHO has published more than 40 nutrition-related guidelines between 2009 and 2016 (e.g. on iron-folic acid supplementation, antenatal care, etc.). Notably, in 2017 WHO published a guideline on supporting breastfeeding in facilities providing maternity and newborn services; and, a guideline on assessing and managing children at primary health-care facilities to prevent overweight and obesity. Operational guidance is also being developed to support countries in implementing World Health Assembly (WHA) resolution WHA63.23 on the inappropriate promotion of foods for infants and young children. In terms of monitoring, WHO collaborates with UNICEF and the World Bank to publish the Joint Malnutrition Estimates (JME) and is supporting countries to strengthen and expand district health systems to include nutrition information.

Victor Aguayo provided an overview of nutrition within UNICEF's newly finalized Strategic Plan 2018-2021, which is aligned with the Sustainable Development Goals (SDG) framework. UNICEF's new ambition for nutrition aims to move away from an intervention-based approach towards putting children, adolescents and women at the centre, looking at what each child needs to guarantee good nutrition at different points across the life cycle. This includes a return to food and diets as the centre of advocacy and programming and ensuring food security during early childhood; a focus on areas where action has been slow – e.g., improving diets, women's nutrition and care for children with SAM; a commitment to responding to new programming areas, e.g., nutrition of school-age children, nutrition of adolescents and the prevention of overweight; and, making knowledge, data and evidence the foundation of policy, advocacy and programming.

UNICEF has more than 650 nutrition staff globally and its work in nutrition falls under Strategic Plan Goal 1 – Every child survives and thrives – with three results areas: 1) countries have accelerated the delivery of programmes for the prevention of stunting and other forms of malnutrition (target = 250 million children under 5 benefit from services for the prevention of stunting and other forms of malnutrition, annually); 2) countries have developed programmes to deliver gender responsive adolescent nutrition services (target = 100 million adolescents benefit from services for the prevention of anemia and other forms of malnutrition, annually); and 3) countries have accelerated programmes for the treatment of severe wasting and other forms of severe acute malnutrition (SAM) (target = 6 million children under 5 benefit from services for the treatment of severe wasting and other forms of SAM, annually).

To achieve results in this areas, UNICEF's nutrition section is organized according to five programmes: 1) early childhood nutrition; 2) nutrition of school-aged children, adolescents and women; 3) provision of care for SAM in all contexts; 4) nutrition in humanitarian settings (comprising work from areas 1-3 in emergency contexts specifically); and 5) knowledge, partnerships and governance for nutrition. Key strategies to support this work include: situation analysis with emphasis on equity; advocacy and communication; policy development; programme design and scale up; systems strengthening; community engagement; knowledge generation and use; and resource mobilization.

Chika Hayashi, Senior Advisor for monitoring and statistics at UNICEF presented the main areas of work for the nutrition team in the Data and Analytics unit, including: maintaining and updating global databases including equity disaggregation (e.g. new database on SAM coverage and quality); providing support to improve country information systems (e.g. developing visualization tools and defining standard data elements and indicators for routine programme monitoring); developing methodologies (e.g. joint malnutrition estimates-JME, IYCF monitoring guide, school-age and adolescent nutrition and unhealthy eating); and data analysis and reporting (e.g. publishing numerous global reports). UNICEF and WHO would like TEAM's support in improving nutrition monitoring efforts at all levels and in engaging with other key stakeholders to expand the collaboration on nutrition monitoring.

### **Points of discussion:**

Questions were raised about the ways of working between UNICEF's Nutrition section and the Data and Analytics section, which are separate units. The separation was noted as a strength, as it helps Nutrition foster links with other sectors and a separate team focusing on data ensures that nutrition is always well reflected in global data reports and initiatives. Efforts are underway to review global estimates on low birth weight (a major data gap) and look at opportunities to better track the nutrition of school-aged children and counseling quality. To improve the nutrition of school-aged children, UNICEF will look at ways to leverage the school platform (not through school feeding programmes, but by making schools

more enabling of healthy diets) and to better document the links between nutrition and school readiness.

## 2.2. Updates on Global Nutrition Monitoring Framework (GNMF) indicators

### 2.2.1 Minimum acceptable diet (MAD)

The MAD indicator was selected as a process indicator in the GNMF, and TEAM recommended minimum dietary diversity (MDD) as a substitute indicator due to its simplicity and relevance across all countries. A technical expert consultation was held in June 2017 to discuss some concerns with the existing IYCF indicators and the need for new indicators to measure continued breastfeeding, dietary quality and the diets of older children.

The concern with the MDD indicator was around counting food groups. Breast milk substitutes were counted as a food group while breastmilk was excluded, thereby giving non-breastfed infants an advantage in measurements of MDD. While the IYCF M&E guide explicitly states to avoid comparisons between breastfed and non-breastfed infants, in practice, these comparisons were frequently being made. The decision was made to include breast milk as a new separate food group, with MDD criteria being met when a child consumes food from  $\geq 5$  of 8 food groups. With this change, there will be a very small decline in the prevalence of children meeting MDD globally. For countries without Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), guidance was provided on generating estimates from other quantitative data sets. The consultation achieved consensus on some classification challenges and affirmed the need for additional indicators to capture the consumption of nutrient-poor foods.<sup>5</sup>

Regarding the minimum meal frequency (MFF) indicator, concerns were raised about the fact that solid feeds were not required for non-breastfed children to meet the definition; however, no changes were made to the indicator. The definition of MAD was revised to reflect the changes to MDD and an error was corrected in the 2010 WHO document.<sup>6</sup> Given the change in MDD definition, non-breastfed infants would require  $\geq 4$  of 6 food groups plus  $\geq 2$  milk feeds (to avoid double counting dairy two food groups of (i) milk products and (ii) breast milk are removed) to meet MAD. The new MAD definition will have only a minimal impact on prevalence estimates. The consultation reviewed concerns around other IYCF indicators (e.g. knowledge gaps on supplemental feeding in the first 3 days of life; precision on age for continued breastfeeding; gaps on the 24-59-month age range; non-milk feedings in the first 6 months; unhealthy eating practices; school-aged children, etc.) and the need to identify or refine methodologies to address them.

Immediate next steps include updating parts 1 and 2 of the manual and global databases (with reference to the correction of the error for the MAD calculation as well as the definition change to 5 out of 8 food groups for MDD) before the next consultation in June 2018. Medium to longer term steps include food group changes, new indicators, sharing the draft with experts, cognitive and pilot testing and looking at data that could be collected through routine monitoring.

#### **Points of discussion:**

There was some discussion about social desirability bias, and whether cognitive testing could be done to measure this in relation to responses to questions on complementary feeding. Regarding the list of



foods, there was discussion about the challenges around the local specificity of unhealthy foods and the need for a list of the biggest disruptors to healthy eating in different contexts.

There were questions about whether any future products would be developed by the working group and concerns about over-burdening countries by adding more indicators. A consultant will help the Secretariat obtain clarity on core versus optional indicators. Many countries have data to answer new questions already but need support to tabulate them. TEAM agreed that a communications plan would facilitate the transition to the new definitions. There was some discussion about countries comparing data between years when the indicator definitions have changed; however, UNICEF updates its time series, so this should not be a problem.

## 2.2.2 Antenatal iron supplementation

TEAM and others identified several issues with the original IFA coverage indicator<sup>7</sup>, including those related to the definition, data access and availability. After discussions between February 2016 and March 2017, TEAM proposed that the indicator be refined and validated, that it include a minimum number of tablets to be consumed, and that 'iron-folic acid' (IFA) should be included in the indicator name. It would be important to have data on antenatal care (ANC) coverage as well as the number of tablets distributed, purchased and consumed.

To help address some of these issues, the TEAM Secretariat sought the help of a consultant to examine the feasibility of reporting on the proposed indicator and the policy context within which reporting would take place. A scoping exercise was conducted among eight diverse countries (Nepal, India, Philippines, China, Nigeria, Senegal, USA, Mexico), including desk review and interviews with global stakeholders. The countries selected had varying anaemia prevalence, ANC coverage, data availability. Key findings of the study: None of the data sources reviewed could report on the originally proposed IFA coverage indicator. There was wide variability in country data sources and in policies on IFA (e.g. in terms of supplement composition and recommended number of tablets), and the lack of validation of maternal recall was problematic.

The IFA indicator was revised in 2017 for reporting to the WHA, using a 'lowest common denominator' definition: the percent of women who consumed any iron-containing supplements during the current or past pregnancy within the last 2 years. The new indicator is an interim solution to allow for reporting in 2018. The revised indicator is intended to align better with major data sources, avoid undue burden on countries and generate the best reliable estimates. There are still issues around IFA measurement and validation. One validation study is underway on Johns Hopkins under the Improved Coverage Grant where delivery interventions are observed and then women are asked to recall if they received them. IFA will be one of the studies included as part of a larger study of services delivered under ANC in Nepal.

### **Points of discussion:**

Some participants expressed concern that the bar was being set too low, without much incentive for countries to provide more than the bare minimum of one tablet. There was also a comment about measuring the impact of IFA. Concerns were also expressed about recall, and a suggestion made to ask more generally about the frequency of consuming the tablet – e.g. almost never, sometimes, all the time.

The revised 'interim' indicator is tied to one of the WHA global nutrition targets and is meant to allow countries to report in 2018; nonetheless, the concerns expressed above should be addressed moving forward. The revised indicator is not an IFA impact indicator but measures progress and the health system's ability to deliver iron supplements via the right pathway. The revised indicator creates accountability and provides an opportunity for all countries to report something – not just low-and-middle income countries with DHS and MICS data. Tracking the number of women receiving any iron-containing supplements is also a step towards closing the gap in those not being reached at all by IFA interventions.

There was a question about using a programme indicator as an alternative (e.g. to measure the existence of a national programme), as was done for the breastfeeding counseling coverage indicator (see discussion, page 8). The working group had not discussed this option as it is too late to include it in the operational guidance for GNMf indicators and discussion in the WHO Executive Board meeting in January 2018.

There were some questions for WHO-UNICEF about the potential for dropping indicators that were deemed problematic. It is not possible to drop an indicator, given that the GNMf operational guidance will be translated and published in January; however, minor edits could be made (e.g. to the indicator title) based on TEAM recommendations. WHO's rationale for having the interim indicator is to avoid inaction on IFA.

#### **Next steps/actions:**

A decision was made to add "any" to the name of the interim indicator making it 'Any antenatal iron supplementation' to be consistent with its definition.

### **2.2.3 Breastfeeding counseling**

Breastfeeding counseling coverage is a core GNMf indicator;<sup>8</sup> however, this indicator does not yet exist and there are no data available for this indicator. Given this gap, the GNMf operational guidance being developed for 2018 will not include the originally proposed indicator; rather, countries will be asked to report on an interim indicator (i.e. availability of national-level provision for breastfeeding counselling services in public health and/or nutrition programmes). There are several identified issues related to the original counseling coverage indicator (described in the 4<sup>th</sup> TEAM meeting report) that will benefit from further discussion with breastfeeding programme and evaluation experts.

Since the last TEAM meeting in March 2017, work has been ongoing to review counseling coverage measures used in the core Alive & Thrive and Performance Monitoring and Accountability 2020 (PMA2020) studies and review and look for opportunities within the DHS and MICS questionnaires, which do not currently include questions to measure counseling coverage. Measurement of this indicator is complex as counseling messages can be delivered at various contact points across the lifecycle, including pregnancy, post-natal and neonatal checkups as well as preventive and curative contacts. There are a number of considerations in designing coverage measures for ICYF interventions, including the type of contact points within households, the type of provider, the nature of the intervention and the frequency of contact.

Alive & Thrive has tailored questions to the context of delivery. While DHS and MICS surveys or routine reporting systems do not have this level of specificity, there are potential entry points for additional questions on counseling. For example, there are opportunities to include questions on counseling and its timing during post-natal support. There are also good questions about care seeking behaviours in these large surveys, and a small addition to the question could measure exposure to counseling during curative contacts. These questions would provide additional data but still do not capture the exact GNMF indicator definition. The PMA2020 work on timed and targeted breastfeeding counseling and support and the IMPROVE/coverage 2017-2020 validation studies provide examples of other possible measurements.

There is still a large and important body of work needed to report on the GNMF counseling indicator. Ongoing testing in survey programmes should continue in the context of existing and functional national programmes that deliver counseling interventions, where initial testing can be done. New questions need to be developed and integrated into a partial set of national surveys and reporting needs to begin. This work requires resources. With the measurement initiatives undertaken by Alive & Thrive and PMA2020, there is enough research to move forward. To do this, a meeting could be convened to share insights from questionnaire reviews and field testing, agree on common core of questions to capture counseling coverage/exposure, identify areas for adaptation and define a meaningful indicator.

#### **Points of discussion:**

There was some discussion about what constitutes a meaningful ‘dose’ of counseling and what such a survey question would look like, as no guidelines exist to define this. An example could be measuring counseling immediately after birth. Alive & Thrive’s work captures ‘dose’ (monthly counseling in the first six months is a minimum expectation); however, recall is a challenge given that so many interventions are happening during those first six months. Participants discussed the possibility of routine data collection for the counseling indicator. There is need to see what is available in health management information systems (HMIS), while ensuring quality standards.

WHO and UNICEF should help identify opportunities for TEAM’s engagement in the process of proposing questions for national surveys and pilot testing. To test questions in MICS, UNICEF will need to make a strong case for which countries to test in and why, and prioritize questions (i.e. those around counseling – or other issues that TEAM is addressing on adolescent diets, anthropometry, etc.). Revisions to DHS are possible in early 2019 and new suggestions will need to be backed by evidence. It would be helpful to develop a timeline for how to contribute to these various processes. TEAM should also examine how reporting on this indicator can be part of a broader TEAM workplan.

### **2.2.4 Trained nutrition professionals**

The original indicator proposed in the GNMF was the *number of health personnel trained to respond to nutrition challenges and implement nutrition-related interventions and programmes at each service delivery level per 100,000 population*. Member states requested operational guidance, including clarification on the standard definitions, availability of data, and operational aspects of data collection.

In January 2016, a background paper was prepared for TEAM to identify concerns regarding implementation of this and the other three deferred indicators. The paper recommended a proxy indicator “density of nursing and midwifery personnel per 10 000 population”, for which data is

available in the WHO Global Health Observatory for 186 countries. Given a number of remaining concerns with the proxy indicator, WHO undertook a scoping exercise to develop and validate a better indicator. Four potential indicators for trained nutrition professionals were proposed and evaluated against five criteria: 1) fit for purpose (specific to measure changes in human resource capacity); 2) validity (based on association with the 6 WHA targets); 3) operational feasibility (based on data availability); 4) operational simplicity (ease of data collection and indicator calculation); and 5) timeliness (availability of baseline data and follow up surveys).

Based on the criteria, the *density of trained nutritionists and dieticians* was evaluated as having the greatest validity as an indicator of the nutrition capacity of countries. Nearly all countries can identify whether trained nutritionists and dieticians are working in nutrition-related areas; 80% provided numbers with higher reporting rates in low- and middle-income countries (LMICs) than in high-income countries (HICs). Data can be collected from WHO's Global Nutrition Policy Review (GNPR) approximately every four years. Inconsistencies remain between countries around the data and the definitions for 'nutritionist' and 'dietician' also appear to differ between some countries.

The technical brief on the recommended indicator has been submitted for review in the WHO Executive Board meeting in January 2018; follow up meetings will take place with WHO regional advisors to compile information systematically; WHO will consider incorporating GNPR questions into the health workforce questionnaire; WHO will disseminate the report of the scoping exercise on TEAM web site and publish a manuscript in peer-reviewed journal.

#### **Points of discussion:**

There was some concern that the title of the indicator was indicative of training rather than professionals actually employed in the field. This detail can be amended; however, it would be important to clarify what question was being asked of respondents<sup>9</sup> and look at which data were being used to populate the questionnaire. There was also some concern that front-line health workers delivering nutrition services would be missed, and this was noted, however, the evaluation deemed that it would not be feasible to include them.

#### **Next steps/actions:**

- Remove 'trained' from the indicator title. Ask a few countries to verify how they responded to the questions.
- Clarify the directions of associations for validation tests noted in the report.
- WHO will identify if any groups have plans to further develop this indicator (e.g. Capacity Building Task Force of the World Public Health Nutrition Association (WPHNA)).

## **2.3 Update on operational guidance for the GNMF indicators**

In 2012, the WHA approved the comprehensive implementation plan on maternal, infant and young child nutrition, with 6 global targets and an action plan with five components – the fifth of which was to monitor and evaluate the implementation of policies and programmes. The GNMF was developed with ten indicators to fulfil the requirements for immediate reporting to WHO and four indicators requiring additional operational guidance, for which reporting would be delayed until 2018 (minimum acceptable diet; IFA supplementation; breastfeeding counseling; and trained nutrition professionals).

In the March 2017 TEAM meeting, an update was provided on the status of the operational guidance and TEAM suggested field testing of the document. Operational guidance has been field tested through WHO and UNICEF regional and country offices. Operational guidance for the four delayed indicators has been developed in consultation with the TEAM working groups for each indicator. A technical brief on the four indicators has been prepared for review during the WHO Executive Board meeting in January. It is currently under the WHO publication approval process and will eventually be translated into all UN languages. TEAM endorsed these four indicators to be used by countries to report to the WHA beginning 2018.

#### **Points of discussion:**

There was some discussion about to what extent changes could be made, given that the draft had already been submitted. Some TEAM members felt it was important to review the document again before publishing. If further reviews were to take place, there were questions about the process for accepting or rejecting new comments. Others cautioned that opening the process up for review again may not add significant value and could hamper translation. There was also clarification that the draft version of the document has been shared with TEAM for review. TEAM's technical contribution to this operational guidance will be acknowledged.

#### **Next steps/actions:**

Small edits can still be made to the current draft (e.g. to correct titles, small inconsistencies or typos). Three small edits to make are: for IFA, add 'any' to 'antenatal iron supplementation', for breastfeeding counseling, add 'breastfeeding' to the indicator definition, and for trained nutrition professionals, delete 'trained' from the title.

## **2.4 Technical report on anthropometry data quality – status update and next steps**

The technical report on anthropometric data quality – *Minimum anthropometry data quality criteria and methods for harmonized data collection, analysis and reporting of nutrition surveys* – was intended to summarize good practices and provide links and available tools and guidance material. It was meant to facilitate minimum standardized data collection, analysis and reporting processes with the focus on how to obtain good quality anthropometric data. The report was developed by a working group of experts who authored different chapters.

The report proposes harmonized definitions and roles for staff involved in anthropometry and suggests a model of questionnaire, training agenda and timeline; describes detailed sampling steps to avoid errors due to survey design; highlights the minimum training process requirements to have efficiently trained teams; provides specific considerations to collect date of birth for age determination; presents common errors while taking anthropometric measurements and provides clear guidance on how to minimize them; advises on how to strengthen the supervision process through the use of field check tables; explains the standard approach for anthropometric data analysis; includes common pitfalls and how to avoid them, based on practical lessons learned; lists practical data syntheses that can be used for evaluating the completeness, coherence and quality of collected data; and provides links to already available tools from different sources, such as DHS, MICS, SMART, etc.

Feedback and reviews from the working group have been slow, leading to significant delays in the process, and there are still important issues to be resolved (e.g. the issue of field checks – which ones, where, when and by whom). The report has been sent to the working group for review by 8 December, with proposed timeline for editing 11 December and return to the working group for final review between 20 December and 7 January, to be ready for WHO clearance mid-January. TEAM was asked to decide whether this timeline should be maintained, despite the unresolved issues, or if the working group should take the time to resolve them first.

#### **Points of discussion:**

There was a lot of discussion about the pros and cons of moving forward versus waiting to resolve the pending issues around assessing data quality. Some participants noted that consensus would never be possible, so the report should move ahead. Others felt strongly that the document was not ready to be published and contained technical and structural problems, quality issues and unanswered questions (e.g. about the audience, age estimations etc.) There were also concerns about biases being introduced in the writing of the various chapters and a suggestion was made to have an independent consultant peer review of the document. It was noted that this project had stalled because no resources had been allocated to it. The beginning of 2019 will be an opportunity to create new systems or indicators for the DHS and it would be useful to have the report available by then.

Different approaches were discussed to address quality concerns – e.g. having an independent consultant draft the contentious sections; having peer reviewers look at different chapters; having a meeting of the working group to go through the various concerns. TEAM members agreed to take more time to address the concerns with the report and invest time to improve the report. There is a need for resources to support this process.

#### **Next steps/actions:**

The proposed steps are as follows:

- 1) feedback on the current draft is provided to WHO by the 3<sup>rd</sup> week of January;
- 2) a revised version will be shared with the working group; and
- 3) a call will be organized in the second half of February to resolve basic structural/technical issues with the draft report and to decide next steps.

## **2.5 Modeling exclusive breastfeeding**

WHO has undertaken preliminary work with a consulting firm (Ipsos) to estimate exclusive breastfeeding rates using retrospective data, for countries without MICS and DHS data (see 4<sup>th</sup> TEAM meeting report). TEAM was asked for feedback about whether WHO should adopt the recommendations stemming from this work.

Background to the discussion: the global database on exclusive breastfeeding has data on less than half of countries, particularly HICs. The standard indicator for exclusive breastfeeding is based on a 24-hour recall and has been adopted by MICS and DHS. An alternative indicator, used by most HICs, is the ‘since birth’ indicator, where respondents are asked how long the baby was breastfed and at what age he/she received another liquid or solid food for the first time. Neither of these is a perfect measure.

Ipsos selected countries with data for both the standard definition indicator as well as alternate indicators and compared estimates to develop a model for describing the relationship between the indicators. They collected microdata from the World Bank and the International Household Survey Network, identifying 42 studies with high quality data. In total, 227 observations from 30 countries were used for the modeling exercise. Data were calculated for different clusters/strata to have models with as high as possible degrees of freedom. All models used the 24-hour recall indicator as the dependent variable and the retrospective recall (i.e. children exclusively breastfed for at least 3, 4 or 6 months and the average of children exclusively breastfed up to ages 1, 2, 3, 4, 5 & 6 months) as the explanatory variable. The 3-month model and the model using the average had a line which was close to 45 degrees, while the 4 and 6-month models showed a log-linear relationship. All models failed to meet the standards for linear regression. Several transformations on the data were performed to meet the criteria, however, this caused the  $R^2$  value to drop. The heteroskedasticity seen in the plot is driven by the clumps at the young age range. Standard errors of national estimates are much larger (roughly double) for the standard 24-hour recall indicator than for the “since birth” indicator.

Recommendations from the modelling exercise: For countries without standard 24-hour recall data that have raw data on % of exclusive breastfeeding from ages 1-6 months, use the average model and apply the standard linear regression – the simplest model with the best performance. The country should be encouraged to report on the standard indicator in the future to avoid estimation. In the absence of raw data, the best option is to employ the 3-month model, or if that is not possible, the 6-month model. Using this model could make reporting exclusive breastfeeding possible for additional countries although further work is needed to know exactly how many.

#### **Points of discussion:**

The group discussed its position on moving forward with the recommendations of the modeling work. Concerns were expressed about the wide variability in the data points shown (e.g. between 20-80% in some cases) and some participants felt it was unacceptable to use such an imprecise estimate for the global database. While standard errors are smaller for “since birth” indicators, it is generally due to larger sample sizes and thus a reflection of sampling error, but this does not account for non-sampling error which may be larger in a recall of feeding patterns for previous years as opposed to the previous day. Regarding the wide variability, there was a suggestion to calculate the standard deviation of residuals to decide if the degree of variability is acceptable. Part of the reason for the observed variability is that the analysis used small strata; there could be potential to reanalyze using only national-level estimates.

While many expressed concern about providing national estimates based on the proposed models, some suggested generating global or regional estimates from these data. A few countries have data points for multiple years and there was a question about whether these could be used to track the accuracy of the predictions.

There was interest in knowing which countries were represented by the different points on the plot. There are 20 countries that have these retrospective data in WHO’s global health observatory; WHO has not yet asked Ipsos to proceed in analysing them. Increased advocacy to countries to extend the age range down to infancy for already existing and regularly implemented dietary surveys could increase the availability of data based on the standard indicator and is another way forward.



**Next steps/actions:**

There are three choices on how to proceed:

- 1) use models proposed by Ipsos to come up with estimates for countries that do not have them;
- 2) use those models to create regional or global estimates but do not publish country estimates;
- 3) do not estimate exclusive breastfeeding from retrospective surveys.

To help make a decision, WHO will also ask Ipsos to do two additional analyses: 1) apply the models using only national-level estimates (instead of strata) to see the amount of variability; and 2) determine how many additional countries would be included in the database if the models were applied.

## 2.6 TEAM research priorities

The TEAM discussed its research priorities and the processes for implementing them, including participation, scope and duration of the work. Two models for developing a research agenda were discussed – one is a global agenda for nutrition monitoring and the other would be more specific TEAM priorities. TEAM members had submitted proposed research priorities in advance of the meeting, which fell into seven broad thematic areas: 1) global monitoring; 2) monitoring, surveillance and evaluation systems at country level; 3) understanding and monitoring policy and implementation processes and decisions; 4) indicator thresholds and public health significance and action; 5) methodological work related to existing indicators; 6) methodological work and development related to new indicators; and 7) miscellaneous.

**Points of discussion:**

There was discussion about TEAM proposing some priority areas for global nutrition monitoring, but encouraging other groups to undertake the work. Some noted that a research agenda was a labour-intensive process requiring background work such as systematic reviews that would be challenging for TEAM to undertake. Others felt that a list of key topics had already been generated and would be an adequate contribution to priority setting.

The point was made that TEAM is meant to serve as an advisor to WHO and UNICEF. Therefore, TEAM's research priorities should reflect those already defined by WHO and UNICEF. At the same time, having a list of general research priorities created by TEAM could also be useful for UNICEF and WHO as a reference if/when the question is raised by partners. There are also a number of groups working on nutrition monitoring with similar agendas – e.g. the information group looking at nutrition metrics in support of Countdown 2030 is writing a paper on improving coverage measurements.

Regardless of the specific approach, communication about the research agenda is important. If research funding bodies are made aware of these research priorities they might create funding opportunities. TEAM could reach out to ask how such bodies can support the agenda. In addition to research, there was also a suggestion that TEAM considers priorities for uptake and action in the future.

A vote was taken, and the majority felt that TEAM should respond in some way to the question of research priorities but not through a long and comprehensive exercise.



## Next steps/actions:

A working group will prepare a list of potential research priorities and a technical brief on TEAM research priorities to be discussed in the next TEAM meeting (see workplan discussion)

## 2.7 TEAM workplan discussion

### 2.7.1 Extension of the WHA targets to 2030

With the adoption of the SDGs, there was a call for the WHA's 2025 global nutrition targets to be extended to 2030. WHO and UNICEF called for a broad group of stakeholders to be included in these discussions, including TEAM and other UN agencies. A background paper is being developed by UNICEF and WHO to be approved by Member States at the next WHA. TEAM is requested to provide feedback on the proposed targets.

Progress towards the 2025 goals varies across countries and regions, and the 2030 goals have a much greater ambition: to end all forms of malnutrition. Therefore, in extending the 2025 targets to 2030, there needs to be a balance between aspiration and feasibility. If targets are too ambitious, then no country can achieve them and there is a risk of de-incentivizing investments and actions. The following were the proposals for extending the 2025 targets to 2030:

*Stunting:* Proposing a continuation of the annual rate of reduction, which would mean a target of 50% reduction in the number of stunted children by 2030 (the 2025 target is a 40% reduction). The current global trend shows a decrease of 2.3% per year, while the required rate is 4% reduction per year.

*Anaemia:* Proposing to maintain the 2025 target for 2030 (target is a 50% reduction in prevalence from a baseline prevalence of 30%). This proposal is realistic as progress has been very slow and there remain important data gaps on this indicator.

*Low birth weight:* Proposing to maintain the 2025 target for 2030, which would mean a target of 30% reduction in low birth weight by 2030 (the 2025 target is 30% reduction from a baseline of 15%). There is a lot of work being done by various groups and initiatives to reduce low birth weight which will help in achieving this target.<sup>10</sup>

*Wasting:* Proposing to reduce and maintain the global prevalence of wasting at 3% (revised from an earlier proposal to continue the current annual rate of decline to 4% by 2030). There has not been much change from the baseline on wasting. Of 145 countries with data on wasting, 29 countries are meeting this 3% target.

*Overweight:* Proposing to reduce and maintain the global prevalence of overweight at 3% (revised from an earlier proposal to use a buffer of 1.5% reduction per year, resulting in 4.3% prevalence by 2030). The 2025 target is 'no increase in childhood overweight'. This is an ambitious target: 22 of 142 countries are meeting this target (no countries in Europe or the Americas).

*Exclusive breastfeeding:* Proposing to set the target to two out of three (67% or around 70%) 0-6 month olds exclusively breastfeeding (revised from an earlier proposal to use a 30% relative reduction in rate of not exclusive breastfeeding, to a target of 62% exclusive breastfeeding). Of 54 countries with trend data, the annual increase in rate is about 3%, so there are 3 possible scenarios: 1) based on the average rate

of increase of these 54 countries, we would reach 58% exclusive breastfeeding by 2030; 2) based on average rate of increase of all countries with an increase in rate of exclusive breastfeeding since baseline, we would reach 74.7% by 2030; and 3) based on the average rate of increase of top ten countries with largest increase AND countries with rate of decrease between -5 and -10%, we would get 72.7%.

#### **Points of discussion:**

On stunting, there were some questions about the feasibility of nearly doubling the rate of reduction. Some countries reduce their stunting rates by focusing on parts of the population that are easiest to reach, leaving the most vulnerable behind.

On wasting, there was agreement that the proposed target was achievable. The No Wasted Lives coalition will help accelerate global action on this target.

On overweight, there was skepticism about HICs' ability to reach the target. However, it was felt that the proposed target was appropriately ambitious and would push HICs towards greater accountability. The buffer was added for this indicator due to issues with confidence intervals.

On exclusive breastfeeding, there was overall support for 70% as an achievable target rate. Some participants noted that the language used should not suggest that 70% was in any way aspirational. The 70% would align with the ambitions of the Global Breastfeeding Collective.

There was a concern expressed about the different logical frames used to develop the proposed targets. Others did not see any problem with the logic given that it was based on extending the current metrics and each indicator topic having different contexts. Questions were also raised about why a 3% reduction was not being targeted for stunting (as it was for wasting and overweight). However, the Secretariat mentioned that given the current stunting rate of 22.9%, the 3% could be too ambitious. Lastly, concerns were expressed about how to communicate these changes with countries if 2025 and 2030 target monitoring approaches are not aligned.

#### **Next steps/actions:**

WHO and UNICEF will discuss further and prepare the final background paper for the WHO Executive Board. TEAM members can further contribute comments during any public consultation between the Executive Board and the World Health Assembly.

## **2.7.2 The extended set of GNMF indicators**

TEAM discussed gaps in the GNMF indicators (including intermediate outcome indicators, process indicators and policy indicators) and potentials of the extended set of indicators that can be used to fill those gaps to monitor progress towards WHA targets. For example, target 3 on low birth weight has no process indicator; targets 2 and 5 have only a few intermediate outcome and process indicators. Of the 16 indicators adopted as part of the extended framework, TEAM had previously selected five to include in its workplan: 1) proportion of children born in the last 24 months who were put to the breast within one hour of birth; 2) percentage of households that have iodized salt (>15 ppm); 3) appropriate use of micronutrient powders for children aged 6-23 months; 4) proportion of children with severe acute

malnutrition having access to appropriate treatment including therapeutic foods and nutrition counseling; and, 5) number of countries with legislation /regulations to protect children from the marketing of unhealthy foods and beverages.

#### **Points of discussion:**

The extended set of indicators have been discussed among Member States but not yet adopted. TEAM's role is to look at the feasibility of these indicators and confirm if they should move forward or not. This would require a new round of discussion with Member States.

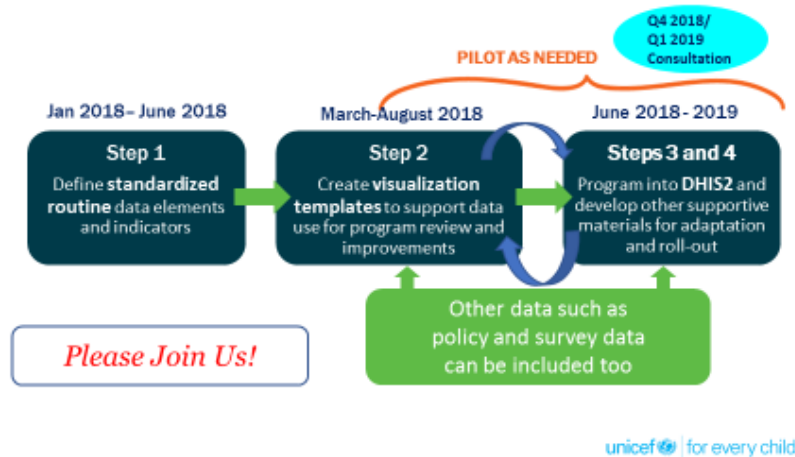
There was a comment that the extended indicators should have been technically vetted first before engaging with Member States. As with the core indicators, there is some discomfort among TEAM members about the extended set of indicators. There was a general agreement that greater thought and mapping were required before returning to the WHA for discussion. There were no specific tasks or timeline discussed. The Secretariat will bring this back to TEAM in next TEAM meeting for further discussion.

### **2.7.3 Strengthening nutrition information systems**

There are important opportunities for TEAM to support nutrition information systems (NIS). The first, is a nutrition monitoring and surveillance guide, which would include information on data content, including what indicators to collect and why as well as methods and frequency of data collection. The guide could work with the national plan cycle which typically has an accompanying monitoring plan to determine which data should be collected and when. To strengthen nutrition information systems, the guide could look at different actors, multi-sectoral engagement, data flow, data quality assurance, etc. A section on data use could include area graphs, score cards or other practical examples. TEAM was asked for feedback on the idea of a guide and its content.

Another opportunity is for TEAM to endorse a core set of routine data and visualization templates for nutrition. The steps for developing such a series of templates and programming them into DHIS2 is described in the figure below. This is an important initiative as nutrition specialists are often not at the table when countries are updating their registers, resulting in missed opportunities to advocate for nutrition to be integrated within the reporting form. A first step is to look at existing health and community based registers to help prioritize indicators. The figure below shows the steps UNICEF is taking and the general timeline for this work. TEAM members were asked if they would be interested in endorsing this work and if they were aware of other efforts to standardize routine data collection.

## General Steps and Timeline: Nutri-Data and DHIS2 Nutrition Module



### Points of discussion:

On the monitoring and surveillance guide, there are many countries asking for more guidance on indicator mapping, routine versus survey monitoring, data platforms and monitoring during nutrition emergencies. Some participants commented that not enough was known at this point about examples of good data use within countries and that more background work was necessary before offering guidance. The general impression was that while there is a need at country level, it can be hard to find exemplars. However, there are upcoming nutrition surveillance systems being set up in Guatemala, Uganda and Burkina Faso. There was a suggestion to link with SUN data systems and the EU-funded National Information Platforms on Nutrition (NIPN) initiative to help countries consolidate data from different sectors. Others asked how country consultations would fit in with the development of the guide. Guidance should lay out some essential criteria that NIS should meet, with different models or pathways countries can consider, rather than a one-size-fits-all approach.

### 2.7.4 Quality adjusted coverage indicators

Quality adjusted coverage refers to the population reached by an intervention with sufficient quality to produce an effect. It is calculated by taking coverage estimates (e.g. household survey estimates) and adjusting them with data on quality (e.g. service provision estimates). Within facilities, service assessments can look at measures of readiness (e.g. equipment, diagnostics), provider competencies, or client satisfaction. Key questions to consider in this work include: how to define a quality service and what are the metrics; and how to link coverage measurements to the delivery point. The quality measurement in nutrition can be challenging given that there are multiple delivery platforms and some interventions (e.g. counseling) require few if any supplies.

Data for Decisions to Expand Nutrition Transformation (Data-DENT), a consortium led by Johns Hopkins, IFPRI and funded by the Bill & Melinda Gates Foundation, is an opportunity to improve coverage

measurements. Data-DENT aims to define and strengthen the data value chain for nutrition, with the understanding that better data and stronger systems are key to achieving global nutrition targets. Data-DENT looks systematically to identify priority indicators, generate high quality data, and ensure that data is aggregated, used and translated into findings that can inform policies and programmes. The Gates Foundation has invested in nutrition programme implementation, advocacy and data/analytics in five focus geographies and wants to report on a core set of indicators. While the Gates Foundation has these particular needs, they also recognize that governments and other implementers want to make similar decisions and are facing similar data challenges. For example, only four GNM core indicators are regularly collected through national surveys in most countries, leaving a wide data gap on coverage. In pushing the measurement agenda in selected countries, data-DENT, therefore, offers an important public good. There is also some space within the project for global level activities.

TEAM should discuss possibilities for further engagement with Data-DENT and IFPRI, for cognitive testing, advanced analysis of the Alive & Thrive coverage data, or additional work on priority indicators with global impact.

#### **Points of discussion:**

It is more challenging to measure counseling quality because there is not yet consensus on the dose required for impact. WHO is developing programmatic guidance on counseling that could provide better insight on this. However, there is already evidence that information alone is not enough to help mothers address the challenges they face in breastfeeding, whereas with complementary feeding, information can sometimes be enough to help families achieve a minimum standard.

The group discussed how methods to adjust coverage had been validated, including differences between redefining coverage and adjusting coverage. This is an emerging area, but some coverage validation studies have been done. Linking studies (e.g. around sick child visits) have also been designed including three methods of tracking and observation to ensure that respondents were linked with the correct facilities.

There was a question about the relationship between Data-DENT and the country's existing infrastructure. The Gates Foundation is not investing in primary data collection, but rather relying on country supported data systems, ensuring that all country data systems feed into reporting.

#### **Next steps/actions:**

TEAM has many workplan priorities without a budget and should consider funding opportunities with Data-DENT.

### **2.7.5 Nutrition in school-aged children and adolescents**

Undernutrition and overweight and obesity are problems among adolescents in low- and middle-income countries. By 2030, among 5-19-year olds, a greater number will be obese than moderately or severely underweight.<sup>11</sup> An overemphasis on pregnant women and children under 5 has meant insufficient investments in this age group. There is also an overall paucity of data, particularly for 5-14-year olds. Momentum is growing for this age group, with a critical mass of programme documents now being developed and increasing evidence, policy and programmes for adolescents. However, there is a need

for a comprehensive set of indicators to monitor nutrition in middle childhood and adolescence, where very few data sources exist. Important gaps exist within global databases as well as national surveys – for example, MICS is missing a nutrition module for school-aged children and adolescents; and DHS has missing links around the nutrition status of school-aged children and early adolescents, with no information on IFA or the food environment among children in these age groups. General data challenges include the lack of indicators, gaps in tracking out-of-school adolescents, lack of information on diet, environment and other determinants, and poor HMIS data quality.

SPRING started an iterative process to understand issues related to diet and eating practices of adolescents<sup>1</sup> (2015). Recommendations highlighted the need to design and use standardized tools and methods for population-based research; the need for implementation research; the need to develop tools and indicators to model adolescent dietary patterns in various settings; and the need to develop indicators that capture healthy and unhealthy diets.

A metrics working group is needed for nutrition of school-age children and adolescents to derive indicators. There could also be an opportunity for a nutrition module for these age groups within MICS and DHS. More work is needed on how to reach those in conflict or out-of-school and a qualitative tool to better understand the drivers of poor nutrition in this age group.

#### **Points of discussion:**

MICS has a new module on children 5-17 years old. It may be possible to include nutrition, but the challenge is that every sector wants to take advantage of this opportunity. There was a suggestion for TEAM to do some preliminary work before proposing a comprehensive nutrition module – for example, by identifying one area of programming and working through the indicators. There is a need for methodologies work around self-administered surveys. There was a comment that sampling issues around reaching out-of-school children were not specific to nutrition and may be better addressed by other groups. UNICEF is considering convening a school-aged and adolescent nutrition metrics working group.

### **2.7.6 Global engagement of TEAM**

TEAM discussed a proposal for the way forward on global engagement. This included: identifying a finite, manageable number of highest priority groups and initiatives for TEAM to engage with; identifying any overlap of TEAM membership with these groups/initiatives; and identifying a TEAM or Secretariat member best situated to reach out to them. TEAM was also asked to agree on how frequently they should reach out to these groups and what messages should be communicated. Engagement could lead to a future partners' meeting in 2018.

Some groups to consider for TEAM to engage include: Global Nutrition Report, Countdown2030 Nutrition Metrics Joint Working Group, Data-DENT, Council of Research and Technical Advice on Severe Acute Malnutrition (CORTASAM), and Committee on World Food Security. TEAM should also consider a more strategic engagement with groups that it wishes to influence (e.g. donors, DHS group and key groups that can put its recommendations into action).

**Next steps/actions:**

- 1) Develop a brief document listing groups and initiatives working on global nutrition monitoring for potential engagement before the next TEAM meeting.
- 2) Review revised ToR, clarify the scope of engagement and how it will be communicated; and look at how these groups may be able to contribute to priorities in the new TEAM workplan.
- 3) WHO will attend a meeting of the advisory body for Mother and Newborn Information for Tracking Outcomes and Results (MONITOR) in March 2018, which is an opportunity to look at potential linkages.

**3. TEAM workplan 2018-2019**

TEAM reflected on the potential workplan priorities that had been proposed prior to the meeting and members were asked to rank their personal preferences. Each topic would be led by a focal point with the support of working group (including WHO and UNICEF as Secretariat members driving the work and direction). The following topics were selected in order of rank, with a summary of initial proposal of TEAM member participation (in addition to the WHO/UNICEF Secretariat):

	<b>Workplan topic</b>	<b>Lead/Co-lead</b>	<b>Working group members</b>	<b>Output</b>
1	Nutrition information systems	Rebecca Heidkamp	Purnima Menon, Eline Korenromp, Faith Thuita, Wenhua Zhao and Ed Frongillo	A roadmap or outline for the monitoring and surveillance guide
2	Diet quality indicators for healthy and unhealthy foods	Jennifer Coates and Mary Arimond	Wenhua Zhao, Ed Frongillo	To be confirmed, in coordination with WHO/UNICEF
3	TEAM engagement in the Joint Malnutrition Estimates group	Ed Frongillo		Serve as a liaison to established JME working group
4	Anthropometric data quality	Rafael Flores-Ayala	Trevor Croft, Faith Thuita	Finalize the report
5	Research priorities	Ed Frongillo	Rafael Flores-Ayala, Purnima Menon, Wenhua Zhao, Jennifer Coates	1. Compile contributions; define priorities and feedback to TEAM. Suggests ideas of group to advance priorities; 2. Publish a technical brief or other product (tbc)
6	Revision of the IYCF guide	Mary Arimond	Trevor Croft	Background work in preparation for the June meeting to finalize update of the IYCF mini guide
7	GNMF indicators IFA	Rebecca Heidkamp with Lynette Neufeld and Omar Dary (TBC - Rebecca Heidkamp to support with the transition.		Address questions about recall and recall validation; conduct mapping to see which groups are working on questions related to IFA; outline a brief roadmap and key stakeholders.
8	GNMF indicators	Purnima Menon		1. Complete empirical work to

	Workplan topic	Lead/Co-lead	Working group members	Output
	Breastfeeding counseling	and Rebecca Heidkamp		compile Alive & Thrive findings and propose suggestions for capturing exposure to breastfeeding counseling (before the final meeting in June of the WHO guidelines development committee producing the counseling guidelines). 2. Compile a global collection of approaches to measurement, potentially using Data-DENT resources.
9	Extended set of GNMFI indicators	TBC		A suggestion was made to put this work on hold and consider 'fast tracking' a few indicators if needed. Secretariat to come back to TEAM later.
10	Team participation in IYCF database technical working group	Mary Arimond (TBC)	Suggestion to ask someone from DHS team to join or others.	The working group would review data quality criteria to improve transparency of the IYCF global database maintained by UNICEF. The time commitment is minimal and the first ask would be to review the data quality checklist.
11	Actions to be triggered by prevalence thresholds			No decision made. Secretariat to follow up with Mercedes de Onis who proposed this action
12	TEAM global engagement	Purnima Menon	Mary Arimond	Light mapping of potential partners for engagement, with support from UNICEF/WHO. Distribute to TEAM for further input.
13	Nutrition of school-age children	TBC (no volunteers – need 1-2 names)	TEAM should propose suggestions for members.	1. UNICEF to send out a concept note and invitations, including time commitment and ToR; 2. Participate in a working group about metrics. There may be seed funding for a paper on data gaps. The group would propose an outline and then the work would be contracted.
14	Quality adjusted coverage indicators			To be folded into other work on coverage.

### 3.1 Way forward – TEAM in the future

TEAM's work is advisory and technical and thus can be difficult to define. It has made significant progress, particularly for the development of the four GNMFI indicators and their operational guidance during the first two years. The Secretariat felt the need to increase TEAM's capacity and it is now



comprised of 12 members instead of the 10 members it had during the first two years. With increased capacity and a workplan for the next two years, TEAM will continue to make an important contribution to the public good in improving global nutrition monitoring. The revised ToR for TEAM will help define the group's role and guide its work moving forward.

#### 4. Closing

France Bégin, Senior Advisor for infant and young child nutrition, closed the meeting on behalf of Victor Aguayo, Associate Director of Nutrition at UNICEF. TEAM's agenda was ambitious, and much was accomplished. She thanked the group for its passion, engagement, time and willingness to contribute to improving global nutrition monitoring and she urged the group to keep the needs of countries at the forefront of its work.

## Annex I – Agenda

### 5<sup>th</sup> Meeting of the WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM)

UN Secretariat Conference Room A  
1st Avenue (between 45th and 46th Streets) New York, USA  
28-29 November 2017

Tuesday, 28 November		
9:00 am-9:30 am	Welcome and introductions <ul style="list-style-type: none"> <li>- Opening remarks</li> <li>- Objectives and expected outcomes of the meeting</li> <li>- Introduction of participants</li> <li>- Administrative issues</li> </ul>	Mark Hereward/Victor Aguayo Chika Hayashi Kuntal Kumar Saha
9:30 am-10:15 am	<b>Session 1:</b> Overview of UNICEF and WHO nutrition work	Victor Aguayo/Francesco Branca
10:15 am-10:45 am Tea/Coffee		
10:45 am-11:30 am	<b>Session 2a:</b> Updates on 4 GNMF indicators Minimum acceptable diet (MAD) indicator: next steps from June IYCF consultation meeting	Facilitator: Larry Grummer-Strawn Presenters: Mary Arimond/Julia Krasevec
11:30 am-12:15 pm	<b>Session 2b:</b> Antenatal iron supplementation – validation	Facilitator: Faith Thuita Presenters: Rebecca Heidkamp
12:15 pm-1:15 pm Lunch		
1:15 pm-2:00 pm	<b>Session 2c:</b> Developing, testing and validating BF counseling indicators	Facilitator: Rebecca Heidkamp Presenter: Purnima Menon
2:00 pm-2:45 pm	<b>Session 2d:</b> Trained nutrition professionals	Facilitator: Rebecca Heidkamp Presenter: Kuntal Kumar Saha
2:45 pm-3:00 pm	<b>Session 3:</b> Update on operational guidance for the GNMF indicators	Facilitator: Elaine Borghi Presenter: Kuntal Kumar Saha
3:00 pm-3:30 pm Tea/Coffee		
3:30 pm-4:15 pm	<b>Session 4:</b> Technical Report on anthropometry data quality – status update and next steps	Facilitator: Trevor Croft Presenters: Elisa Dominguez/Julia Krasevec
4:15 pm-5:00 pm	<b>Session 5:</b> Modeling exclusive breastfeeding: updates	Facilitator: Eline Korenromp Presenter: Larry Grummer-Strawn
7:30 pm	Group dinner	Specifics to be provided

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**Wednesday, 29 November**

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9:00 am-10:00 am **Session 6**  
TEAM research priorities  
Facilitator: Mary Arimond

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**10:00 am-10:30 am Tea/Coffee**

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10:30 am-11:15 am **Session 7a:**  
TEAM workplan 2018-2019: Discussion  
- Extension WHO targets to 2030  
Facilitator: Rafael Flores-Ayala  
Presenters: Chika Hayashi/ Elaine Borghi

11:15 am-11:30 am **Session 7b**  
- Extended set of GNMF indicators  
Facilitator: Rafael Flores-Ayala  
Presenter: Kuntal Kumar Saha

11:30 am-12:00 pm **Session 7c**  
- Strengthening nutrition information systems  
Facilitator: Rafael Flores-Ayala  
Presenter: Chika Hayashi

12:00 pm-12:30 pm **Session 7d**  
- Quality-adjusted coverage indicators  
Facilitator: Mary Arimond  
Presenters: Purnima Menon/Rebecca Heidkamp

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**12:30 pm-1:30 pm Lunch**

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1:30 pm-2:00 pm **Session 7e**  
- Nutrition in school-aged children and adolescents  
Facilitator: Mary Arimond  
Presenter: Roland Kupka

2:00 pm-2:30 pm **Session 7f**  
- Global engagement of TEAM  
Facilitators:  
Mary Arimond/Rafael Flores-Ayala

2:30 pm-3:30 pm **Session 8**  
TEAM workplan 2018-2019: Identifying specific activities and resource persons for each topic  
Facilitators:  
Mary Arimond/Rafael Flores-Ayala

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**3:30 pm-4:00 pm Tea/Coffee**

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4:00 pm-4:30 pm **Session 8 (contd.)**  
TEAM workplan 2018-2019: Identifying specific activities and resource persons for each topic  
Facilitators:  
Mary Arimond/Rafael Flores-Ayala

4:30 pm-4:50 pm **Session 9**  
Way forward – how do we want to see TEAM in the future?  
Rafael Flores-Ayala/ Mary Arimond

4:50 pm-5:00 pm **Session 10**  
Closing remarks  
Wrap up  
Victor Aguayo  
Rafael Flores-Ayala

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## Annex II – List of participants

**5<sup>th</sup> Meeting of the WHO-UNICEF Technical Expert Advisory group on nutrition Monitoring**  
**UN Secretariat Conference Room A**  
**1st Avenue, New York, USA**  
**28-29 November 2017**

### **TEAM Members**

1. Rafael Flores-Ayala – Chair
2. Mary Arimond – Co-Chair
3. Trevor Croft – Member
4. Rebecca Heidkamp – Member
5. Eline Korenromp – Member
6. Purnima Menon – Member
7. Faith Thuita – Member
8. Abul Kalam Azad – Member
9. Edward Frongillo – Member
10. Jennifer Coates – Member
11. Wenhua Zhao – Member

### **TEAM members who could not attend the meeting**

1. Lynnette Neufeld – Member
2. Omar Dary – Member

### **TEAM Secretariat (WHO)**

1. Kuntal Kumar Saha
2. Elaine Borghi
3. Larry Grummer-Strawn
4. Elisa Dominguez

### **TEAM Secretariat (UNICEF)**

1. Victor Aguayo
2. Chika Hayashi
3. Julia Krasevec
4. Vrinda Mehra
5. Richard Kumapley
6. France Begin
7. Roland Kupka
8. Deepika Sharma

### **Observers**

1. Ellen Piwoz – Bill and Melinda Gates Foundation
2. Rahul Rawat – Bill and Melinda Gates Foundation
3. Erin Milner – United States Agency for International Development
4. Julia D'Aloisio – Rapporteur/report writer

## Endnotes

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

<sup>2</sup> 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.

<sup>3</sup> 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

<sup>4</sup> Report on the Third Meeting of the WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM), 15-16 September 2016, Geneva, Switzerland, October 2017.

<sup>5</sup> See full report: Meeting report on reconsidering, refining and extending the World Health Organization infant and young child feeding indicators, 2017.

<sup>6</sup> In part 2 of the IYCF indicator guide, computation of minimum acceptable diet for non-breastfed children was more strict for dairy than intended to be in definition. As per the old calculation, a non-breastfed child required 4 out of 6 food groups plus 2 milk feeds. Considering that dairy was added as a mandatory part of minimum acceptable diet of a non-breastfed child, the computation should actually have required 3 out of 6 food groups plus 2 milk feeds.

<sup>7</sup> The proportion of women with a birth in the last 2 years who received or bought iron and folic acid supplements for at least 6 months during their last pregnancy, in amounts that were in accordance with recommended protocols.

<sup>8</sup> The original indicator is: proportion of mothers of children 0-23 months who have received counseling, support or messages on optimal breastfeeding at least once in the last year.

<sup>9</sup> Member states are respondents and the WHO country office identifies the appropriate people to complete the different modules.

<sup>10</sup> Further analyses carried out after the meeting based on new preliminary data indicated the level of ambition for 2025 is already very high compared to country's progress. Thus, the revised proposal is to maintain the 2025 target for 2030 (target is a 30% reduction in prevalence from a baseline prevalence of 15% in 2012).

<sup>11</sup> Lancet NCD RisC-2017