

Jun 26, 2023

## Responses to Participant Questions

[Webinar] Promoting a Continuum of Care for Wasted Children:  
Lessons Learned from the Democratic Republic of Congo

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### **Question 1: What key interventions did the project undertake that had an impact on wasting indicators?**

Answer 1: USAID Advancing Nutrition only documented other wasting prevention and treatment-related projects and activities in the Democratic Republic of Congo (DRC). We did not engage in any direct implementation and therefore did not have any impact indicators for our activities.

### **Question 2: What strategies were used by the project for different communities and populations?**

Answer 2: We did not do any direct implementation at the community level. In terms of the populations of key informants (government and health facility staff, implementing partners, UN staff, and donors) we gathered information primarily through one-on-one key informant interviews. At the end of the coordination and collaboration work we also sent out a survey to understand if our work had affected how stakeholders interacted with each other along the continuum of care.

### **Question 3: How were the children and the mothers who were guardians of children approached and enlisted by the project?**

Answer 3: We did not enroll or speak to beneficiaries as part of our work in DRC. We only spoke to government, partners, and UN officials.

### **Question 4: Have there been any recent impact assessments on integrated management of acute malnutrition (IMAM) or severe wasting in DRC? Have there been any studies on the relationship between wasting and emerging diseases (e.g. Zika, Ebola, COVID-19) in DRC?**

Answer 4: We did not come across any assessments or studies of this kind for DRC as part of our desk review and interviews.

### **Question 5: How can prevention activities be optimally coordinated to avoid posing challenges to nutrition?**

Answer 5: This is one of the biggest challenges to providing a holistic continuum of care for wasted children because prevention activities, if implemented effectively, can have many impacts beyond just those benefiting wasted children and their families but also beyond the nutrition and health sector as

well. From our work, we feel that prevention of wasting should be integrated into broader discussions about the benefits of multi-sectoral coordination and collaboration and that multi-sectoral nutrition coordination platforms are likely the best place to host these discussions. This will require a close link between the Nutrition Cluster and humanitarian actors with these multi-sectoral groups, which typically consist of primarily development-focused actors. At present, there isn't a platform in DRC where humanitarian and development actors regularly convene, which is critical to ensure that all aspects of the continuum of care are coordinated and supported.

**Question 6: Often we observe relapses and regressions after total recovery of children from severe wasting. How can we maintain the nutritional status of children who have recovered from wasting?**

Answer 6: Counter-referrals for children and their families when exiting treatment are an important part of the continuum of care. However, in DRC we did not document any examples of this happening systematically between health facilities and their partners who are supporting treatment and projects supporting prevention activities. Prevention work should take into consideration not only the prevention of first instances of wasting but also work to prevent relapse. Efforts, including follow up and referral into supportive services to prevent relapse, does still seem to be a gap in the continuum of care in DRC.

**Question 7: Did you see any programs using enriched porridge using local ingredients as a back-up when the supply chain of RUTF was broken?**

Answer 7: Yes, the use of "four-star porridge" was mentioned by key informants as part of our supply chain work. When there is a break in RUTF supply, several informants mentioned that they provide caregivers with IYCF counseling and encourage them to prepare this porridge for their children. This strategy is not part of the DRC National IMAM Guidelines. However, the four-star porridge recipe is part of DRC's IYCF Guidelines. It gets its name from the four food groups that should be included when it is prepared. It consists of staple foods, pulses, animal source foods, fruits and vegetables with oil, sugar, and salt added.

**Question 8: What can be said about coordination and collaboration with other sectors like food security, social protection, and WASH to assure that more integrated support is provided for wasted children and their families?**

Answer 8: Coordination and collaboration of nutrition actors with these sectors did not emerge as a major theme in our key informant interviews. It was mentioned that sometimes the same organizations or individuals may also attend coordination meetings for these clusters (e.g. the same person might attend both Nutrition Cluster and Food Security Cluster meetings) but direct coordination between these platforms, as it pertains to wasting treatment and prevention, was not mentioned. The lack of

functional multi-sectoral coordination platforms where actors from across these sectors would convene seems to be a limitation to this type of coordination and collaboration occurring more systematically.

**Question 9: Why not focus more on preventing wasting and stunting from birth to 3 months?**

Answer 9: Prevention is a critical part of the continuum of care and many of the same actions taken to prevent wasting can also contribute to the prevention of stunting. We agree that there should be a stronger focus on prevention. For children less than six months of age, there are specific approaches that can be used for treatment such as the MAMI Care Pathway Package which can be used to screen, assess, and manage small and nutritionally at-risk infants under six months and their mothers (MAMI). However, use of this approach in DRC was not mentioned by key informants.

**Question 10: How was RUTF supply managed between health facilities? Is an integrated approach used whereby supplies are procured for all clients within a given geographic area, inclusive of products required for severe and moderate wasting and prevention interventions to help minimize stockouts?**

Answer 10: Data on the prevalence of severe and moderate wasting are usually available down to the health zone level. Caseloads are estimated using these health zone-level figures and targets are set for each health zone. However, separate targets are set for the number of children to be reached with severe wasting treatment, moderate wasting treatment, and preventative services (e.g. IYCF counseling or BSFP). Each type of supply is planned separately as different UN agencies manage treatment for severe wasting (UNICEF) and moderate wasting (WFP) and there are a large range of actors working on prevention with different types of interventions. If an RUTF stockout occurs, we documented instances where health facilities or implementing partners may reach out to health zone management teams, other partners, or the Nutrition Cluster to see if there are additional supplies available or supplies that can be borrowed from another health facility or implementing partner until the stockout is addressed. The Nutrition Cluster in DRC tries to track the total amounts of RUTF available in the country and helps facilitate loans. However, this is happening on a largely ad hoc basis and would benefit from more systematic management. For this to succeed, implementing partners and UN agencies that are procuring nutrition commodities need to share their stock data with the Nutrition Cluster.

**Question 11: Did cultural beliefs or norms pose a challenge?**

Answer 11: This did not come up as a major theme in our key informant interviews. However, our work focused more on how stakeholders were coordinating their efforts to prevent and treat wasting and less on the delivery of services at the community level. This may be why this type of information did not come up in the interviews.

**Question 12: Can you share information about the relationship between wasting and stunting and if possible share some articles? Understanding this relationship could help with making programming decisions.**

Answer 12: Many of the activities implemented to prevent wasting will also help to prevent stunting. Therefore, understanding this relationship and the relative risks for each form of malnutrition could be useful in making decisions about interventions, especially if tradeoffs must be made. The Emergency Nutrition Network has a range of resources about the relationship between wasting and stunting which are available [here](#). Recent research shows that children can be concurrently wasted and stunted (an estimated 8 percent of children globally may be both wasted and stunted) and that these children have an elevated risk of death.

**Question 13: DRC is huge and difficult in terms of geographical access. Such a high number of severely wasted children is unacceptable. How are local authorities working to address the food security situation? What actions are global partners taking?**

Answer 13: Government key informants did not give specific details about actions they are taking to address food security. However, implementing partners are ideally supposed to work hand-in-hand with government officials on their activities. Implementing partners are supporting both general food distributions and blanket supplementary feeding programs (BSFP) are supported in prioritized health zones through WFP. Additionally, USAID through Feed the Future and its Development Food Security Activities (DFSAs) support activities to strengthen value chains, agriculture, and livelihoods. What is key is to ensure that the households with wasted children benefit from these programs and that the most vulnerable are identified and enrolled before their children become wasted.

**Question 14: Did you plan for specific preventive and mitigating strategies to avoid or limit impacts of shortages/ruptures in supplies?**

Answer 14: USAID Advancing Nutrition did not provide direct support to the delivery of RUTF nor did we provide any realtime guidance to partners. We only documented how others were supporting the supply chain. The final report will include recommendations, based on our observations and analysis, on how stakeholders can strengthen the RUTF supply chain.

**Question 15: What is being done in DRC to promote the use of local foods to treat wasting, as a more sustainable alternative to RUTF? Are other alternatives, such as Positive Deviance/Hearth, Nurturing Care Groups, or Nutrition Impact and Positive Practice Circles being implemented as possible alternatives when there are supply chain breaks?**

Answer 15: Other than the mention of counseling on the use of four-star porridge where there were RUTF supply chain breaks, key informants did not mention activities using local foods for the treatment of wasting. At one time, there were discussions about introducing the “[Tom Brown](#)” approach to

support treatment of moderate wasting in DRC but we did not hear if this was adopted by any partners. Other community-based treatment models were not mentioned by our key informants. Our work focused mostly on “traditional” treatment programs, as outlined in DRC’s National IMAM Guidelines. It is possible that more local foods-based treatment approaches are being implemented but they were not mentioned by the key informants that we spoke to. USAID Advancing Nutrition has another activity to document these types of approaches to treating moderate wasting in Nigeria, Senegal, and Uganda. Check back [here](#) later in the year for this report.

**Question 16: What is the main challenge in working with multisectorial actors in improving nutrition outcomes?**

Answer 16: The main challenge we saw in DRC was a lack of a convening platform that was a good fit for multi-sectoral actors. Although there are national, regional/provincial-level Nutrition Clusters active in DRC, they have a very specific emergency mandate and it is unclear if they should also play a broader role of bringing together multi-sectoral nutrition actors, especially when the Government of DRC has policies in place to establish multi-sectoral nutrition coordination platforms at the national, province, and territory levels. However, during our work the multi-sectoral nutrition coordination platforms at the province level were non-functional and it was unclear if those at the territory level had even been established.

Additionally, drawing from experiences in other countries, one of the common challenges is getting sectors to see how their routine work contributes to nutrition outcomes. Without this common understanding, commitment to and ownership of shared nutrition goals and objectives can be difficult to obtain from sector actors. There is also a need for institutionalization of nutrition within the sectors. Having a single focal person or champion often is not enough to ensure the systematic inclusion of nutrition specific or sensitive actions in sector planning and budgeting.

**Question 17: Having a pipeline break at any time will surely jeopardize the “six rights” of the logistics of these products. What are some of the best practices that can be harnessed to avoid these breakages? For instance the prolonged time taken to deliver these projects that the blockages that were highlighted during your presentation.**

Answer 17: Logistics is an entire field of study - I would point you to the [Supply Chain Manager’s Handbook](#) for a good read on the subject. Specifically for DRC’s nutrition sector, one of the biggest problems seems to be the availability of reliable and regular transportation. One strategy to combat this that is commonly used in min/max inventory management systems is to increase the amount of minimum stock at each facility, such that the minimum amount of a product that a facility should have on hand when it expects to receive its resupply is increased. In this way, if the expected resupply is late, or if the product is being used at a faster rate than anticipated, there’s a greater quantity of the products on hand

that can act as a buffer against such variations in product use and resupply. Of course the downside to increasing the minimum stock at facilities is that this stock takes up storage space, and there's an increased risk that the product will expire or spoil if the rate of use of the product falls unexpectedly. Other suggestions we mentioned during the presentation include improved gov and facility level targeting, expanded role of the cluster in supply coordination, and advocacy with health systems actors for improved infrastructure and supply integration.

**Question 18: Is the RUTF supply to the health facility to distribute freely or it is under a drug revolving fund? If it is free, what is the sustainability plan set up for the government to continue to supply it?**

Answer 18: RUTF is provided for free in DRC. It is correct that financing is a huge contributing factor, whether it's ensuring that there's enough funding for local implementing organizations to have enough product and the means to distribute it, or whether that's ensuring that the government itself has enough funding to procure and distribute the product. At present in DRC, RUTF is funded by donors and implementing partners. There are plans to pilot the integration of RUTF into the national supply chain system, supported by UNICEF and the World Bank, but these have not yet started. There is a drug revolving fund in DRC, but the use of this kind of system for RUTF - which is meant to be free for all clients - could be quite complex.

**Question 19: About targeting children for wasting treatment, and thus on supply procurement. In many contexts we found that even if we use recent survey prevalences, we end up under calculating the target, and thus running out of supplies. Reasons can also be related to unreliable population figures, which mostly are underestimations (we have noticed this from over reaching targets during vaccination campaigns). However, is it recommended by you to review the K factor [incidence] in the caseload calculation?**

Answer 19: It is a valid point that incorrect population estimates may also have an impact on caseload estimations. This is also likely a factor in DRC, where the last census took place in 1984. However, plans were announced in 2022 that a new census was to be conducted. An underestimation of the population of children 6-59 months and an underestimation of incidence both result in an underestimation of caseload. If both values are underestimated, the underestimation of caseload will be even greater. It is important to note that first caseloads must be estimated to know the total number of children 6-59 expected to be wasted within a given year. Targeting then happens after this caseload number is estimated. Because targets are rarely set at 100 percent, there is an even further underestimation of children that takes place at the targeting stage, which then has direct consequences for resource allocation, planning, and supply procurement. An example is given below, using the current and estimated incidence rates for DRC. We have used the same population estimate for children 6-59 months (17.9

percent) and severe wasting prevalence rate for Kibua health zone in Nord Kivu that was used by the DRC Nutrition Cluster for the 2022 Humanitarian Response Plan estimates for this example.

The basic caseload estimation formula is as follows: case load = N (population) × P (prevalence) × K (incidence) × C (coverage)

Using the current incidence factor of 2.8:  $20,702 \times 1.9\% \times 2.8 \times 1 = 1,101$

Using estimated incidence factor of 5:  $20,702 \times 1.9\% \times 5 \times 1 = 1,967$

Increasing the incidence factor leads to an additional 866 estimated cases of severe wasting. If targets of less than 100 percent are then applied to the lower caseload estimation (e.g. 80 percent of the 1,101 children) it means that a program might only plan to treat 880 children when in reality there could be nearly double that number in need. These examples illustrate the potential impact this could have on the supply chain.

**Question 20: There has been work done by UNICEF on the caseload calculation but it hasn't been validated despite it having been done several years ago. Could USAID push for this to be validated and shared?**

Answer 20: At this time, USAID is not aware of the caseload calculation efforts by UNICEF. USAID will look into this.

**Question 21: Could the inclusion of the for-profit/private sector in collaboration and coordination help to improve the distribution supply chain?**

Answer 21: Discussions about private-sector involvement in the supply chain for nutrition commodities usually relate to the local production of the commodities. However, because many of the ingredients for RUTF, for example, such as milk powder or the vitamin premix often still need to be imported, it can be very challenging to produce these products locally at a more competitive price. Although some attempts were made to locally produce RUTF in DRC, at present we are not aware of any local production efforts in the country. Private companies are used to support the distribution of RUTF in some areas. Use of private sector actors in supply chain management is a big area of study and potential opportunity, but not a magic bullet. For example, might either the DRC government or a donor sign a contract with a local transportation company (i.e. a 3rd party logistics company, 3PL) to ensure transportation of nutrition products from the warehouse to the health facilities? That might be possible, but such contracts require a high degree of expertise to be able to write and manage properly, and there's still an open question about whether a local 3PL could overcome some of the existing transportation issues, and about how such contracts would be funded in a limited funding environment.

**Question 22: Can links to the reports be shared?**

Answer 22: The report on the coordination and collaboration work that was conducted from 2019-2021 can be found [here](#). The supply chain and BSFP reports will be available in the coming months. Check the [DRC country page](#) on the USAID Advancing Nutrition website for updates.