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# **Strengthening the Continuum of Care for Wasting Management through Coordination and Collaboration**

Findings from Facilitated Learning in  
the Democratic Republic of the Congo



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## USAID Advancing Nutrition

JSI Research & Training Institute, Inc.  
2733 Crystal Drive  
4th Floor  
Arlington, VA 22202

Phone: 703-528-7474

Email: [info@advancingnutrition.org](mailto:info@advancingnutrition.org)

[www.advancingnutrition.org](http://www.advancingnutrition.org)

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Food for the Hungry

International Rescue Committee

INTERSOS

Médecins d'Afrique (MDA)

Médecins du Monde (MDM)

Mercy Corps

Nutrition Cluster

Projet de Santé Intégré de l'USAID (PROSANI)

Save the Children International

Sud Kivu Value Chains Activity

Social Development Center (SDC)

United Nations Children's Fund

World Food Programme

World Vision



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## ACRONYMS

<b>APEDE</b>	Amis des Personnes en Détresse (Friends of Persons in Distress)
<b>BHA</b>	Bureau for Humanitarian Assistance
<b>BSF</b>	blanket supplementary feeding
<b>CAC</b>	<i>cellule d'animation communautaire</i> (Community Action Groups)
<b>CDCS</b>	Country Development Cooperation Strategy
<b>CMAM</b>	community-based management of acute malnutrition
<b>ComPAS</b>	Combined Protocol for Acute Malnutrition Study
<b>CONOPRO</b>	Congo Nouveau Prospère (New Prosperous Congo)
<b>COVID-19</b>	coronavirus disease of 2019
<b>CSB</b>	corn-soya blend
<b>DFSA</b>	Development Food Security Activity
<b>DHIS-2</b>	District Health Information System 2
<b>DPS</b>	Direction Provinciale de la Santé (Provincial Department of Health)
<b>DRC</b>	Democratic Republic of the Congo
<b>F-75</b>	formula 75
<b>F-100</b>	formula 100
<b>GAP</b>	Global Action Plan on Child Wasting
<b>GHSC-TA</b>	USAID Global Health Supply Chain Program—Technical Assistance
<b>GHSC-PSM</b>	USAID Global Health Supply Chain Program—Procurement and Supply Management
<b>GIBS</b>	Groupe Inter Bailleurs de la Santé (Inter Donor Health Group)
<b>HF</b>	health facility
<b>HRP</b>	Humanitarian Response Plan
<b>IFA</b>	iron–folic acid
<b>IMAM</b>	integrated management of acute malnutrition
<b>IPC</b>	Integrated Food Security Phase Classification
<b>IYCF</b>	infant and young child feeding
<b>LSCI</b>	Leadership in Supply Chain Initiative

<b>MDA</b>	Médecins d’Afrique (Doctors of Africa)
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>MAM</b>	moderate acute malnutrition
<b>MUAC</b>	mid-upper arm circumference
<b>NGO</b>	nongovernmental organization
<b>OptiMA</b>	Optimizing Treatment for Acute Malnutrition
<b>PAO</b>	<i>plan d’action opérationnel</i> (operational action plan)
<b>PRONANUT</b>	Programme National de Nutrition (National Nutrition Program)
<b>PROSANI</b>	Projet de Santé Intégré de l’USAID (USAID Integrated Health Program)
<b>PSNMN</b>	<i>Plan Stratégique National Multisectoriel en Nutrition 2016–2020</i> (National Multi-sectoral Nutrition Strategic Plan)
<b>PUNC</b>	Pool d’Urgence Nutritionnelle Congo
<b>RECO</b>	<i>relais communautaire</i> (community volunteer)
<b>RISE II</b>	Resilience in the Sahel Enhanced II
<b>RUSF</b>	ready-to-use supplementary food
<b>RUTF</b>	ready-to-use therapeutic food
<b>SAM</b>	severe acute malnutrition
<b>SCC</b>	Sahel Communication and Collaboration
<b>SCICA</b>	Supply Chain Investment Coordination and Advocacy
<b>SDC</b>	Social Development Center
<b>SIGL</b>	<i>Système d’information en gestion logistique</i> (logistics management information system)
<b>SMART</b>	Standardized Monitoring and Assessment of Relief and Transitions
<b>UN</b>	United Nations
<b>UNICEF</b>	United Nations Children’s Fund
<b>UNS</b>	<i>Unité Nutritionnelle Supplémentaire</i> (MAM supplementary feeding program)
<b>UNTA</b>	<i>Unité Nutritionnelle Thérapeutique Ambulatoire</i> (SAM outpatient treatment)
<b>USAID</b>	U.S. Agency for International Development
<b>WASH</b>	water, sanitation, and hygiene
<b>WFP</b>	United Nations World Food Programme

## EXECUTIVE SUMMARY

The Democratic Republic of the Congo (DRC) is one of 10 countries that make up 60 percent of the global burden of wasting in children under five (GAP 2021). Approximately 4.1 million children under five in DRC will experience wasting in 2022, with an anticipated prevalence of nearly 15 percent in some health zones (OCHA 2021a). Factors that drive wasting in DRC include acute and chronic food insecurity, communicable disease outbreaks, natural disasters, and ongoing security challenges. Numerous ongoing humanitarian responses in DRC are addressing both the acute and protracted crises arising from these factors.

DRC is also among the many countries where treatment for wasting is fragmented, with different actors supporting treatment of moderate wasting and severe wasting. Prevention approaches tend to be poorly defined and are not systematically integrated or linked with treatment components. At the start of 2022, 29 international nongovernmental organizations (NGOs) and 35 national NGOs were supporting nutrition activities in the country (DRC Nutrition Cluster 2022). Many additional actors are working to build resilience and implement important prevention and development-focused programs. Given all these factors, it is critical that **actors coordinate and collaborate to align services and activities, share information, and generate synergies across their individual efforts.**

### OBJECTIVE

The U.S. Agency for International Development (USAID) Bureau for Humanitarian Assistance (BHA) and the USAID

Mission in DRC asked USAID Advancing Nutrition to undertake a facilitated learning activity on purposeful co-location of nutrition partners in four provinces in DRC.

The objectives of this activity evolved over the course of our three years of work based on ongoing learning, the expressed needs of in-country nutrition actors, and limitations related to the coronavirus disease of 2019 (COVID-19) pandemic. Based on findings from the preliminary phase of work and in response to the COVID-19 pandemic, we developed a learning agenda with three objectives:

1. Document partners' experiences collaborating to deliver the continuum of care for wasting.
2. Identify and pilot actions to strengthen coordination and collaboration.
3. Develop recommendations for how to strengthen collaboration to deliver the continuum of care for wasting.

We used a collaborating, learning, and adapting approach throughout, adjusting our activities based on information gathering and learning and in response to COVID-19-related challenges. Our process can be grouped into three main phases, summarized in the following Activity Phases figure. In each phase, **we shared our learning with nutrition actors through interim reports as well as during site visits and national- and provincial-level Nutrition Cluster and health zone management meetings for validation, input, and action.**

### Activity Phases

#### PHASE 1

##### Activity Design (2019)

- Desk review of national systems and structures
- National-level workshop
- Province visits and key informant interviews

#### PHASE 2

##### Subnational Consultations (2020)

- Development of a learning agenda
- Nutrition partner mapping
- Documenting existing coordination and collaboration actions and platforms

#### PHASE 3

##### Identifying Actions to Strengthen Coordination and Collaboration (2021)

- Review of the quality of wasting treatment services
- Development of coordination and collaboration action plans
- Action plan monitoring
- Validation of learning



PHOTO CREDIT: KATE HOLT/MCSP

Counseling is an important way to discuss good health, hygiene, and nutrition practices with caregivers in order to prevent wasting in young children.

We also worked closely with the Programme National de Nutrition ([PRONANUT]; National Nutrition Program) and the Direction Provinciale de la Santé ([DPS]; Provincial Department of Health), and in coordination with the national and provincial Nutrition Cluster coordinators.

### FINDINGS, OBSERVATIONS, AND LESSONS LEARNED

Our three-year learning activity yielded a wealth of information about the role of coordination and collaboration in delivering a holistic continuum of care for wasted children. Coordination is not the responsibility of a single manager, official, or program, but requires clear roles and responsibilities for all involved. Many of the challenges identified are, in part, due to or exacerbated by the **lack of a functional multi-sectoral coordination platform** through which government, emergency, and development actors regularly engage.

We should be concerned not only with the lack of coordination and collaboration between actors supporting the wasting continuum of care; we should also **seek to strengthen multi-sectoral coordination and collaboration for nutrition**

**more broadly.** Achieving these shared, multi-sectoral nutrition outcomes will strengthen the continuum of care for wasting, as so many nutrition programming elements overlap and share interdependencies. Additionally, focusing on wasting coordination and collaboration may reinforce the incorrect impression that wasting is a stand-alone, emergency activity, which can undermine efforts to strengthen its integration into the health system. Overall, without a clear platform to foster the participation of all multi-sectoral nutrition actors, coordination and collaboration will likely remain ad hoc, especially among emergency and development actors and non-health sector actors contributing to wasting prevention, and the continuum of care persistently fragmented. Below, we provide highlights of our findings, observations, and lessons learned on management of wasting services, planning, supply chain, and data and information sharing.

We found much room for improvement in the **coordinated management of treatment and prevention services**, including integration and coordination of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) treatment services, the extent to which prevention activities are coordinated with health facility-based treatment services, and internal and cross-project activity management and coordination.



**Coordinated planning** between nutrition actors on both the operational and technical aspects of implementation is integral to delivering a seamless, holistic continuum of care. Well-coordinated planning reduces duplication of efforts, creates service delivery efficiencies, and facilitates better and more equitable service coverage. Coordinated planning can also help ensure harmonization of approaches, preventing contradictory operational standards, like differing incentives for community volunteers that can lead to demotivation, and can reduce the risk of overloading community members with numerous, potentially competing demands on their time. However, the mix of long-term development programs and short-term emergency interventions add a layer of complexity to the planning process, making the need for good communication and coordination essential. The short-term, intermittent nature of emergency-funded support to wasting treatment services and the potential for termination of or delays in issuing contracts with local nutrition partners make consistent engagement between emergency and development actors challenging.

The implications of an unreliable **supply chain** are well known. When treatment is not available due to a lack of the necessary products, caregivers lose faith in health services and children's lives are at risk. The brief, intermittent nature of UNICEF and World Food Programme (WFP) contracts do little to support the goal of ensuring that integrated wasting treatment services—and required products—are reliably available at all health facilities, as articulated in the DRC's integrated management of acute malnutrition (IMAM) protocol. Contracts structured to meet the needs of acute emergencies cannot support the long-term delivery of integrated IMAM services.

The variety of processes used to plan and budget for last-mile delivery transportation requirements are complicated, especially for health zone officials, who in the eyes of communities are ultimately responsible for the availability of services. During interviews with health facility staff and health zone officials, there was no mention of a combined strategy for coordinated last-mile delivery of products among UNICEF, WFP, nutrition partners, and the health zones. They consistently cited misalignment of procurement estimates with actual needs as a challenge to supply chain planning that can cause friction between the health facilities and the communities.

Nutrition actors face many challenges to collecting, managing, integrating, sharing, and using nutrition **data** for decision-making. They rely on disjointed systems all along the continuum of care,

and data quality was found to be poor along the data collection chain. SAM and MAM treatment services use different registers and reporting systems; national health and logistics information systems tend to focus only on SAM treatment, excluding MAM treatment and prevention elements; community-level screening and prevention activity data collection systems are not harmonized; and government, health facilities, and nutrition partners do not systematically exchange information. The absence of routine data and information sharing is especially problematic, as there is a general lack of information about wasting in general. The 2022 *Humanitarian Needs Overview* states that funding for Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys has been decreasing; the number of those conducted has declined approximately 50 percent each year since 2019 (OCHA 2021a).

## RECOMMENDATIONS

The operating environment and nutritional needs in DRC are complex and will likely remain so for some time. Much of what we recommend will not happen quickly and may require systemic change at levels beyond what is achievable in DRC alone. Our work, however, seeks to underscore the dire consequences for children and families if things do not change. Coordination and collaboration must improve at multiple levels—between emergency and development actors, between NGOs and government, between sectors—to have any hope of turning back wasting in DRC. We urge nutrition actors in DRC take these observations, lessons learned, and recommendations into consideration as they continue their work.

### I. Recommendations for Government

Government ownership and leadership are essential for the activities along the wasting continuum of care to be scaled, integrated, and sustainable. While external support is required as long as government resourcing gaps remain, government officials retain an important role in directing and coordinating partner support to meet prioritized needs, reduce duplication of efforts, and capitalize on potential efficiencies.

#### [Integrate nutrition coordination and collaboration activities into provincial and health zone annual plans](#)

We recommend that government officials continue to embrace and scale up the nutrition coordination and collaboration action planning process in line with government-mandated multi-sectoral nutrition action planning efforts. To the extent possible, government contributions—either in kind or financial—to

implement the actions will be important to ensure sustainability and reduce the uncertainty that comes with reliance on nutrition partner support. We specifically recommend that the DPS prioritize the allocation and timely release of resources to PRONANUT to support these efforts, as good nutrition is central to so many other important health outcomes. Government entities should also consider innovative financing options to support coordination and collaboration for nutrition.

#### More clearly define the role of multi-sectoral nutrition committees and invest in strengthening their capacity

The *National Multi-Sectoral Nutrition Strategic Plan (Le Plan stratégique national multisectoriel pour la nutrition [PSNMN])*, which expired in 2020, mandated the creation of province- and territory-level multi-sectoral nutrition committees but did not define their roles and responsibilities well. The accompanying operational plan did not clarify roles and responsibilities for these entities either. We recognize these committees' potentially critical role in convening multi-sectoral nutrition actors engaged in both emergency and development activities. Without this shared space for dialogue, discussion, and coordination, progress toward the delivery of a holistic continuum of care for wasting will be impeded.

We recommend clearly articulating the roles and responsibilities of these committees vis-à-vis other existing nutrition coordination platforms, such as the Nutrition Cluster, in the forthcoming *National Multi-Sectoral Nutrition Strategic Plan 2022–2026*. We also recommend that adequate human and financial resources be allocated to establishing and strengthening these committees at provincial and territorial levels.

## 2. Recommendations for NGO Nutrition Partners

Many aspects of the wasting continuum of care depend on partner support yet are hindered by a lack of coordination between partners and government, and sometimes even within single projects or organizations. Nutrition partners—both local and international NGOs—must consider the potential consequences of operating in silos, and instead work to reap greater benefits by taking additional steps to ensure their activities are harmonized with other actors and truly align with government priorities and community needs.

#### Ensure coordination and collaboration are integrated into project work plans and activities

The recommendations for government actors cannot be fully realized—at least in the short term—without support from

nutrition partners. We recommend that nutrition actors engage with the government in a meaningful and transparent manner to discuss where and how support needs can be integrated into project work plans. Too often, nutrition partners complete their work plans without consulting government authorities or other partners, meaning that opportunities to cross-leverage partner capacities or strategic advantage to improve nutrition programming may be missed. Both emergency and development partners should integrate coordination activities into their work.

Projects and implementing partners also need to support government entities, such as DPS and PRONANUT, in their convening roles. When providing capacity strengthening, logistical, and financial support, government partners should lead by calling meetings, developing and approving activities and action plans, and following up with agreed-upon next steps.

#### Strengthen multi-sectoral nutrition committees to convene nutrition actors working along the wasting continuum of care

If the multi-sectoral nutrition committees were strengthened, they would be an appropriate mechanism through which to convene the diverse group of actors supporting the wasting continuum of care. The Nutrition Cluster could share its emergency-focused information and plans, and representatives engaged in other sectoral coordination mechanisms could share similar updates to strengthen prevention programming. Participation in regular meetings through these committees, coupled with ad hoc engagement with other coordination bodies when there is an identified need around specific activities, would promote information sharing without nutrition actors becoming overloaded with meetings. Despite the clear advantages these multi-sectoral committees offer, however, few resources have been dedicated to their setup or capacity strengthening.

Our experience highlights the need for dedicated resources to facilitate coordination and collaboration so that these become routine ways of working at the province and health zone levels. Partners supporting this work should integrate transition planning for the financial support of multi-sectoral nutrition committee activities, such as routine meetings and supervision visits, into their work plans, clearly communicate them, and seek agreement from government actors from the outset. Ideally, financing to support multi-sectoral nutrition coordination would be included and financed through the annual province- and health zone-level action plans.

### 3. Recommendations for UN Agencies and the Nutrition Cluster

United Nations (UN) agencies like UNICEF and WFP are crucial in the fight against wasting. In complex settings such as DRC, which include areas experiencing protracted ongoing crises and acute emergencies, the Nutrition Cluster also has an important role in coordinating nutrition actors that respond to the resulting needs. Given the important role of UNICEF, WFP, and the Nutrition Cluster—particularly regarding wasting treatment—we recommend ways to strengthen coordination and collaboration between UN agencies and with non-emergency actors.

#### Contract the same implementing partner to support all aspects of wasting treatment services and align award duration and cycles

The treatment aspect of the continuum of care is fractured, increasing the possibility that children will not receive lifesaving treatment due to poor operational and administrative coordination between UNICEF and WFP. As they recover, children should be able to seamlessly transition between outpatient services for SAM and supplementary feeding programs for MAM. This is challenging, however, when different implementing partners are contracted to support SAM and MAM services in the same health zone, especially when funding and contracting cycles are misaligned. Although co-location of services provided by different nutrition partners is better than not having services available at all, weak coordination leads to inadequate referral systems that put children at risk as they transition between services. Rather than continuing to prioritize co-location of UNICEF- and WFP-supported programming elements, which is still not optimal due to funding and targeting constraints, UNICEF and WFP should consider adopting more coordinated approaches, as used by the agencies in other countries. The most important first step is to work toward contracting the same partner to support both SAM and MAM services within a given health zone. UNICEF and WFP should also invest in strengthening the capacity of their local partners to ensure they can efficiently and effectively deliver holistic SAM and MAM treatment.

In addition, UNICEF and WFP should work to harmonize their award durations and cycles with the ultimate aim of giving longer-duration awards to local partners. In a 2020 evaluation, WFP acknowledged the importance of its partners and flagged the need for more strategic long-term engagement with them to improve programming continuity. WFP has also suggested

organizing internal planning sessions with partners to agree on activity and payment schedules and provide partners more support with expense and financial reporting (WFP 2020). Despite these recommendations, when new awards were issued in January 2021, they were standardized to a duration of only six months, with the option for a six-month extension. UNICEF awards also tend to be for a six-month period.

#### Add guidance on coordinating and collaborating with non-emergency actors to the Nutrition Cluster Guidelines for DRC

The Inter-Agency Standing Committee, which oversees humanitarian cluster activation, advises that cluster activation be based on an assessment of needs and time-limited (IASC 2015). Yet in DRC the Nutrition Cluster has been activated since 2006. The complexity of emergency response has changed dramatically in the past 10 years with the emergence of many more protracted crises layered with acute emergencies. It is important to determine if the current operating standards for cluster members align with operational realities.

The DRC Nutrition Cluster Guidelines were last updated in 2016. Because much has changed in terms of wasting treatment best practices and the implementation context, an update may be appropriate. While these guidelines already include information on multi-sectoral nutrition interventions, we suggest the inclusion of more information about how emergency actors can coordinate efforts with development actors. Many development actors screen and refer children to health facilities for wasting treatment. However, information sharing on these activities with treatment partners, who are often also Nutrition Cluster members, is virtually nonexistent. Likewise, Nutrition Cluster members do not actively inform co-located actors about disruptions to treatment services, nor do they work collaboratively to find appropriate, temporary solutions for communities in these circumstances.

### 4. Recommendations for Donors

Although our learning efforts have focused on USAID-funded work, all donors have an important role in ensuring that their projects and partners coordinate and collaborate. We have seen that co-location of projects does not always lead to effective coordination, collaboration, or even basic communication. Donors' technical guidance on and sometimes even facilitation of engagement among these entities may be required. However, the extent to which donors can hold their partners accountable for coordination and collaboration actions varies

greatly based on the funding mechanism and the type of organization funded. In bilateral development awards, the donor is in a stronger position to influence the level to which its partners coordinate with each other, the government, and coordination structures. For emergency awards, which benefit from reduced reporting requirements under the Grand Bargain, the Nutrition Cluster may hold more sway over how these partners interact with other nutrition actors, as these accountability structures are stronger than what donors can impose. We present recommendations for emergency and development awards separately to help identify appropriate strategies for these different systems. We also highlight cross-cutting recommendations for donors to consider regardless of project type and funding modality.

#### [Use the GAP DRC Country Operational Roadmap to guide coordination of wasting-related programming](#)

The *GAP Country Operational Roadmap for DRC* was finalized recently. This document represents the prioritization of the government's and nutrition partners' actions to address the basic, underlying, and root causes of wasting by strengthening health; water, sanitation, and hygiene (WASH); social protection; and food systems. This plan, though not comprehensive of issues we highlight here, will facilitate coordination of donor programming priorities for wasting and nutrition more broadly. The Inter Donor Health Group (Groupe Inter Bailleurs de la Santé [GIBS]) is another platform that health and nutrition donors can leverage to better coordinate nutrition programming and financing. Donors should be mindful, however, that non-nutrition and non-health actors must be consulted to ensure support for a holistic prevention package.

#### [Encourage, and when possible require, partner participation in and support for multi-sectoral nutrition coordination committees](#)

Just as we recommend that government actors prioritize the continued scale-up of multi-sectoral nutrition committees and ask nutrition partners to integrate capacity strengthening and leadership support activities into their work plans, we recommend that donors value and prioritize strengthening these committees as well. Dedicated funding, time, and resources are required to overcome the challenges facing their establishment and operationalization. Donors should encourage partners implementing multi-sectoral nutrition activities to include capacity strengthening and support to the committees in their work plans and to participate in them. A dedicated project or project work stream may be required to catalyze these efforts.

While opportunities to provide support through emergency mechanisms will likely remain more ad hoc and somewhat limited, donors and multilateral agencies like UNICEF and WFP should, at minimum, plan support in close consultation with development partners to ensure their efforts are complementary, layered, and sequenced.

#### [Identify opportunities for humanitarian-development nexus programming and financing in DRC](#)

Enhancing engagement between humanitarian and development actors is a crosscutting commitment that is part of the Grand Bargain. While there is much rhetoric from both humanitarian and development actors about the willingness to work together, the ways to do so are less clear. Perhaps even less so is how to implement programs that span the humanitarian and development divide. Donors should work with each other, their implementing partners, and the government to strengthen and increase nexus programming opportunities in DRC, especially given that many operating areas fit this type of context.

The USAID Mission in DRC emphasizes humanitarian-development nexus contexts as a priority for integrated programming in its current *Country Development Cooperation Strategy (CDCS) 2020–2025*. However, there is little mention of the need for partners to coordinate and collaborate on integrating this purposefully into the Mission's programming. This is an opportunity for strengthening in the next iteration of the CDCS.

#### **Emergency Programs**

Emergency programs, given their need to be administratively nimble to ensure timely response to urgent needs, tend to have much lighter reporting requirements than development programs due to commitments under the Grand Bargain. Nevertheless, emergency actors should all strive to adhere to the principles of accountability outlined in the Core Humanitarian Standards and the Sphere Handbook. Emergency actors working in protracted crises need to consider how to work alongside development actors and local authorities and through existing systems (Sphere 2018). In the evolving emergency operating environment, some donors are beginning to embrace longer-term emergency funding packages.

#### [Consider multi-year funding horizons for emergency programs](#)

None of the emergency projects we examined as part of this work exceeded one year; most were six-month awards. These short, intermittent periods of funding are inappropriate for supporting integrated services and are detrimental to efforts



to strengthen service quality and the health system as a whole. They also lead to gaps in service delivery and create a higher administrative burden for both the donor and local partners, adding complexity to planning processes.

There has been some innovation in this space globally, with multi-year funding increasing by 75 percent between 2016 and 2018 (Development Initiatives 2020). We recommend that donors explore more of these multi-year funding opportunities, including for local organizations, for use in DRC.

### Development Programs

There are many opportunities for donors to integrate coordination and collaboration into their multi-year development programs. Because these programs often come with contractual agreements that allow substantial involvement and oversight, and more rigorous reporting, monitoring, and evaluation requirements, donors have an opportunity not only to suggest that coordination and collaboration be central to programs but also to hold them more accountable for these actions.

#### Plan for and integrate coordination and collaboration into every stage of the project cycle

The most effective way for donors to ensure that implementing partners engage in meaningful coordination and collaboration is to integrate them into every stage of the project cycle. Ideally, they are embedded within the project design and results frameworks. Planning for coordination and collaboration from the design phase and holding partners accountable through routine monitoring and project evaluations will help systematize these aspects within and across projects. Donors should consider the following entry points to strengthen coordination and collaboration.

1. Consult internally and with other donors when designing co-located projects.
2. Promote common objectives and results frameworks for key activity areas
3. Encourage co-located development projects and partners to consult with each other during workplanning.
4. Make coordination and collaboration a core component of project evaluations.

#### Strengthen follow-up, reporting, and data sharing requirements for development projects that conduct community-level screening

Many development projects have integrated screening for wasting into their community-level activities. Small changes to reporting requirements for these programs could prompt a shift in ways of working that could strengthen the community and health facility linkages needed to ensure a holistic continuum of care for wasting.

At a minimum, donors should consider requiring or encouraging projects doing screening to report the number of children seeking services or enrolled at the health facility following a referral. Reporting on referral completion would not only prompt development partners to engage directly with health facilities on wasting treatment, but would also create a valuable information-sharing opportunity with health facility staff. To strengthen reporting mechanisms further, donors should consult with the government and the Nutrition Cluster to identify a common set of wasting-related indicators for partners to report on.



A mother and child wait at a health center. Caregivers, usually women, may have to travel long distances to access health services, including those for wasting. Preventing wasting through community-based programs is one way to help alleviate this burden.

PHOTO CREDIT: KATE HOLT/MCSP

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## **BACKGROUND**



## BACKGROUND

The Democratic Republic of the Congo (DRC) is one of 10 countries that make up 60 percent of the global burden of wasting in children under five (GAP 2021). It is estimated that 4.1 million children under the age of five in DRC will experience wasting in 2022, with an anticipated prevalence of nearly 15 percent in some health zones (OCHA 2021a). Despite ongoing efforts to improve access to wasting treatment, the number of wasted children in DRC remains unacceptably high and continues to impede the country's development. Not only are wasted children at an increased risk of death, they are also more susceptible to illness and long-term developmental delays, putting additional and potentially long-term strain on limited health and social protection resources.

As acknowledged in the *Global Action Plan on Child Wasting* (GAP), a policy shift is required to give equal importance to the prevention of wasting, while still ensuring that children who require treatment have access to high-quality services (WHO 2020). While it is well known that frequent illness and inadequate diets are the immediate drivers of wasting, mitigating its underlying causes requires a range of actions from those working beyond the health sector to ensure that households and communities have access to improved water, sanitation, and hygiene (WASH); social protection; and food systems. The underlying causes of wasting vary by context and season, adding to the complexity of ensuring that they are adequately and appropriately addressed (WHO 2020).

In many countries, treatment for wasting is fragmented, with different actors supporting treatment of moderate wasting and severe wasting. Prevention approaches tend to be poorly defined and are not systematically integrated with or linked to treatment components. Global efforts such as the GAP seek to overcome this challenge by promoting a more holistic continuum of care to ensure that children receive appropriate and timely care to enable their full recovery, regardless of whether they present as moderately or severely wasted. Furthermore, prevention approaches should be purposefully aligned with integrated treatment services to prevent relapse and reduce the number of children who become wasted for the first time (McGrath and Shoham 2019).

Many factors drive wasting in DRC. An estimated 27 million people in DRC are living with acute food insecurity, which is



PHOTO CREDIT: WFP/ARLETTE BASHIZI

The World Food Programme delivers lifesaving food assistance to populations in need across DRC. Food assistance programs are an important way to help prevent children from becoming wasted.

the highest number of any country in the world (OCHA 2021a). The most recent available data estimated the same number of individuals to be experiencing moderate to severe chronic food insecurity, which represented 34 percent of the population at that time (IPC 2016). The country has ongoing security challenges and is prone to natural disasters, like the recent volcanic eruption and earthquakes, and communicable disease outbreaks, such as cholera and Ebola. The coronavirus disease of 2019 (COVID-19) has exacerbated this complex operating environment. As of June 2022, DRC has registered more than 91,000 confirmed cases of COVID-19 and over 1,300 deaths. Although vaccination efforts are ramping up, only approximately 3.5 million doses have been administered to the country's 89.5 million people (WHO 2022; World Bank 2021).

Numerous ongoing humanitarian responses in DRC are addressing both the acute and protracted crises arising from the above-mentioned shocks, stresses, and ongoing insecurity. At the start of 2022, there were 29 international nongovernmental organizations (NGOs) and 35 national NGOs supporting nutrition activities in the country (DRC Nutrition Cluster 2022). In fiscal year 2021, the U.S. Government contributed \$87.2 million in dedicated support for emergency food and nutrition assistance (USAID 2021). Table 1 summarizes contribu-



**Table I. Nutrition Funding to UNICEF and WFP by Source for 2021\***

Donor	UNICEF	WFP
British Government	–	\$ 354,207
Canadian Government	–	\$ 1,441,652
Central Emergency Response Fund (Pooled Fund)	\$ 2,694,206	\$ 301,000
German Government	\$ 3,359,462	\$ 4,756,398
Japanese Government	–	\$ 1,000,000
Norwegian Government	–	\$ 1,402,405
Swedish Government	–	\$ 325,108
U.S. Government	\$ 11,636,237	\$ 35,718,071
<b>Total</b>	<b>\$ 17,689,905</b>	<b>\$ 45,298,841</b>

Source: OCHA 2021b.

\*Includes paid contributions and commitments.

tions made to the United Nations Children’s Fund (UNICEF) and the United Nations World Food Programme (WFP) by national government and pooled fund mechanisms to the emergency response efforts. In addition to these efforts, direct funding is provided to discrete projects and programs by a range of donors. There are also many actors working to build resilience and implement important prevention and development-focused programs not included in these estimates. With all these factors at play, it is critical that actors coordinate and collaborate to align services and activities, share information, and generate synergies across their individual efforts.

Purposeful, multi-sectoral coordination of government, partners, and donors is critical to ensuring that children and their families have access to services that prevent and treat wasting so they can meet their full developmental potential. Ensuring coordination and collaboration among partners working along the continuum of care for wasting has been a long-standing

challenge, partially because not all contributing actors view themselves as a part of it. This is even more so the case amongst those implementing prevention activities outside the health sector. In places like DRC, coordinating these actors is even more complex, given the often-divergent mandates, funding sources, and project timelines of development and emergency programs that seek to serve the same communities. Furthermore, these actors encompass government, United Nations (UN) agencies, national and international NGOs, and local civil society organizations all beholden to different accountability mechanisms, creating an unfavorable environment for changing the status quo.

### OBJECTIVE OF THE DRC FACILITATED LEARNING ACTIVITY

The U.S. Agency for International Development (USAID) Bureau for Humanitarian Assistance (BHA) and the USAID Mission in DRC asked USAID Advancing Nutrition to undertake a facilitated learning activity on purposeful co-location of nutrition partners in DRC. The objective of this activity was to bring nutrition partners together to identify opportunities and a path forward to collectively achieve improved nutrition outcomes. The partners would achieve this by 1) establishing and/or articulating a shared vision of and their role within the nutrition continuum of care, 2) identifying programmatic linkages with the potential to improve impact, and 3) strengthening coordinated and collaborative action around identified linkages.

Co-located nutrition partners that were part of this work included entities supporting wasting treatment activities through funding from UNICEF, WFP, and USAID, as well as partners working on prevention and other nutrition-sensitive activities, such as USAID health and nutrition projects, Feed the Future agriculture and value chain projects, and BHA Development and Food Security Activities (DFSAs).<sup>1</sup>

The objectives of this facilitated learning activity evolved over the course of our three years of work based on ongoing learning, the expressed needs of in-country nutrition actors, and limitations related to the COVID-19 pandemic. Based on findings from the preliminary phase of work and in response to the COVID-19 pandemic, we developed a learning agenda with learning questions to further refine the focus of our work.

1. These BHA investments are now known as Resilience and Food Security Activities. However, the ongoing awards in DRC were made under the previous investment name so are referred to as DFSAs throughout this report.

Our learning agenda had three objectives (see annex I for the corresponding learning questions):

1. Document partners' experiences collaborating to deliver the continuum of care for wasting.
2. Identify and pilot actions to strengthen coordination and collaboration.
3. Develop recommendations for how to strengthen collaboration to deliver the continuum of care for wasting.

Throughout, USAID Advancing Nutrition's primary role in this learning activity was to serve as a facilitator across nutrition partners toward strengthening coordination and collaboration to improve the continuum of care for wasting. Our team of DRC- and internationally based consultants and staff engaged

with a variety of nutrition actors, including USAID nutrition partners, government officials, and UN agencies to document coordination and collaboration and related platforms. Based on the findings from this work, we facilitated a process to identify and plan actions to improve coordination and collaboration that would ultimately help strengthen the continuum of care for wasting.

While many nutrition actors supporting the wasting continuum of care are likely well aware of the coordination and collaboration challenges in DRC and other countries, we aim to add value by documenting the complexity of these challenges in a single place. This report presents the findings, observations, and lessons from our three years of work with nutrition actors in DRC. We also provide recommendations to support ongoing strengthening of the coordination and collaboration efforts started through this learning activity.

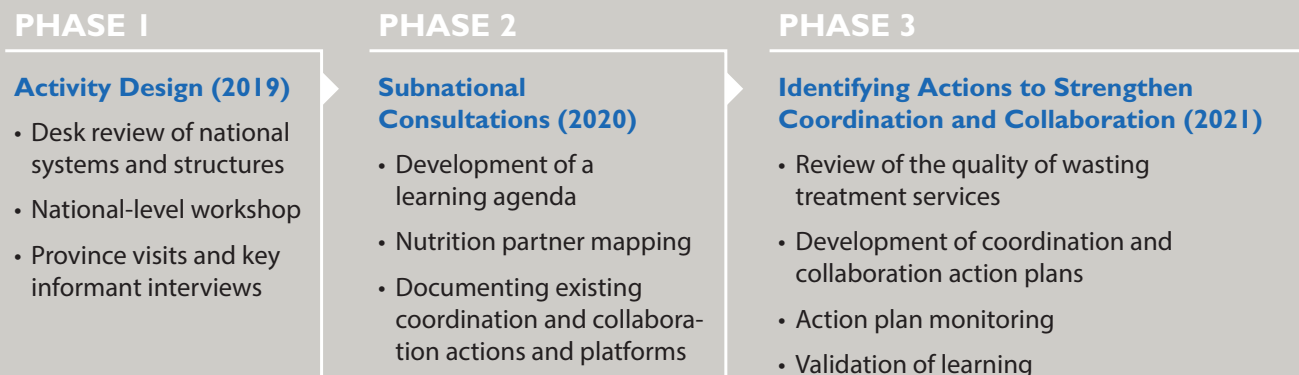
## APPROACH

We used a collaborating, learning, and adapting approach throughout, adjusting our activities based on information gathering and learning and in response to COVID-19-related challenges. Our process can be grouped into three main phases, summarized in figure I and described below. In each phase, we shared our learning with nutrition actors through interim reports as well as during site visits and national- and provincial-level Nutrition Cluster and health zone management meetings for validation, input, and action. We also worked closely with the Programme National de Nutrition ([PRONANUT]; National Nutrition Program) and the Direction Provinciale de la Santé ([DPS]; Provincial Department of Health), and in coordination with the national and provincial Nutrition Cluster coordinators.

### PHASE I. ACTIVITY DESIGN

We began by documenting national approaches to wasting management through a desk review. We reviewed policies and protocols and mapped nutrition-related roles and responsibilities at the different administrative levels (national, provincial, health zone, community) to understand how wasting treatment services are delivered. We also documented community-level structures by sector to understand what types of prevention programming was in place and if and how it was linked with wasting treatment services and other elements of the health system. The desk review was complemented by key informant interviews conducted during scoping visits to Kinshasa, Kananga (Kasaï Central), and Bukavu (Sud Kivu) and

Figure I. Activity Phases



a consultative national-level workshop. At the conclusion of this phase, we selected Kasai Central, Kasai Oriental, Sud Kivu, and Tanganyika Provinces for the second phase of work, based on the variety of co-located USAID investments present and in consideration of potential access and security challenges (figure 2). Although the data presented from the 2017–2018 Multiple Indicator Cluster Survey (MICS) show relatively low rates of SAM and MAM, more recent health zone–level survey data paint a dramatically different picture. Global acute malnutrition rates (inclusive of both SAM and MAM) have exceeded 17 percent in some health zones, according to data collated by the Nutrition Cluster in 2022. Due to limited resources and restricted access during COVID-19 outbreaks, routine surveys have not taken place at the necessary frequency, creating a severe lack of information on recent wasting prevalence throughout the country.

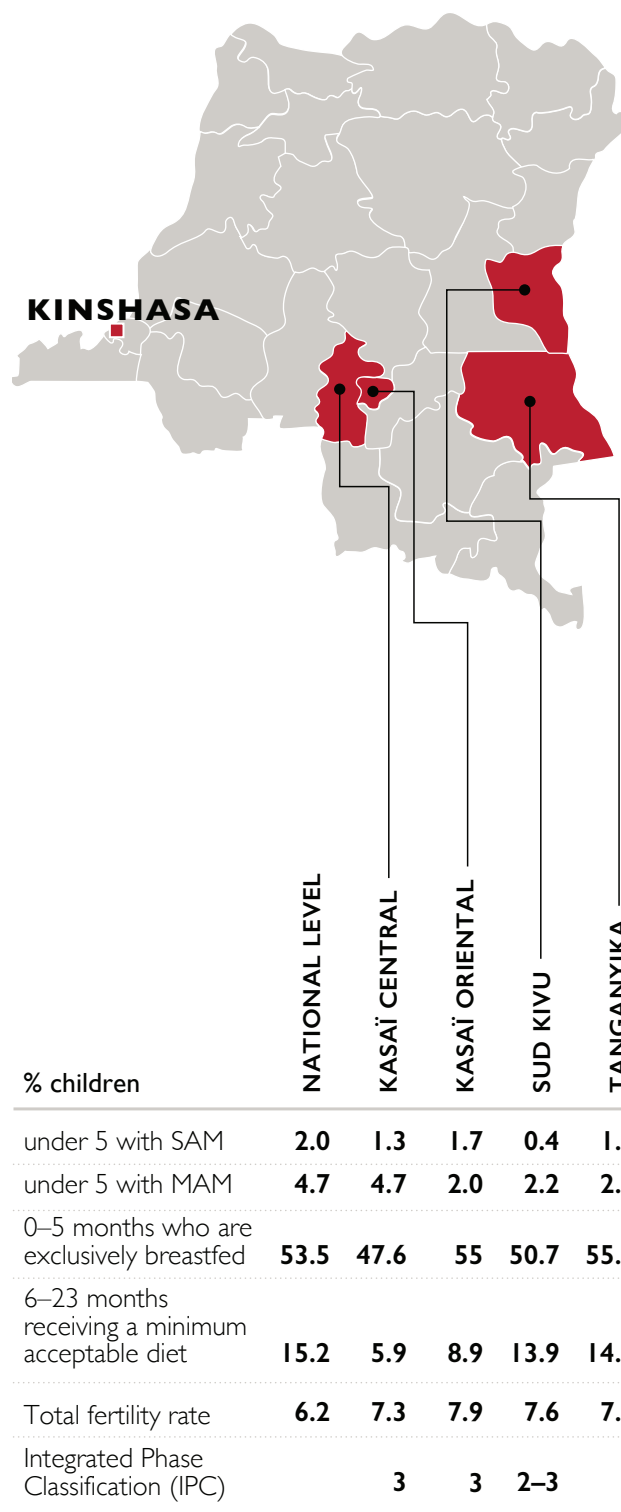
### Defining Coordination and Collaboration

As part of the desk review, we examined different definitions of coordination and collaboration to help us frame how we would document and categorize the level of engagement we found among nutrition actors as they implemented activities along the continuum of care and fulfilled individual mandates.

We adopted the definition outlined in table 2, which includes coordination and collaboration as part of a spectrum of engagement levels. At one end of the spectrum, individual actors may compete with each other for resources with possibly detrimental outcomes. On the opposite end, collaboration happens when actors jointly implement activities within a program, which may or may not be coordinated by design. Within this framework, collaboration is the result of typically longer-term interactions between actors that have a shared mission and goals, engage in joint decision-making, and may even have shared or pooled resources. Levels of engagement evolve over time and may vary across aspects of work. For example, nutrition actors might coordinate training activities but may only engage in communication on other work plan activities. As actors move along the spectrum from competition to integration, the level of trust between them increases, facilitating stronger engagement across more aspects of their work.

We have used these descriptions to define coordination and collaboration throughout our work and to frame engagement with nutrition partners in workshops. In discussing these definitions, nutrition actors noted that levels of coordination and collaboration are context-specific, depending on leadership

Figure 2. Focus Provinces at a Glance



**Table 2. Levels of Stakeholder Engagement**

Level	Description
Compete	Competition for resources, partners, and public attention
Coexist	No systematic connection between agencies and activities
Communicate	Interagency information sharing
Cooperate	As needed, often informal interaction on discrete activities or projects
Coordinate	Organizations systematically adjust and align work with each other for greater outcomes
Collaborate	Longer-term interaction based on shared mission, goals, decision-making, and resources
Integrate	Fully integrated programs, planning, and funding

Source: Adapted from the Tamarack Institute Collaboration Model (Tamarack Institute 2017).

and resources. They also recognized the need to coordinate with each other before coordination at the community level—where the majority of activity implementation takes place—can happen.

### National-Level Workshop

Following the desk review and scoping visits, we held a national-level workshop to deepen our understanding of coordination challenges and strengthen collaboration among actors as they identified ways to implement a holistic continuum of care for wasting. On the first day of the workshop, participants reviewed the continuum of care for wasting and described how their organizations’ activities fit within the continuum. The facilitators presented the levels of stakeholder engagement, explaining the differences along the pathway from competition to integration. This laid the foundation for the second and third days, when participants analyzed coordination challenges and identified steps to overcome them at the provincial and health zone levels.

## PHASE 2. SUBNATIONAL CONSULTATIONS

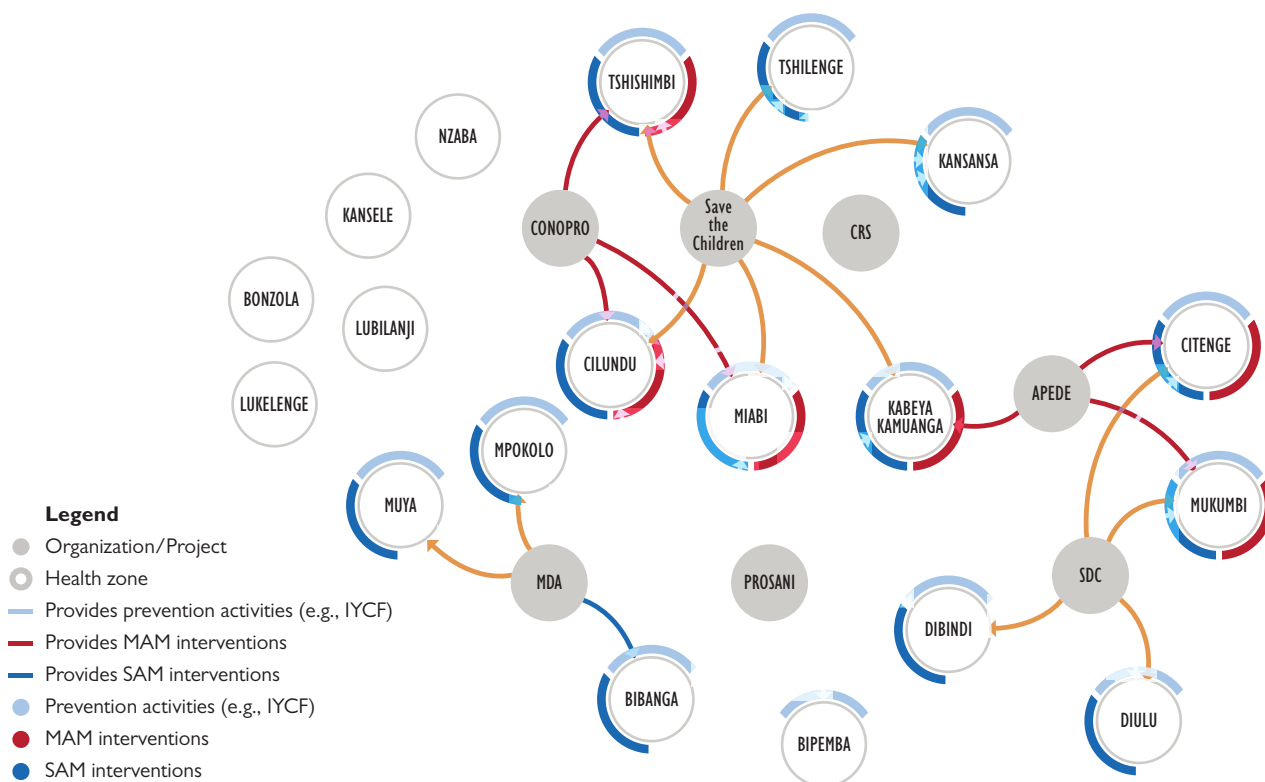
In phase 2, we intended to replicate the national-level workshop in each of the four focus provinces. However, the COVID-19 pandemic required that we modify our approach. The province-level workshops were indefinitely canceled because large

in-person gatherings were restricted and it was unclear when international and domestic travel would resume. Instead, we recruited a team of in-country consultants to gather information about the continuum of care, coordination, and collaboration at the sub-national level through individual consultations and participation in relevant platforms, including Nutrition Cluster and health zone management meetings. The majority of the consultations were virtual, in observance of COVID-19 protocols. Although we intended to conduct the same level of information gathering in all four provinces, because interprovincial travel remained restricted throughout much of 2020, our work advanced more quickly in Kasai Oriental and Sud Kivu, where our consultants were based. We were able to complete some information-gathering activities in Kasai Central and Tanganyika because during this period the Nutrition Cluster meetings shifted to an online format, which facilitated our remote participation.

During this phase, we identified focus health zones in Kasai Oriental and Sud Kivu in which we examined health zone-level coordination and collaboration opportunities and challenges. Finally, we undertook an additional desk review to identify lessons and promising practices from other countries potentially applicable to strengthening coordination and collaboration in DRC. As we worked, we also identified non-nutrition programming examples from within DRC that seemed relevant or adaptable to nutrition interventions.



Figure 3. Example of a Systems Map, Kasai Oriental



### Development of a Learning Agenda

We developed a learning agenda with learning questions to help guide the work of our in-country consultants and remote team (annex 1). The new learning questions were designed to adjust our approach from workshop-based group consultations to be suitable for one-on-one consultations.

In phase 2, we focused on learning questions 1 and 2, which focused on understanding the extent to which nutrition actors are already coordinating and collaborating with each other. To gather and document information to respond to questions, we began by mapping nutrition actors in the provinces and developed organizational profiles for the identified nutrition partners that included their activities, geographic areas of operation, and perspectives on opportunities and barriers to coordination and collaboration. We continued to use this learning agenda, with a focus on the remaining questions, in phase 3 of our work.

### Nutrition Partner Mapping and Health Zone Selection

We developed systems maps for Kasai Oriental and Sud Kivu that gave a visual overview of the nutrition partners and the services they provide along the continuum of care at the health zone level (figure 3). Based on these maps, we selected focus health zones in which to conduct more detailed information gathering. Our selection criteria included the presence of at least two co-located USAID-funded partners—one with an emergency focus or funding and one similarly for development.<sup>2</sup> We also aimed to ensure a mix of activities that included prevention and treatment. The selected health zones also had to be identified as priority areas for engagement by nutrition actors such as PRONANUT and implementing partners. We did not select focus health zones in Kasai Central or Tanganyika because ongoing COVID-19 restrictions limited our engagement in those provinces to the virtual Nutrition Cluster meetings.

2. Although wasting treatment is meant to be an integrated service in DRC, partners supporting treatment aspects of the continuum of care are classed as emergency interventions, given the short-term nature of their funding.

**Table 3. Selected Health Zones and Illustrative Continuum of Care Components Present at Time of Selection (2020)**

Province	Health Zone	Continuum of Care Component Activity Examples
Kasai Oriental	Cilundu	Treatment: SAM, MAM Prevention: health, infant and young child feeding (IYCF) promotion, general food distributions, growth monitoring, cooking demonstrations, WASH
	Kabeya Kamuanga	Treatment: SAM, MAM Prevention: health, IYCF promotion, general food distributions, growth monitoring
	Miabi	Treatment: SAM, MAM Prevention: health, IYCF promotion, general food distributions, growth monitoring, cooking demonstrations, WASH
Sud Kivu	Kalehe	Treatment: SAM Prevention: health, IYCF promotion, WASH, value chains/agriculture, cooking demonstrations, early case detection, deworming
	Mubumbano	Treatment: SAM, MAM Prevention: IYCF promotion, mid-upper arm circumference (MUAC) screening, cooking demonstrations, general food distributions, vitamin A supplementation and deworming

When selecting health zones, we tried to ensure representation of a variety of nutrition partners to reflect a diversity of approaches and issues. Due to safety concerns for the consultants and lack of a full-time country-based logistics or security team, we removed health zones from consideration if they were in insecure areas or more than four hours from the cities where consultants were based.

In certain instances, not all criteria could be met in one health zone at the time of selection. For example, in consultation with nutrition actors we selected Kalehe Health Zone in Sud Kivu, despite its lacking a partner conducting MAM treatment. However, Kalehe did have a Feed the Future value chain activity present, which added a unique dimension to our work there. Table 3 summarizes the focus health zones for Kasai Oriental

and Sud Kivu and the components of the continuum of care for wasting present at the time of selection.

### Understanding Existing Coordination and Collaboration Actions and Platforms

Once we selected health zones, we developed organizational profiles by conducting in-depth key informant interviews to understand how actors were coordinating and collaborating as they delivered services along the continuum of care. We collected information on the partners' operating areas, financing, and contract duration, activities implemented along the wasting continuum of care, and the entities with which they were coordinating on these activities. To complement the operational aspects of their work, we asked them to identify challenges and describe factors that facilitated their success. We also spoke with government officials about their perspectives on working with nutrition partners, their level of engagement with them, and the extent to which wasting and nutrition more generally were discussed in existing coordination platforms. Table 4 summarizes the interviews conducted in each health zone.

At the conclusion of phase 2, we synthesized information from the mapping and key informant interviews and identified elements of success, challenges and gaps, and factors that facilitated coordination and collaboration.

### PHASE 3. IDENTIFYING ACTIONS TO STRENGTHEN COORDINATION AND COLLABORATION

While the first two phases of work documented experiences with and challenges to coordination and collaboration, phase 3 focused on taking action to strengthen coordination and collaboration based on that information. However, to validate and

**Table 4. Summary of Phase 2 Key Informant Interviews**

Province	Key Informant
Kasai Oriental	Cilundu: 4 partners and health zone management team
	Kabeya Kamuanga: 2 partners and health zone management team
	Miabi: 4 partners and health zone management team
Sud Kivu	Kalehe: 2 partners and health zone chief medical officer
	Mubumbano: 3 partners and health zone nutritionist and head of medicine

refine the gathered information, it was important that nutrition partners and their government counterparts worked together to identify and analyze the issues themselves. Taking this step was intended to increase ownership of the identified actions and to ensure that they were tailored to the specific context and set of partners in each of the focus health zones. In this phase we also took a closer look at the treatment component of the continuum of care to better understand coordination between treatment actors and the overall quality of services. Due to the slowdown in work in Kasai Central and Tanganyika caused by COVID-19, this phase of work took place only in Kasai Oriental and Sud Kivu. Our team composition also changed in phase 3, from two in-country consultants to one full-time staff member co-located with one of the Kasai Oriental DFSA partners, which facilitated our collaboration with that project.

### Review of the Quality of Wasting Treatment Services

Although treatment services represent only one component of the continuum of care, their availability, reliability, and quality can affect other components. For example, prevention activities that include screening rely on the availability of the treatment services to which they make referrals. If these services are unavailable and referred mothers and children are turned away, caregivers may lose confidence in community-based workers and activities, undermining the effectiveness of the prevention and follow-up components of the continuum of care. In addition, based on our mapping we knew that there was often more than one nutrition partner supporting wasting treatment in a single health zone. We therefore wanted to understand if and how these partners were coordinating to ensure seamless and high-quality treatment for wasted children, particularly as they moved through the different treatment components (e.g., from outpatient treatment for children with SAM to supplementary feeding programs for children with MAM). This included understanding how well national integrated management of acute malnutrition (IMAM) treatment protocols were adhered to, the availability of a selection of nutrition commodities and essential medicines, and the existence of referral systems both to and within wasting treatment services and back to the community for follow-up support after recovery.

We collected data on wasting treatment services from the three focus health zones in Kasai Oriental between December 2020 and January 2021, which included direct observation of service provision and key informant interviews with health facility staff. We visited a total of 15 sites providing outpa-



PHOTO CREDIT: MORGANA WINGARD/USAID

This health facility in Kalehe health zone in Sud Kivu is one of the places where wasted children go to seek treatment.

tient SAM and MAM services. We selected a mix of high- and low-performing sites based on health facility monthly reporting and in consultation with PRONANUT and DPS. We reviewed nutrition records and client cards for both outpatient treatment for SAM (Unité Nutritionnelle Thérapeutique Ambulatoire [UNTA]) and supplementary feeding programs for MAM (Unité Nutritionnelle Supplémentaire [UNS]) services to understand which aspects of service delivery need improvement. We also visited the medical stores of the visited health facilities to assess availability of a selection of nutrition commodities and other essential medicines required for SAM and MAM outpatient treatment. PRONANUT and DPS participated in these visits, and we shared results with nutrition actors during the health zone coordination and collaboration action planning workshops, described in the following section.

### Development of Coordination and Collaboration Action Plans

In phase 2, in response to objective 1 in our learning agenda we hoped to identify coordination and collaboration actions that could be replicated and leverage coordination platforms that nutrition actors used regularly. Unfortunately, we found very little structured coordination. Although we identified several coordination platforms such as the Nutrition Cluster, provincial-level multi-sectoral nutrition committees, and monthly health zone management meetings, none had the regular par-

ticipation of both emergency and development nutrition actors. Engagement from outside the health and nutrition sectors was also minimal.

Because of this, we again adjusted our approach and embarked on the process of working with nutrition actors to develop health zone–specific coordination and collaboration action plans. We undertook this during a workshop to ensure the participation of all nutrition actors—provincial and health zone–level governments, UN agencies, and emergency and development partners—and allow adequate time to discuss coordination and collaboration challenges and identify practical solutions. The workshops were co-facilitated by the project’s Kasai Oriental–based nutrition specialist, nutrition partners, and PRONANUT, which further facilitated government and partner ownership of the process.

During these workshops, we shared our phase I definition of coordination and collaboration based on the levels of stakeholder engagement and explained why coordination and collaboration are critical to the delivery of a holistic continuum of care for wasting management. Participants then conducted a root-cause analysis of the factors affecting the implementation of a holistic wasting continuum of care. Discussions focused on four aspects of service delivery: planning, management of services, supply chain management, and data management. At the end of the workshops, participants produced action plans that included prioritized actions to mitigate the root causes of the identified challenges. Each action had an associated target, time frame, estimated budget, and responsible organization(s). The wasting coordination and collaboration action plans were annexed to the annual health zone *plan d’action operationnel* ([PAO]; operational action plan), as they were finalized after the conclusion of the annual health zone planning process, during which the PAOs are developed and approved.

### Action Plan Monitoring

Nutrition actors designated health zone chief medical officers (*médecin chefs de zone*) as responsible for the monthly monitoring of the coordination and collaboration action plans. These officers are also responsible for overseeing the implementation of the annual health zone PAO, to which the coordination and collaboration action plans were annexed. PRONANUT and nutrition partners were to assist chief medical officers by providing updates on nutrition activities implemented in the health zone. We developed a spreadsheet

that used a traffic-light system to document whether actions were completed, in process, or not completed relative to the designated timeline and targets (figure 4) to facilitate action plan monitoring.

The USAID Advancing Nutrition nutrition specialist supported the health zone chief medical officers by reminding partners of their commitments in the action plans and helping to gather updates to include in the monitoring tool. The nutrition specialist also conducted two rounds of in-person follow-up visits in Kasai Oriental and one in Sud Kivu, during which nutrition actors convened to review and discuss progress on action plan implementation and adjust the plans as needed.

### VALIDATION OF LEARNING

Once implementation of the coordination and collaboration action plans was underway, we documented each health zone’s progress through virtual and in-person follow-up. We also gathered opinions through one-on-one discussions and an online survey about what aspects of coordination and collaboration improved since the initiation of the action plans. At the end of phase 3, we synthesized our learning and developed recommendations to strengthen coordination and collaboration along the continuum of care.

We shared these findings and our recommendations for strengthening coordination and collaboration with nutrition actors during validation workshops in Kasai Oriental and Sud Kivu in November 2021. During these workshops, health zone staff presented progress and challenges in implementing their nutrition coordination and collaboration action plans. Participants brainstormed solutions to these challenges and identified ways to continue strengthening coordination and collaboration following the finalization of USAID Advancing Nutrition’s facilitated learning activity. Nutrition actors used outputs from these workshops as a first step in developing nutrition coordination and collaboration action plans for 2022.

### LIMITATIONS OF OUR APPROACH

The primary objective of USAID Advancing Nutrition’s work in DRC was to document learning about the coordination and collaboration between nutrition actors working along the continuum of care for wasting. This limited mandate raised challenges at various points throughout our work, particularly at the subnational level. Initially, government actors were un-

**Figure 4. Nutrition Coordination and Collaboration Action Plan Monitoring Tool**

1	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2	Province:	Kasaï Oriental												
3	Zone de santé	CILINDU												
4	Objectif global du plan	Renforcement de la coordination/collaboration dans les domaines de l'environnement propice du Continuüm de soin de la MA												
5									Evaluation du plan d'action de Nutrition au Kasaï Oriental (la notation va de 0 à 3 pour chaque activité)					
6	Domaine	Activités	Indicateur d'activités	Cibles/années	Période	Budget nécessaire	Responsable	Co-responsable	T2	T3	T4			
7	GESTION DE SERVICE	1.1.1. Reproduire les outils de collecte des données (jetons de rations UNS et fiches de suivi individuel UNS)	% d'outils de collecte des données (jetons et fiches de suivi individuel)	1	T2, T3, T4	2000\$	Partenaires locaux (CONOPRO)	PAM/ PRONANUT	0	0	2			
8	GESTION DE SERVICE	1.1.2. Déployer les outils au niveau de la zone de santé conformément au plan de distribution élaboré conjointement avec l'ECZ.	% d'outils déployés dans les structures conformément au plan de distribution	1	T2, T3, T4	Sans cout	PTF (CONOPRO)	ECZ/ DPS	0	0	2			
9	GESTION DE SERVICE	1.1.3. Organiser les réunions d'évaluation des activités planifiées par les partenaires	Nombre des réunions d'évaluation réalisées avec livrables	3	T2, T3, T4	600\$	Coordonnateur de l'ECZS	ECZ/ DPS	2	1	3			
10	GESTION DE SERVICE	2.1.1. Organiser un plaidoyer auprès de PTF en faveur de la formation des autres membres de l'ECZ non capacités sur la Nutrition.	Nombre de séances de plaidoyer réalisées sur prévues avec livrable	1	T2,	50\$	ECZS (Coordonnateur)	PRONANUT	0		3			
11	GESTION DE SERVICE	2.1.2. Organiser la formation des autres membres de l'ECZ sur la Nutrition.	Nombre des formations planifiées et réalisées	1	T2	1850 \$	PRONANUT	ECZ	0		1			
12	GESTION DE SERVICE	2.1.3. Organiser les formations des prestataires sur sites	Nombre des missions formations réalisées sur prévues	2	T3, T4	Lors des occasions des descentes de l'ECZ sur site.	ECZS	PRONANUT		1	2			
13	PLANIFICATION	1.1.1. Elaborer le plan de sortie avec toutes les parties prenantes intervenant dans les activités nutritionnelles au niveau de la zone de santé et de la communauté.	Nombre de plan de sortie élaborés avec les partenaires.	1	T2 2021	800 dollars	Partenaires (CONOPRO, SCI)	/ coordonnateur ECZ,	1		1			
14	PLANIFICATION	1.1.2. Organiser les réunions de validation du plan de sortie des activités nutritionnelles élaboré.	Nombre de réunions de validation du plan de sortie organisés.	1	T2	200 dollars	Partenaires SCI et CONOPRO	ECZS (Coordonnateur) et les leaders	1		3			

sure of our contribution to their wasting management efforts because we were not providing direct financial or technical implementation support like other nutrition partners. There was also some initial confusion about our role to facilitate improved coordination and collaboration given that several coordination platforms already existed. The Nutrition Cluster initially perceived our support as a duplication of its role, while other nutrition partners felt that we were there to evaluate performance. However, through our ongoing engagement we were able to demonstrate that we were there in a supportive role and show that there was a gap in coordination between emergency and development actors and between those working on prevention and treatment aspects of the continuum of care. By the end of our work, both government officials and the Nutrition Cluster were interested in replicating our participatory approaches in other provinces and health zones.

Because our work was conducted through close engagement and consultation with nutrition actors, their identified challenges, opportunities, and interests heavily influenced the direction of our work. As a result, some aspects of the continuum of care were not investigated as closely as others. The majority of our work focused on wasting treatment challenges and linkages between emergency and development actors, which are both integral to the strengthening of a holistic continuum of care. Prevention activities, including food security activities such as blanket supplementary feeding and other integrated programming approaches, did not feature as strongly.

Finally, although we worked with national, provincial, and health zone–level government officials to plan and implement our learning activities, we were challenged by requests for support beyond our documentation and facilitation role. This was most acute during the nutrition coordination and collaboration action plan development process, when nutrition partners committed to supporting specific actions. We were unable to support actions in the same way as other nutrition actors; however, we did provide support to their monitoring as it was in line with our documentation mandate. We were also limited in our ability to scale up the coordination and collaboration action planning activity, despite requests for technical assistance from the government and Nutrition Cluster to do so.

**COVID-19 Considerations**

As described above, the COVID-19 pandemic required us to continue to adapt our approach during phases 2 and 3 of our work, which limited the geographic scope of the learning activity. Originally, we had hoped to capture an equal amount of learning from each of the four focus provinces. However, ongoing domestic travel requirements, including COVID-19 testing, lengthened the duration of transit time and overall cost of travel within DRC, thereby limiting our level of in-person engagement outside Kasai Oriental and Sud Kivu, where our consultants and staff were based. As a result, the majority of our learning comes from these two provinces.





Reaching people with prevention services in their communities and ensuring treatment services are located as close to communities as possible improve the impact of both types of services.

PHOTO CREDIT: MOLLY BERGEN/WCS



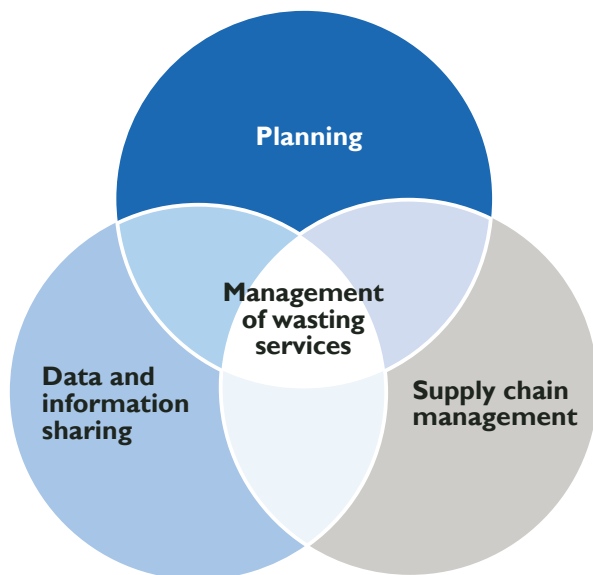
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**FINDINGS, OBSERVATIONS,  
AND LESSONS LEARNED**

## FINDINGS, OBSERVATIONS, AND LESSONS LEARNED

Our three-year learning activity yielded a wealth of information about the role of coordination and collaboration in delivering a holistic continuum of care for wasted children. In this section, we present a synthesis of these findings, observations, and lessons learned organized by domains similar to those used to develop the health zone coordination and collaboration action plans: management of wasting services, planning, supply chain management, and data and information sharing. Although we present the domains separately in this report, in reality there is a great deal of overlap and interplay between them. One weak point can have repercussions in multiple areas. For example, as shown in figure 5, coordination and collaboration on data and information sharing not only influence data-specific performance aspects like frequency, timeliness, and quality, but can also affect planning, supply chain management, and overall wasting service management, as each of these rely on data for decision-making and monitoring. Throughout the section we also highlight promising practices from within and outside DRC as counterpoints to the challenges we have identified to illustrate how some of these challenges have been overcome in different contexts.

**Figure 5. Interconnected Domains Influencing the Delivery of a Holistic Continuum of Care**



### MANAGEMENT OF WASTING SERVICES

In this section, we focus on the coordination aspects of management, which are important to ensure seamless delivery of the continuum of care for children and their caretakers. We examine the integration and coordination of SAM and MAM treatment services, the extent to which prevention activities are coordinated with health facility-based treatment services, and internal and cross-project activity management and coordination.

### FINDINGS AND OBSERVATIONS

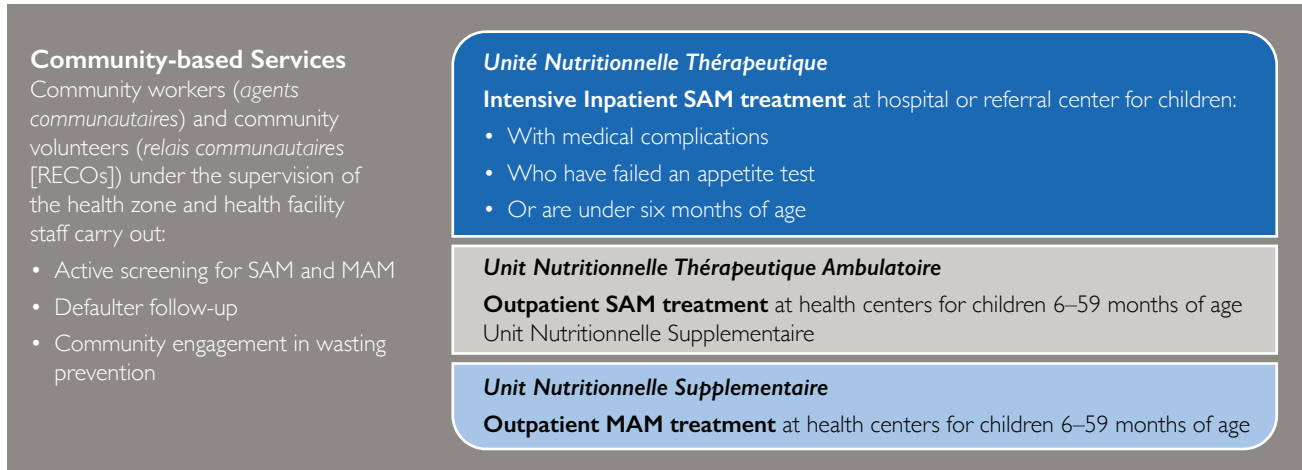
#### Wasting treatment services are fragmented

The DRC *Protocole National Prise en charge de la Malnutrition Aiguë (National Protocol on the Management of Acute Malnutrition)* provides the policy framework for the implementation of the wasting continuum of care. Wasting treatment services are to be integrated at the health facility level through IMAM. IMAM services in DRC include all the standard components of care as per global community-based management of acute malnutrition (CMAM) standards, as illustrated in figure 6.

Despite the structure laid out in the national IMAM protocol, there is limited integration of IMAM services in the DRC health system and the treatment component of the continuum of care is extremely fragmented. This is due, in part, to the numerous contextual challenges and limited government resources to support health services in general. As a result, available services are often of poor quality and highly dependent on external support from implementing partners. Evaluations and assessments often cite this limited (or lack of) service integration as a key challenge to implementation and scale-up of IMAM services in DRC (UNICEF 2019; MQSUN+ 2020). This challenge is not unique to DRC and is often driven by funding, as short-term emergency-funded projects typically focus on lifesaving treatment components and longer-term development projects on community-based services.

We found that SAM and MAM treatment services are typically siloed, using different client registers, client cards, and supply chains. Additionally, SAM and MAM treatment services are almost always supported by different nutrition partners, even in the same health zone. Through partner mapping we conducted in 2021 in our four focus provinces, we found that in all but 2 of 90 health zones, different partners supported SAM and MAM

**Figure 6. IMAM Services in DRC**



treatment services. This was the case even when a partner with both SAM and MAM support capacity was present within a province. For example, in Kasai Central, the Adventist Development & Relief Agency supported MAM in some health zones through WFP financing and SAM in other health zones through UNICEF financing, but was not contracted to provide both MAM and SAM support within the same health zone. UNICEF and WFP’s

selection of different local partners to support SAM and MAM services creates conditions for children to be missed when seeking or transitioning between services and complicates the management of service provision and supply management across wasting treatment components. Box 1 highlights the benefits of using the same partner to support both SAM and MAM services, as experienced in Cameroon, Somalia, and South Sudan.

**Box 1. Promising Practice from Cameroon, Somalia, and South Sudan: Benefits of Using the Same Implementing Partner to Deliver SAM and MAM Treatment Services**

In DRC, UNICEF and WFP often contract different nutrition partners to support SAM and MAM services within the same health zone. However, other countries have made efforts to ensure that UNICEF and WFP hire the same partners to support SAM and MAM services in a shared geographic area. For example, about half of the operational areas in Cameroon use the same implementing partners to ensure a robust referral system for SAM and MAM cases (Ngwenyi et al. 2019).

In Somalia, a bottleneck analysis of wasting treatment services found that a lack of integration of SAM and MAM services into the health system was a major challenge. One gap was a lack of definition about what fully integrated SAM and MAM services should entail. In response, minimum requirements for SAM and MAM service integration were developed, and as of 2019 a majority of sites provided SAM and MAM services with support from the same partner, and in the north of the country about 75 percent of treatment services are integrated into health facilities (Ntambi et al. 2019).

In South Sudan, as part of a concerted effort to improve coordination between UNICEF and WFP (see box 4), co-location of SAM and MAM treatment services increased from 45 percent to 91 percent of all nutrition sites. This integrated way of working led to an increase in geographic coverage and the number of children reached as well as better alignment of SAM and MAM services (Aburmishan et al. 2019).



## SIMPLIFICATIONS TO TREAT WASTING IN DRC



PHOTO CREDIT: KATE HOLT/MCSP

Child health visits are an important opportunity to screen children for wasting. Simplifications to treat wasting help to streamline the screening process—for example, using only MUAC tapes, like the one seen on the table here, to identify and enroll children.

There are several simplifications to treat wasting that are being trialed globally. These approaches seek to improve the efficiency, effectiveness, coverage, and quality of wasting treatment (State of Acute Malnutrition, n.d.). Simplifications can include using the same product to treat both SAM and MAM, simplifying product dosages, or changing the delivery platform for services.

Three different approaches that involve changes in products and dosages have been introduced in DRC. The first to be completed was a randomized controlled trial called Optimizing Treatment for Acute Malnutrition (OptiMA) that was recently completed in the province of Kasai. Under this approach children are admitted based on a MUAC of  $< 125$  mm or the presence of edema and all are treated with a single product—ready-to-use therapeutic food (RUTF). The amount of RUTF given is adjusted based on the degree

of wasting (ENN 2020). Recently published results from the OptiMA trial found that it performed better than the standard treatment strategy (as per current national IMAM protocols), with potential cost-savings benefits as well (Cazes et al 2022).

The second trialed approach was led by the Ministry of Public Health in partnership with UNICEF and the Nutrition Cluster using the Combined Protocol for Acute Malnutrition Study (CompPAS) protocol in two health zones in Ituri and Kinshasa. This approach uses the same admission criteria and single product as OptiMA but also simplifies the dosage, with all SAM children receiving two sachets of RUTF per day and all MAM children receiving one sachet per day. The pilot examined differences in care between services provided by a nurse and the community volunteers—known as relais communautaires (RECOs)—and found a non-inferior standard of care when the RECOs used the CompPAS approach (GNC-TA 2022).

The third approach—Modelling an Alternative Nutrition Protocol Generalizable for Outpatient (MANGO)—is being trialed in Kasai Oriental and will take place through 2023. This approach also uses RUTF as the single treatment product with the dosage adjusted based on the degree of wasting, but it uses different admission criteria of MUAC  $< 115$  mm or a weight-for-height z-score  $< -3$  (ENN 2020).

The government has not yet made any official changes to the national IMAM protocol, but it seems likely that simplifications will be endorsed if found safe and effective. It remains unclear how the implementation of a simplified approach that involves changes in products will cascade to health facilities and how the impact on the two parallel RUTF and ready-to-use supplementary food (RUSF) supply chains will be managed. While any modification to the IMAM protocol presents an opportunity to overcome some of the challenges in the continuum of care for wasting, they may also introduce new challenges—such as additional or new supply chain strains—that should be kept in mind if and when they are scaled up. Coordination between donors, UN agencies, implementing partners, and government will be essential to ensure that scale up is as smooth and undistruptive to service delivery as possible.

### Coordination between prevention and treatment elements of wasting management is limited

The national IMAM protocol highlights the importance of the continuum of care as part of its recommendations for implementation, noting that treatment services should link to prevention strategies such as IYCF and Essential Nutrition Actions. Beyond the services highlighted in the protocol, connections with the WASH, agriculture, education, and social protection sectors are also critical to addressing and mitigating the underlying causes of wasting and malnutrition more broadly. Wasting prevention is particularly important, given the resource constraints that limit geographic coverage of and access to treatment services.

Numerous nutrition and non-nutrition partners are implementing projects with activities that could support the prevention of wasting if coordinated at several levels: between community- and facility-based health and nutrition activities; within individual projects; and between projects, as discussed below.

### Coordination of community- and facility-based health and nutrition activities

There are coordination gaps between community-level prevention activities and health facility-based wasting treatment programs. For example, DFSAs conduct screening and referrals for wasting treatment as part of their community-based health and nutrition sensitization activities, but do not routinely follow up to ensure that the children they refer are able to access those services. Neither do they systematically share referral information so that the health facilities can follow up these referrals. This means that caregivers who do seek services risk being turned away if services have been interrupted, and that children who do not seek treatment—or try and do not receive it—are unlikely to receive further support.

Coordination gaps also occur when children are discharged from treatment. Ensuring that children and their families are referred to appropriate support services upon discharge from treatment can help break the cycle of malnutrition within the household and prevent relapse. In some settings in DRC, there are specific care group–based activities targeting mothers of malnourished children, but it is unclear how counter-referrals into these programs are managed or who is responsible. In their project reports, DFSAs do not mention taking specific actions to enroll discharged children in additional support services to prevent relapse or reduce the risk that other children in the same household become wasted (CRS 2020; FH 2020).

During health facility visits in Kasai Oriental, we confirmed that there is no mechanism for referrals to preventive or support services in the community in the health zones that we visited. The consequences of a weak referral mechanism are captured in a quote from a mother who was participating in a DFSA-supported care group in Sud Kivu: “Me, I’m tired of the instructions from [the project]. One day the *maman lumière* [lead mother] came to my home and tested my child, saying he is malnourished. [She] gave me a paper to go to the health center, but I returned home from the [health center] without even a tablet. The nurse told me to go home and make a porridge. Where was I going to find money to buy the mix of ingredients to make the porridge?” The midterm review for this project reported that mothers in both Sud Kivu and Tanganyika were refusing referrals to the health center, likely due to these kinds of coordination challenges (IMPEL 2020c).

The midterm review reports for all three DFSAs recommended that the projects develop stronger linkages with health system structures, both with government actors like PRONANUT and health zone management teams and with other health-focused projects like the *Projet de Santé Intégré de l’USAID* ([PRO-SANI]; USAID Integrated Health Program) (IMPEL 2020a; IMPEL 2020b; IMPEL 2020c). However, even health projects may have limited engagement with nutrition activities at the health facility level, as was the case of PROSANI at the time of our review. Nutrition is one of PROSANI’s thematic program areas but the majority of nutrition-specific support happens at the community level, with health facility support focused on other services (e.g., malaria and tuberculosis) and broader health system strengthening efforts. The project’s engagement with nutrition at the health facility level is limited and does not include support for wasting treatment services. Therefore, even though closer coordination between the DFSAs and PROSANI on their community-level nutrition activities may be beneficial, it may not improve linkages with facility-based wasting services.

### Coordination of prevention activities within a single project

Many of the projects that implement prevention activities are multi-sectoral, presenting numerous opportunities to harmonize individual activities to improve nutrition outcomes. However, these types of projects are often large and employ experts whose primary focus is on their sector-specific objectives and activities. In these instances, internal project coordination is critical to ensure that complementary components are delivered on time and that adjustments are made across activities if delays occur.



PHOTO CREDIT: KATE HOLT/MCSP

A community health site worker shows women how to prevent their children from getting ill. The nearest health center to the village is an eight-hour pirogue (small boat) journey away and many young children under the age of five were dying from easily treatable illnesses until the community health site was established.

An example from Sud Kivu and Tanganyika illustrates what can happen when multi-sectoral project activities are poorly coordinated and do not actively revise their activity plans. A DFSA project planned to distribute recipe booklets to its care group members to encourage the use of local ingredients for the treatment of MAM and prevention of SAM (FH 2020). This is a promising strategy, especially given frequent gaps in RUSF supply and the limited coverage of MAM treatment. However, because of poor sequencing and adaptation of individual activities, the broader multi-sectoral effort was unsuccessful. Delays in the delivery of recipe booklets meant that cooking demonstrations could not start as planned. Despite the fact that the recipe booklets were not yet available, health promoters began conveying messages about the recipes, leading to confusion among the *mamans lumières* in charge of the care groups. In Sud Kivu, once cooking demonstrations of the promoted recipes were able to start, the project had challenges with the related activities that were meant to ensure that households had access to the required foods, including problems with seed distribution and small-animal husbandry activities. The project did not provide interim food or cash support so that mothers could secure the foods necessary to prepare the recipes during this period. These compounding problems led to a loss of cred-

ibility of *mamans lumières* in the eyes of care group members, and the positive nutrition outcomes of these multi-sectoral activities were not realized (IMPEL 2020c).

#### Coordination of prevention activities across projects

In many cases, different projects are responsible for delivering separate but complementary sets of activities. We found that coordination challenges between projects can begin as early as the design stage, even when the best intentions for coordination and collaboration are integrated into the awards. USAID Advancing Nutrition found an example of this when examining the coordination between a co-located Feed the Future value chains project and DFSAs in Sud Kivu. These projects were meant to work together to strengthen value chains and were implementing important prevention programming components with the potential to ensure the availability of key nutritious foods and increase household incomes, which can lead to improved food security, dietary diversity, health-seeking behavior, and resilience.

Although these projects were intended to be complementary, several challenges hindered coordination. The value chain project was contractually limited to supporting the post-har-



vest aspects of dried bean and soybean value chains, operating on an incorrect assumption that the co-located DFSAs would support the other elements. However, DFSAs did not support the soybean value chain and the Feed the Future project was left contractually unable to fill the support gap to the pre-harvest aspects of that value chain, thereby reducing the overall effectiveness of the intervention. Challenges were encountered even when the projects supported a shared value chain, as was the original vision of the project. A lack of communication led to confusion about roles and responsibilities when transitioning support from one project to another. Among other factors, a discontinuation of USAID-facilitated coordination between the projects was cited as contributing to these disconnects in programming (McMillan et al. 2020).

### Multi-sectoral coordination platforms exist but are largely nonfunctional and poorly supported

Given the complexity of the coordination challenges we identified, it is clear that nutrition and non-nutrition actors could benefit from a space where they can share, discuss, and harmonize their activities. Yet none of the partners we spoke to held meetings specific to nutrition-related information sharing or problem solving. At the start of our subnational work, nutrition information was shared at the monthly health zone meetings only and was limited because the meetings cover a wide range of health topics.

As laid out in the *Plan Stratégique National Multisectoriel en Nutrition 2016–2020* ([PSNMN]; National Multi-Sectoral Nutrition Strategic Plan) intersectoral multi-sectoral nutrition committees are to be established at the province and territory levels. While the role of these committees is not articulated clearly in the PSNMN, our discussions with nutrition actors indicated that they are intended to coordinate actors implementing nutrition-related activities as outlined in the plan. Although the provincial-level committees have been established, they are largely nonfunctional. Territory-level committees, for the most part, do not yet exist. While the Office of the Prime Minister is the main oversight body for DRC's national multi-sectoral nutrition activities, PRONANUT guides the day-to-day running of activities in its role as executive secretariat at national level. Similarly, province-level PRONANUT staff have the day-to-day responsibility for multi-sectoral activities in the provinces. Based on the information we gathered, support to PRONANUT to operationalize the provincial multi-sectoral nutrition committees has been limited and nonexistent for the territorial committees. UNICEF support to the provincial

committees was limited to the facilitation of a small number of planning meetings as part of developing multi-sectoral nutrition strategic plans and Save the Children supported finalizing Kasai Oriental's plan. Beyond planning process support we are not aware of ongoing capacity strengthening support to the committee or its members to help them implement the plan.

In addition to the committees outlines in the PSNMN, there are numerous non-nutrition-specific multi-sectoral structures, often referred to as development committees that are intended to help coordinate, direct, and oversee the implementation of activities at the provincial, territorial, community, and neighborhood levels. One of the most common multi-sectoral coordination structures with which nutrition partners engage is the *cellule d'animation communautaire* ([CAC] community action group). Each CAC is under the leadership of the village chief and comprises religious and opinion leaders and delegates from community-based organizations and the WASH committee (MSP 2016). However, it is unclear which subnational-level sector is responsible for overseeing these structures. At present, the default supervisory entity is the Ministry of Health, but the level of supervision and support it provides is inadequate (IMPEL 2020a). There are also many other sector-specific committees such as health management committees, parents' committees that help to manage schools and social protection structures. In addition, RECOs are often asked to support various activities related to wasting treatment and prevention, such as screening and follow-up, and linking households with basic social services such as health, education, social protection, WASH, housing, and food security. However, as our examples in this report illustrate, the opportunities that these entities present are not leveraged for the benefit of nutrition coordination and referrals between nutrition-specific treatment services, and multi-sectoral prevention services are weak or nonexistent.

### LESSONS LEARNED

The examples above make it clear that coordination is critical for the management of wasting treatment and prevention activities and services and its lack weakens the entire continuum of care. As our findings illustrate, coordination is not the responsibility of a single manager, official, or program, but requires clear roles and responsibilities for all involved. We have learned that without a platform through which to share information and harmonize actions, effective coordination is especially challenging.



**Wasting coordination and collaboration requires a multi-sectoral approach to nutrition programming, involving both development and emergency actors**

The operating environment in DRC necessitates ongoing development activities to strengthen systems and focused, short-term emergency responses to mitigate acute crises. With numerous actors supporting activities along this spectrum, a single coordination platform is unlikely to be able to meet all of these needs. However, this means that in addition to being clear on their individual mandates, each coordination platform must have clearly defined processes for sharing pertinent information with other coordination entities. For example, the Nutrition Cluster is vital to the coordination of nutrition-specific emergency actors but it must ensure that its government and development counterparts are aware of its activities and have access to its information, as appropriate. Because the wasting continuum of care encompasses prevention and treatment activities, it requires a multi-sectoral space for coordination that includes government, emergency, and development actors.

Although their official mandate remains unclear, under ideal circumstances, the province- and territory-level multi-sectoral nutrition committees would facilitate this engagement. However, these platforms are under-resourced and lack necessary external support to establish routine activities, rendering them largely nonfunctional and in need of significant capacity strengthening in joint planning, monitoring, and budgeting and financial support before they fulfill this role. During our work, we did not identify any nutrition actors that were providing ongoing capacity strengthening support to these committees.

The absence of functional multi-sectoral nutrition committees means there is no logical place for development and emergency nutrition actors to convene and share information about wasting activities or nutrition issues more broadly. Monthly health zone management meetings, due to the large number of health activities that need to be covered, do not always include nutrition issues. An ad hoc solution in some provinces has been for development partners, like those implementing DFSAs, to participate in Nutrition Cluster meetings. While Nutrition Cluster coordinators are open to inviting more actors to meetings and are interested in hearing about development partners' activities to identify areas of complementarity, adding more content and participants to these meetings risks diluting the Nutrition Cluster's emergency mandate and may not be a good use of time for development and non-health-focused partners. It is important to remember, especially for non-health actors,

that each sector has its own coordination mechanisms in which it participates, thus constraining the amount of time these actors have to dedicate to participation in numerous health- and nutrition-related coordination structures.

The lack of a clear platform for multi-sectoral nutrition engagement is especially problematic for actors supporting prevention, even when the activities are health-related, such as IYCF promotion. As an example, at the start of our information gathering, we found that DFSAs did not engage with the DPS or PRONANUT, despite implementing health and nutrition activities like screening and counseling. DFSA engagement with local governments, however, has improved over the course of our work in response to gaps that we identified as part of our documentation and feedback processes. Several of the projects have signed memorandums of understanding with the DPS and PRONANUT. Beyond government engagement, DFSAs are now also working more closely with health sector projects like PROSANI and the Nutrition Cluster.

Overall, without a clear platform to foster the participation of all multi-sectoral nutrition actors, coordination and collaboration will likely remain ad hoc, especially among emergency and development actors and non-health sector actors contributing to wasting prevention, and the continuum of care persistently fragmented. In box 2, WFP describes a practice the organization used in Cameroon to leverage blanket supplementary feeding (BSF) programs to promote the integration of wasting prevention and treatment that could be pursued while multi-sectoral nutrition committees are being strengthened.

## **PLANNING**

Coordinated planning between nutrition actors on both the operational and technical aspects of implementation is integral to delivering a seamless, holistic continuum of care for wasted children. Well-coordinated planning reduces duplication of efforts, creates service delivery efficiencies, and facilitates better and more equitable service coverage. Coordinated planning can also help ensure harmonization of approaches, preventing contradictory operational standards, like differing incentives for community volunteers that can lead to demotivation, and can reduce the risk of overloading community members with numerous, potentially competing demands on their time. However, the mix of long-term development programs and short-term emergency interventions add a layer of complexity to the planning process, making the need for good communication and coordination

## Box 2. Promising Practice from Cameroon: Using Blanket Supplementary Feeding Programs as a Platform for Prevention Services

Parts of Cameroon are challenged by regional insecurity, leading to the influx of internally displaced persons and refugees and disruption of markets. Rates of wasting were particularly high among these populations, while supplementary feeding programs for children with MAM were underperforming and not reaching those in need. In response to this situation, the Ministry of Public Health and WFP shifted focus to an expanded prevention program for children and pregnant and lactating women. Existing BSF sites were used to provide an integrated package of prevention services including health interventions (e.g., vitamin A supplementation, deworming, human immunodeficiency virus services), WASH, household cash and food assistance, IYCF promotion, and MUAC screening. As a result, the number of children with MAM reached through the BSF platform more than doubled when compared to previous treatment-focused approaches, and the cost of the BSF approach was less than half of that of the treatment program in two of the pilot regions. This was due to the lower cost of the products used (Supercereal plus compared to Plumpy'sup) and lower logistics, training, and equipment costs. MAM rates also dramatically decreased and although this decline cannot be attributed solely to the integrated BSF approach, it is likely a contributing factor (Ngwenyi et al. 2019).

DRC has similar challenges with the coverage and reliability of MAM treatment services and supplies. Leveraging existing BSF sites to promote prevention could be a cost-effective way to begin to overcome these challenges. However, success would also rely on the coverage and availability of BSF services.

essential. In this section, we explore the implementation challenges caused by poorly coordinated planning and take a closer look at the level of coordination between nutrition actors when planning for nutrition commodities and supervision visits.

### FINDINGS AND OBSERVATIONS

#### Poorly coordinated activity planning creates implementation challenges

We found that a lack of coordinated planning led to several challenges during implementation in the focus health zones. In some cases, poor planning led to the use of differing technical approaches, causing confusion at the community level. We found several examples of this in Kasai Oriental. In Cilundu, the DFSA partner was implementing a community-led total sanitation approach that included different steps than the DPS-sanctioned Village Assainis (Healthy Village) approach. Additionally, in some of the same geographic areas, the DFSA's health promotion activities used a care group model with a positive deviance component led by *mamans lumières*, which was a slightly different approach from what other partners working in the communities used. This reportedly led to confusion among the RECOs and *mamans lumières*, who have an important role in the implementation of these approaches. The health zone management teams noticed that at the time that the partner promoting these activities was not

actively participating in the monthly health zone management meetings, which may have contributed to these planning disconnects. In other instances, poorly coordinated activity planning may have led to inefficiencies and duplication. In Kasai Oriental, on one occasion three different partners conducted similar training on IYCF and growth monitoring around the same time with no coordination of their efforts. One partner conducted IYCF training without follow-up or supervision activities, calling into question the sustainability of its capacity strengthening efforts. In Mubumbano, we found a similar situation in which many of the partners were undertaking IYCF activities without coordinating their planned activities. This is a missed opportunity to increase the coverage of common activities and ensure that all components, from training to supervision, are adequately covered. If resources are limited, coordination could help partners fill gaps.

Failure to coordinate operational aspects of implementation can also cause problems, even if similar technical approaches are used. For example, WFP and UNICEF partners pay different amounts to the RECOs they work with, which can create tensions if both partners are operating in the same geographic area.

Nutrition partners have said that one of the barriers to coordinated planning is a lack of health zone team availability. In the context of short implementation timelines among emergency



PHOTO CREDIT: KATE HOLT/MCSP

Delivering medical supplies, including commodities, can be a challenge due to poor infrastructure. At certain times of year, roads may become impassable and other modes of transportation, such as boats, may be required to reach health centers.

nutrition projects, continuous engagement may be less of a priority, especially if the perception is that health zone teams are unresponsive. However, health zone management teams expressed equal levels of frustration with the short-term nature of emergency projects, which may also reduce their willingness to engage with these actors. In Mubumbano, partners said that they wait for the health zone chief medical officer to call meetings; however, the health zone chief medical officer indicated that partners do not always attend meetings when invited. Health zone chief medical officers and other government officials from Kasai Oriental and Sud Kivu contended that partners did not always share their work plans with the health zone team, and monthly monitoring meetings suffered from low participation. This led to “surprises,” or difficulties when new projects begin without accounting for ongoing activities and existing projects.

#### Development actors find it challenging to plan with emergency actors

The short-term, intermittent nature of emergency-funded support to wasting treatment services and the potential for termination of or delays in issuing contracts with local nutrition partners make consistent engagement between emergency and development actors challenging. There is also the potential for emergency actors to change, making it difficult to ensure that new partners understand coordination and collaboration needs. Multi-year development programs and health zone

teams felt that they bear the burden of problems that result from short-term projects with few continuity plans—at least until the next project begins. For example, DFSAs conduct community-based social and behavior change activities to strengthen demand for and facilitate linkages with treatment services. Inability to access products and/or services at facilities—which tend to occur and/or be exacerbated during gaps or transitions between emergency projects—jeopardizes community trust in their activities and demotivates the RECOs who made the referrals. These longer-term projects also felt it was harder to adhere to an annual work plan when emergency nutrition projects change the landscape of “who does what” along the continuum of care for a short period, especially if there are delays in when UNICEF and WFP issue the next round of emergency contracts. However, planning challenges are not exclusively between emergency and development actors. Disconnects can also occur between UN agencies and other nutrition actors when UN support ends in a particular geographic area, as is described in box 3.

#### Planning processes for nutrition product delivery and procurement differ widely and are not always fit-for-purpose

While there are many difficulties related to the nutrition supply chain, as we discuss in the next section of this report, poor planning and budgeting for the transport of nutrition products from the central health zone office to health facilities and communities exacerbates them. The supply chains for therapeutic and supple-



### Box 3. The Challenges of Multiple Wasting Treatment Partners in Kabeya Kamuanga

Kabeya Kamuanga Health Zone in Kasaï Oriental had RUTF supply chain challenges in 2020. Based on interviews we conducted, it seems that these were caused by a significant gap between the end of a UNICEF-funded contract with a local nutrition partner, Médecins d’Afrique (MDA), in February 2020 and at the start of a USAID-funded project in August 2020. This UNICEF funding was provided through the DRC Humanitarian Fund, which included allocations for coordination support, including logistics. When UNICEF’s contract with MDA ended, UNICEF stopped providing support for SAM services, including the distribution of RUTF. Informants could not state why UNICEF funding ended or why it was not promptly renewed. The long gap between supporting projects led to leftover RUTF from MDA going unused. The health zone also experienced a resulting drop in SAM cases presenting at the health facility, as word spread among communities that RUTF was unavailable. During this period, there was a surge in SAM cases that could not be managed properly without nutrition partner support. Health facility staff had to treat children who had SAM with MAM products, which then led to difficult trade-offs based on the severity of the child’s condition and supply availability, as there were not enough MAM supplies to treat both SAM and MAM children. A separate issue related to a surplus of RUSF for MAM (which was managed by yet another partner, funded by WFP) led to those extra MAM products being given to families of SAM children. While the use of products like RUSF to treat SAM is acceptable in cases of supply shortages, in this instance the practice may have exacerbated the surge in SAM cases, as fewer children were being brought to health centers where their treatment could be closely monitored.

The RUTF supply improved since the start of USAID-funded activities in August 2020. As part of this project’s activities, the nutrition partner directly procures and delivers RUTF to health facilities, independently from the UNICEF RUTF supply chain. Planning for the last-mile delivery of RUTF has been conducted between the nutrition partner and health zone officials. Although the nutrition partner initially faced challenges with the timely importation of RUTF into DRC, it has been able to borrow products from other partners that also procure RUTF directly (e.g., Action Contre la Faim and Médecins Sans Frontières). Despite challenges with the delivery of RUTF from the central health zone warehouse to individual facilities due to a lack of vehicles and poor road infrastructure, the RUTF supply situation in Kabeya Kamuanga seemed to remain acceptable into 2021. However, in 2021 the supply chain for supplementary foods, which is still supported by a local nutrition partner through financing from WFP, experienced significant stockouts. This highlights the need for ongoing, close coordination and planning between government and nutrition partners to ensure that the system can adapt to supply chain breaks and that all children who require treatment for either SAM or MAM receive it.

mentary products are separate from each other and from the supply chains for other nutrition-related essential medicines and supplies. This has led to a situation in which planning of last-mile delivery of therapeutic and supplementary foods differs from partner to partner, with the processes, timing, and requirements often driven by the partner’s contractual obligations, rather than by health zone processes and needs. Additionally, health zone officials often have little say in these processes.

UNICEF and WFP contract local partners to support the last-mile delivery of nutrition products within the health zones. However, both UNICEF and WFP partners have cited

a lack of resources to ensure timely delivery of products to health facilities.

UNICEF partner awards were not available for review to assess how transport is budgeted under these agreements or allow us to understand why partners cite resources for product delivery as inadequate. However, in examining WFP’s logistics planning for supplementary food products, we identified specific last-mile delivery planning challenges that nutrition partners face. WFP uses metric tons to estimate the amount of supplementary food products required for import into the country, which is appropriate for the large amount of products



it is managing. However, WFP also requires its locally contracted partners to use metric tons when estimating transportation costs for the delivery of supplementary products to the health facilities and communities. This is a challenge for partners, who have asked that transportation costs be estimated based on the number of days required because transportation inputs—such as vehicles and drivers—are typically estimated based on days of use or hire. The amount of time required to transport products may also vary greatly depending on the time of year. Given the poor road infrastructure, there may be delays during the rainy season or roads may become impassable, requiring alternative transportation like boats in certain locations. These variations will undoubtedly result in cost differences not easily captured when using metric tons as the primary unit for estimating transportation costs, which also may contribute to shortfalls in transportation resources. Partners also reported frequent reimbursement delays from WFP, which further hindered their operational capacity.

UNICEF, WFP, and their partners are not the only actors supporting the last-mile delivery of nutrition products in the health zones. In some, including our three focus health zones in Kasai Oriental, NGOs may directly procure and transport nutrition commodities to the health facilities, independent of national-level UNICEF and WFP systems. These arrangements have their own planning and budgeting processes.

The variety of processes used to plan and budget for last-mile delivery transportation requirements are complicated, espe-

cially for health zone officials, who in the eyes of communities are ultimately responsible for the availability of services. During interviews with health facility staff and health zone officials, there was no mention of a combined strategy for coordinated last-mile delivery of products among UNICEF, WFP, nutrition partners, and the health zones. They consistently cited misalignment of procurement estimates with actual needs as a challenge to supply chain planning that can cause friction between the health facilities and the communities. At the national level, UNICEF and WFP target only a proportion of estimated caseload, which is reflected in the planning of their local partners. This target is always set below 100 percent of the estimated need, due in part to assumptions about coverage and service delivery capacity but also because of UN agency budget constraints. Health zone officials have expressed dissatisfaction about their inability to adjust the predetermined targets based on actual needs. In contrast to the situation in DRC, box 4 describes the benefits of close coordination between UNICEF and WFP when planning SAM and MAM support.

#### Planning of supervision visits requires strengthening

Of all aspects of wasting prevention and treatment discussed above, supervision is the most integrated but still requires strengthening when it comes to planning. One positive aspect of supervision activities is that nutrition partners and health zone staff typically conduct joint visits. However, each nutrition actor still schedules individual visits for its implementation sites and conducts them on different schedules. For example, table 5 shows supervision visit schedules from Kasai Oriental, where

#### Box 4. Promising Practice from South Sudan: Encourage Coordinated Planning between UNICEF and WFP

Prior to the start of South Sudan's civil war in 2013, UNICEF and WFP provided limited nutrition support largely in parallel. However, due to the increased needs caused by the crisis, UNICEF and WFP took steps to develop a more coordinated way of working. The organizations developed the Joint Nutrition Response Scale Up Plan, which included both joint and individual actions needed in order to reach agreed-upon targets. Other factors, in addition to the joint action plan, that were identified as facilitating WFP and UNICEF's effective partnership include mutually agreed principles and commitments, close coordination at both the country and field level, quarterly and annual reports and reviews, and scheduled management meetings between the organizations, and dedicated staff to facilitate coordination (Aburmishan et al. 2019).

In stark contrast, UNICEF and WFP nutrition partner selection and contract periods in DRC are not aligned, leading to unpredictable gaps in services that hinder health facilities and development projects that have to cope with increased demand. Stronger, coordinated planning between UNICEF and WFP could help prevent these problems.

**Table 5. Summary of Supervision Visit Schedules and Coverage in Kasai Oriental as of March 2021**

Actor	Frequency	Number of Sites Covered per Visit	Date of Most Recent Supervision
Government (e.g., PRONANUT, DPS)	Quarterly	5 health centers and the inpatient facilities per visited health zone	December 2020*
Nutrition Cluster	Quarterly	Unknown; likely to vary by province	October 2020
Save the Children	Monthly	All facilities in the targeted health zones	February 2021
UNICEF	Monthly for financed health zones and quarterly participation in government-led visits	Two types of visits: programmatic visits and spot checks Number of facilities visited per month varies based on available financing.	February 2021
WFP	Monthly	8 (approximately 2 facilities every 2 days)	November 2020

\*Dates from 2020 indicate that the first quarterly or monthly visit(s) of 2021 did not take place as scheduled.

government officials, in addition to their own nutrition supervision visits, participate in those of at least four other entities. Also of note is that WFP, Save the Children, and UNICEF conduct separate monthly supervision visits, which are not all-inclusive of all service delivery sites, even though the SAM and MAM services they supervise are, in many cases, offered at the same sites and use the same staff.

In addition to poor scheduling, several other problems arise from how nutrition supervision visits are planned and conducted. For government-led visits, the focus is typically informed by the health zone monthly monitoring meetings. However, as previously noted, discussion of nutrition at these meetings is limited, so nutrition-related issues that require support or follow-up during government-led monthly supervision may not be integrated into these visits if they are based solely on issues identified for follow-up during the monthly health zone meetings.

The Nutrition Cluster conducts the most integrated supervision visits, with participation of government and nutrition partners. These visits are meant to cover all nutrition services at the community and health facility levels. The Nutrition Cluster’s supervision tool is comprehensive, but the information captured is not always detailed enough to ensure informed follow-up can take place to address identified problems—especially if this follow-up is conducted by someone who did not participate in the original supervision visit. Neither is there clarity about who is responsible for the follow-up actions that are identified during these supervision visits, meaning that in

most cases neither the Nutrition Cluster, the partners, nor the government plan for follow-up support.

Contractual delays may disrupt the planned supervision schedule. For example, in January 2021 the UNICEF-funded provincial cluster coordinators had a lapse in their contracts and did not return to their posts until April 2021. As indicated in table 5, Nutrition Cluster supervision visits are supposed to be quarterly. However, as of March 2021, when supervision data were last collected, there had not been a Nutrition Cluster-led supervision visit since October 2020, indicating that the gap in support from the coordinators disrupted the supervision schedule. In contrast, some nutrition partners are able to conduct frequent, high-quality supervision visits. However, these partners typically have dedicated budgets and staff to support supervision, and these visits are driven primarily by the partner’s need to monitor their project activities, rather than by the government.

### LESSONS LEARNED

Many of the coordinated planning challenges link to the lack of a functional multi-sectoral coordination platform through which government, emergency, and development actors regularly engage. The lessons presented here highlight the benefits of convening nutrition actors and government to undertake joint planning, which was the objective of our support to develop nutrition coordination and collaboration action plans for the focus health zones. We also identified benefits of strength-

ening the capacity of government officials to fulfill their roles as leaders and coordinators.

### Nutrition actors need dedicated time to discuss wasting management challenges and brainstorm solutions

Given the limitations of the existing coordination platforms, we convened nutrition actors to discuss wasting coordination and collaboration during a series of workshops in Kasai Oriental and Sud Kivu. These workshops gave nutrition actors the opportunity for extended, structured engagement; critical thinking; and identifying solutions to the root causes of challenges to the coordination of wasting prevention and treatment activities. The workshops also ensured that a range of interests and perspectives was represented throughout the process and integrated into the action plans.

Platforms such as the Nutrition Cluster and health zone monthly meetings do not have room in their already full agendas for these types of important but extended discussions. Even if nutrition actors met regularly through multi-sectoral nutrition coordination committee meetings, a dedicated nutrition coordination planning period would still likely be required on an annual basis. Ideally, these discussions would be timed so that the outcomes could be integrated into the health zone and provincial annual planning processes. When nutrition actors agree on objectives and corresponding actions and come up with an annual plan, it is more manageable to integrate coordination and collaboration progress checks into routine coordination platform meetings.

### The process of developing nutrition coordination and collaboration action plans opened communication channels between nutrition actors

Many of the activities in the health zone coordination and collaboration action plans focus on ensuring improved and ongoing communication between nutrition actors. One example from Miabi, was the inclusion of a meeting to discuss joint supply chain planning. This discussion was held between the health zone management team, Save the Children (which supports treatment for SAM), and WFP (which supports treatment for MAM through local partner Congo Nouveau Prospère [CONOPRO]). Due to an RUSF supply chain break, partners agreed to adjust criteria to ensure that children discharged from SAM were fully cured since follow-on MAM treatment products were not available. Subsequent communication led partners to revert to the original discharge protocol after MAM supplies became available. In our stakeholder survey,

Save the Children also mentioned that it now engages with CONOPRO in joint planning of IYCF in emergency activities to ensure complementarity in their shared implementation areas.

The process of convening emergency and development actors to develop nutrition coordination and collaboration action plans was also found to be useful in Sud Kivu. The action planning workshop for Kalehe Health Zone included participation from the Feed the Future–funded value chains activity, which facilitated discussions between its DFSA counterparts and other nutrition-specific actors that otherwise would have been unlikely to have occurred.

### Capacity strengthening enables and motivates government officials to fulfill their leadership roles

Nutrition partners often cite a lack of PRONANUT leadership and follow-up as one of the main challenges to nutrition coordination and collaboration, especially during planning processes. As part of the feedback about our support to coordination and collaboration efforts, nutrition partners noted the need to support government entities such as PRONANUT and the health zone management teams to take up the coordination role that USAID Advancing Nutrition facilitated because they are “the foundation for implementation...and [have] the objective of responding to day-to-day challenges.”

PRONANUT’s most cited challenge to fulfilling its coordination and oversight role is its lack of financial resources. For example, support visits to the health zones are an essential part of this role, and transport and per diem for government staff for these visits are valid needs. As the provincial arm of the Ministry of Health, DPS oversees PRONANUT, making PRONANUT dependent on DPS during planning and resource allocation processes. Both nutrition partners and PRONANUT have mentioned challenges related to resource allocation and the release of nutrition funds as well as a lack of transparency from government officials about the amount of funding available. Therefore, advocacy, coordination, and capacity strengthening for nutrition to enable improved action from PRONANUT must include DPS.

It is understandable that financial and other resource limitations dampen PRONANUT staff motivation. There was a marked difference in PRONANUT staff performance and motivation in Kasai Central, where PROSANI supports PRONANUT’s activities. In this province, nutrition actors were organized and PRONANUT fulfilled routine responsibil-

ities. PRONANUT convened quarterly meetings of nutrition actors; there was a signed memorandum of understanding between DPS, PRONANUT, and nutrition partners, all of whom were undertaking joint supervision visits. However, it is worth noting that at the time of our visit in 2020 the focus in Kasai Central was mainly on emergency activities, with nutrition partners supported by either UNICEF or WFP. No DFSAs or Feed the Future projects were active in the province at the time of our work, thus removing a layer of complexity in coordinating among actors that work on a wider range of prevention activities. The fact that UNICEF and WFP partners were already engaged with each other through Nutrition Cluster meetings may have also facilitated strong coordination.

Health zones with proactive and dynamic chief medical officers and health zone management teams also had better participation from nutrition partners in their monthly meetings. However, as was the case at the provincial level, these health zones often benefited from dedicated partner support that included capacity and systems strengthening. For example, health zones that benefited from PROSANI's health systems strengthening approach had more opportunities to plan, implement, and review activities. Similar benefits were seen in Cilundu, where the health zone chief medical officer received significant partner support, including funding for supervision, data monitoring, and nutrition activities, which likely contributed to his high level of engagement.

These examples highlight the importance of improving government staff motivation through opportunities for professional development and ensuring they have the skills, time, and resources to do their jobs efficiently and effectively. Mitigating the underlying causes of demotivation could create more proactive and motivated individuals and improve leadership. However, ensuring that nutrition partner support is phased out appropriately to ensure sustainability of these benefits is an important challenge that must be considered.

**Thorough planning is a first step in enabling government officials and nutrition actors to hold each other accountable**  
The inclusion of targets, budget estimates, and responsible and co-responsible actors for each activity in the nutrition coordination

and collaboration action plans was meant to enable health zone officials to monitor progress and follow up with designated nutrition actors to ensure that activities happened according to an agreed-upon timeline and were rescheduled when delayed. In our experience, this was partially successful, both in terms of the actual implementation of commitments and the follow-up of activities.

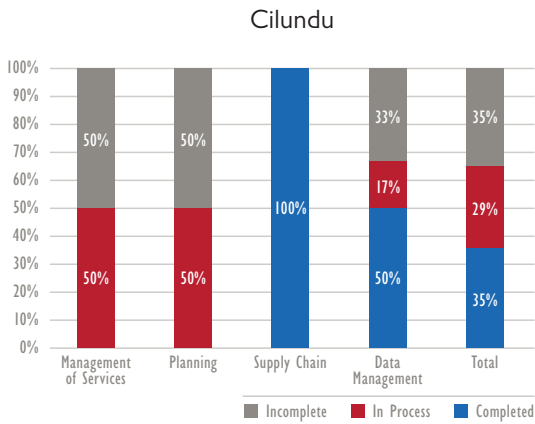
When USAID Advancing Nutrition met with nutrition actors six months after the action planning workshops to review the coordination and collaboration action plans, they made appropriate follow-up and adjustments to activities in the plans. However, this level of monitoring and follow-up did not occur without the project's support. As with many of the challenges discussed, this may be because of a lack of a regularly convened platform in which all nutrition actors participate. Because nutrition actors do not meet regularly—especially at the health zone level—individual partners had to be followed up, making the process more time-consuming for the health zone chief medical officer. Monitoring of coordination and collaboration for nutrition may require dedicated monitoring meetings that are planned and budgeted as part of the health zone PAOs. There may also be a role for the multi-sectoral nutrition committees in this monitoring, once they are strengthened. Without ongoing monitoring of progress, the coordination and collaboration action plans will have limited effect, as nutrition actors, including partners and government, will not be accountable to their commitments.

During these monitoring meetings, we learned that implementation of the activities in the coordination and collaboration action plans was mixed. As of November 2021, which was just one month from the end of the action plans<sup>3</sup> implementation periods, we found that proportion of completed activities ranged from a high of 57 percent in Mubumbano to just 35 percent in Cilundu. It is difficult to compare achievements across the health zones, as the activities included in the action plans and the resources available to support them varied. However, looking across the health zone-specific charts in figures 7 and 8, no clear pattern emerges across health zones or activity domains in terms of what types of activities were more likely to be completed, incomplete, or still in process.

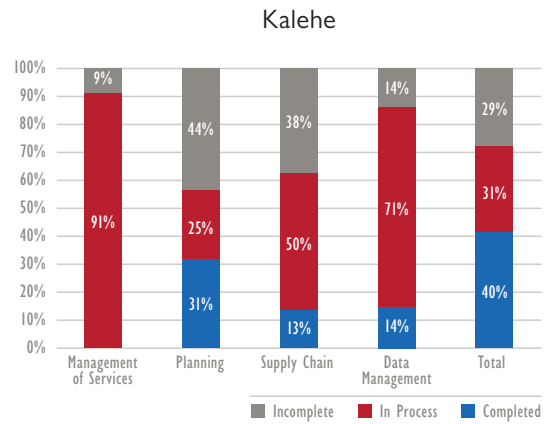
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<sup>3</sup> The action plans in Kasai Oriental cover the period from March to December 2021. The action plans in South Kivu covered the period from May to December 2022. The difference in time frame is due to the timing of the action planning workshops.

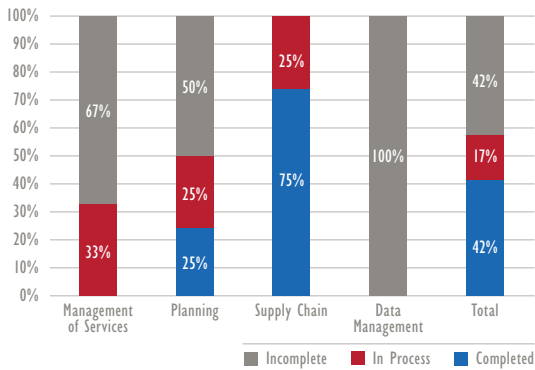
**Figure 7. Coordination and Collaboration Action Plan Progress in the Kasai Oriental Focus Health Zones, November 2021**



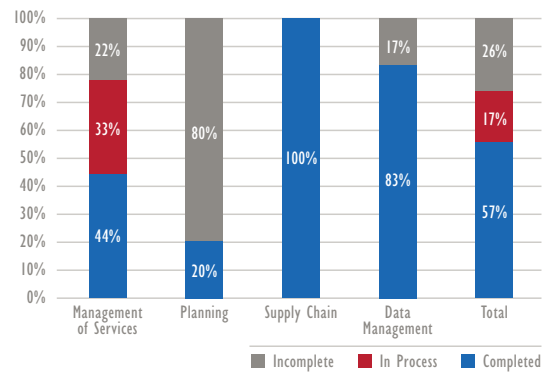
**Figure 8. Coordination and Collaboration Action Plan Progress in the Sud Kivu Focus Health Zones, November 2021**



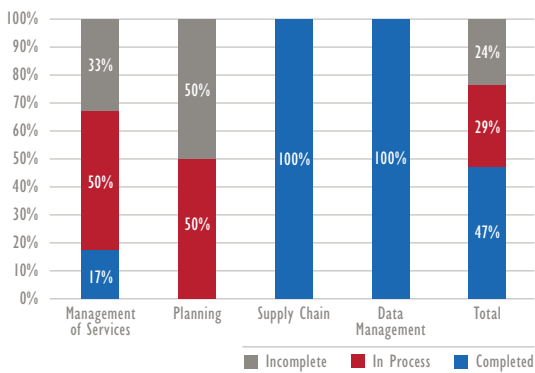
**Kabeya Kamuanga**



**Mubumbano**



**Miabi**



The timing of the coordination and collaboration action plan development created some challenges regarding the ability of government officials and nutrition partners to commit resources to support the prioritized actions, which likely had different levels of impact on the ability of health zones to show progress in implementing their action plans. Government actors made health zone annual planning resources available to support action plan activities; however, their ability to do so was limited as PAO activities were already approved for the year and government resources to support the already approved plans were extremely limited. Therefore, government commitments were mostly limited to activities that aligned with things that were already included in the approved health zone PAO, like support to supervision visits, for example.



Nutrition partners designated responsible or co-responsible in the action plans also had challenges to take on activities, based on their own planning cycles and approved work plans and budgets. In some cases, they were able to formally integrate nutrition coordination and collaboration actions into their project work plans, either because they were closer to their annual planning processes or because they had some flexibility within their financing and activity plans to take on activities that aligned with their overall mandates and programming objectives. When workplanning cycles did not align, some partners made slight adjustments to planned activities to integrate nutrition-related aspects. For example, in response to the need for better joint supervision of nutrition activities, a DFSA partner began including health zone officials in its routine monitoring visits of their care groups. Similarly, UNICEF and WFP implementing partners began jointly monitoring health facility activities, sharing data, and holding coordination meetings with the health zone chief medical officer.

If future iterations of nutrition coordination and collaboration action planning are undertaken, the timing should align so that activities can be directly integrated into and financed as part of the larger PAO process. This may increase the amount of government resources that can be dedicated to nutrition coordination and collaboration activities and facilitate nutrition partner commitments.

### **Joint supervision visits are a best practice but need strengthening**

We have seen some improvements in the planning of joint supervision efforts over the course of our work. As mentioned, DFSA partners are now involving government officials in their supervision visits. In Kasaï Oriental, the DFSA partner has also started to participate in Nutrition Cluster supervision visits, thereby strengthening linkages between emergency and development nutrition actors.

Despite these improvements, much more is needed to further coordinate supervision efforts, especially planning for necessary follow-up support to facility- and community-based staff and volunteers. Although PRONANUT's follow-up on supervision actions remains limited, DFSAs are now creating opportunities to strengthen PRONANUT's ownership of and capacity to respond to supervision issues through increased engagement. However, more efforts to leverage other partners such as PROSANI are needed.

Finally, in phase I of our work, we found that joint supervision of wasting treatment was being undertaken in parts of Sud Kivu where WFP and UNICEF were funding the same implementing partners to support SAM and MAM services. However, in 2021 there were only two health zones in which the same partner was supporting both services, so the opportunity for this single-partner joint supervision is limited. Further integration of supervision visits undertaken by the different partners supporting SAM and MAM treatment will help reduce the overall number of visits, lessen the burden on the health facilities, and improve communication between government and nutrition partners about what follow-up to supervision visits is needed and who is responsible for providing it.

## **SUPPLY CHAIN MANAGEMENT**

All actors engaged in wasting programming in DRC cite the exceptionally challenging logistical context as a major impediment to program effectiveness. A 2018 assessment of DRC's supply chain conducted by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) found that the system is fragmented and suffering a lack of leadership, ownership, and coordination across partners and programs. The system comprises multiple parallel supply chains, and procurement is often based on outdated caseload data or targets that capture only a portion of actual needs. This situation is complicated by poor basic infrastructure and logistics systems, including warehousing and data management (GHSC-TA 2019). Ongoing insecurity in parts of the country increases the complexity of these challenges.

USAID Advancing Nutrition reviewed the national policies that govern the structure of DRC's supply chain systems to identify what might be affecting the availability of nutrition products in the health zones. We also conducted medical store visits in Kasaï Oriental to review stock cards and interview staff about the availability of nutrition products and a selection of essential medicines required as part of wasting treatment protocols. We identified several major barriers as well as some promising opportunities, discussed in the following sections.

## **FINDINGS AND OBSERVATIONS**

### **Inclusion of nutrition products in national supply chain management systems is mixed**

Medicines and other products on DRC's National Essential Medicines List should be available at any time, in sufficient quan-

ties, and be financially accessible<sup>4</sup> to the majority of the country's population (MSP 2010). Despite this national guidance, the availability of essential medicines and supplies remains a major challenge for the health system. The inconsistent availability of drugs and weak regulation of pharmaceutical services are among the main health system deficiencies noted in UNICEF's draft Management of Malnutrition Scale-up Plan. Reasons for these challenges include weak management by the government and difficulties with logistics and transport, including cost, distribution, and pre-positioning of stock (UNICEF 2019). The Global Nutrition Cluster also cites low capacity for supply chain management of nutrition products as a main challenge in DRC (Global Nutrition Cluster 2019). RUTF, therapeutic milks (formulas 75 [F-75] and 100 [F-100]), and RUSF are included in the October 2020 version of the Essential Medicines List. Based on our review of the versions of this list available online, RUSF was added in 2020 (MSP 2020). However, other supplementary food products, such as fortified flours, are still excluded.

Efforts are being made to upgrade logistics information systems, but supplementary foods are excluded from these efforts. Since 2013, the government has been in the process of introducing a Logistics Management Information System (*Système d'Information en Gestion Logistique* [SIGL]) to provide timely information for decision-making about the procurement and distribution of essential medicines and other commodities (MSH 2014; MSP 2020). In the initial phases of the SIGL setup and rollout, nutrition commodities were not among the items to be tracked, but F-75, F-100, and RUTF are included in the latest SIGL guidance, released in May 2020 (MSH 2014; MSP 2020). Stock data for these same products are also reported in the District Health Information System (DHIS)-2. RUSF and other supplementary food products are not included in either national data management system. Instead, WFP monitors supplementary food stocks through its own management system.

Individual projects have also created stock management tools, which may be useful stopgap measures but could also result in duplication of certain aspects of existing national systems like SIGL and the DHIS-2. PROSANI has developed an Excel-based tool that monitors stock levels across its nine focus provinces, but this tool is not comprehensive and does not include nutrition inputs. It is unclear how items were selected for inclusion in the tool, as it does not include all items that PRO-

SANI provides to facility and community-level service points (e.g., vitamin A is not included, while iron–folic acid [IFA] and deworming tablets are), nor does it cover all essential medicines as defined by the government Essential Medicines List (PROSANI 2020b). When we spoke with project staff, they did not describe how or whether this tool interfaces with SIGL. These parallel and sometimes duplicative efforts indicate that there is room for improvement in coordinated design, planning, and rollout of supply management systems.

#### Availability of essential nutrition products for distribution by health facility staff is highly variable

When we visited health facilities in Kasaï Oriental to observe their wasting treatment services, we also visited the health facility medical stores to understand the implications of the fragmented nature of nutrition supply chains on product availability for distribution by the health facility staff on SAM and MAM outpatient treatment days. We visited our three focus health zones, which are supported by WFP but not UNICEF partners. In these health zones, RUTF is directly procured and delivered by a USAID-funded NGO. Because we only reviewed stock information for UNTA and UNS treatment services, we do not include primary data on the SAM inpatient supplies for the Unité Nutritionnelle Thérapeutique Intensive services—such as F-75, F-100, and other medical inputs—in this review. We did, however, examine the availability of other essential medicines, including vitamin A, deworming tablets, antibiotics, and IFA, compared to RUTF and RUSF.

#### Availability of therapeutic food products

On the day of data collection, all 15 health facility medical stores we visited had RUTF stock available for distribution by the health facility staff. While some facilities in all three health zones experienced stockouts at some point in the previous one to two months, these were relatively minimal and concentrated primarily in one health zone. The reasons cited for stockouts included receiving only a partial order, a lack of transport from the health zone office to the facility, and stockouts at the health zone–office level. Although we did not conduct primary data collection on RUTF availability in health zones supported by UNICEF-funded partners in Kasaï Oriental, when we spoke to these partners they reported that their UNTAs had no RUTF stocks for three months (January–March 2021). It is important to note that UNICEF contracts are issued for a much shorter period, typically six months, than the 12-month award

<sup>4</sup> Therapeutic and supplementary food products are provided free of charge and are only available from trained personnel. They are not available for purchase.

of the NGO supporting the visited health zones. As mentioned earlier, there are often gaps between when contracts expire and new ones are issued, which can exacerbate supply shortages as buffer stocks are limited and rarely well integrated into supply planning.

#### Availability of supplementary food products

The national IMAM guidelines allow use of either corn-soya blend (CSB), often provided with vegetable oil and sugar, or RUSF for treatment of MAM in children. The availability of these supplementary food products was the most problematic during our site visits. All but 1 of the 15 health facilities that we visited had a complete stockout of RUSF on the day of data collection. Stocks of other supplementary food products, such as CSB+<sup>5</sup>, vegetable oil, and sugar, were also typically unavailable. Stockouts of RUSF appeared to be getting worse over time. When asked about the reason, facility staff cited stockout at the health zone office or indicated that partners did not provide stock, but did not offer details. Similar to UNICEF, WFP typically issues six-month contracts to their local implementing partners to support the delivery of supplementary products to the health facilities. Contracting gaps and reimbursement delays were commonly cited ongoing challenges.

#### Availability of other essential medicines

In addition to RUTF, other essential medicines, including vitamin A, deworming tablets, antibiotics, and IFA, were in stock at most facilities, pointing to a specific problem with supplementa-

ry food products rather than a wider supply chain or access issue. Table 6 summarizes stock availability of essential medicines and therapeutic and supplementary food products during our primary data collection period.

#### LESSONS LEARNED

The implications of an unreliable supply chain are well known. When treatment is not available due to a lack of the necessary products, caregivers lose faith in health services and children's lives are put at risk. Despite these challenges, we identified several promising opportunities to strengthen nutrition supply chains.

#### Integrate emergency response capacity into the health system

While there are few new lessons to be drawn from the DRC supply chain experience, it is worth highlighting that the short, intermittent nature of UNICEF and WFP contracts may not be an appropriate mechanism to ensure that integrated wasting treatment services are reliably available at all health facilities, as is the intention articulated in the national IMAM protocol. These contracts are structured to meet the needs of acute emergencies, not to support the long-term delivery of integrated IMAM services.

In 2020, Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+) conducted a learning review on the nutrition response in DRC that included an appraisal of emergency

**Table 6. Availability of Essential Nutrition Supplies (Primary Data Collection Only, Kasai Oriental, December 2020–January 2021)**

Item	Health Facility (HF)* with Verified Stock available on Day of Visit	HF That Had a Stockout in the Past One Month	HF That Had a Stockout in the Past Two Months
RUTF	100% (15/15)	73% (11/15)	73% (11/15)
RUSF	7% (1/15)	27% (4/15)	60% (9/15)
CSB+	20% (3/15)	Not collected	Not collected
Vegetable oil	7% (1/15)	Not collected	Not collected
Sugar	13% (2/15)	Not collected	Not collected
Vitamin A	87% (13/15)	7% (1/15)	0% (0/15)
Deworming tablets	54% (8/15)	27% (4/15)	20% (3/15)
Antibiotics	93% (14/15)	13% (2/15)	20% (3/15)
IFA	93% (14/15)	27% (4/15)	13% (2/15)

<sup>5</sup> CSB+ is a type of CSB currently provided by WFP in DRC.

response models in use. According to the report, the DRC context requires nutrition approaches that can respond to emergency needs while building health system resilience, capacity, and sustainability. It suggests that all development actors strengthen the resilience of health and community systems by including surge capacities to help bridge the divide with emergency programs, and that emergency programs to adopt a systems approach. PRONANUT, with support from Action Contre la Faim through financing from UNICEF, European Commission's Directorate-General for European Civil Protection and Humanitarian Aid Operations, and UK Aid (MQSUN+ 2020; ACF 2017), is implementing this type of hybrid approach. The Pool d'Urgence Nutritionnelle Congo (PUNC) model relies on data from rapidly completed nutrition surveys (via the *Système National de Surveillance et d'Alerte Précoce* [National Surveillance and Early Warning System]) and the IPC food security surveillance system. If a nutrition problem is suspected, an investigation team made up of PRONANUT and implementing partner staff is deployed. Support activities are undertaken if needed, including actions such as training local health authorities; community screening approaches using RECOs; the family MUAC approach, in which caregivers screen their children for wasting; and in-kind donations of medical equipment to wasting treatment programs in health facilities. Box 5 describes CMAM Surge, which has been implemented in a number of other countries and could be an appropriate model for DRC. Although this approach has in many locations

historically been funded with emergency funds, a shift to more development funding is needed. Both PUNC and CMAM Surge documentation highlights that these approaches work best when multi-year funding can be secured (ACF 2017; Golden and Whitney 2021). Facilitating this requires coordination and collaboration at the donor level as well as between nutrition partners and government officials.

#### Avail opportunities to add essential nutrition products to supply chain monitoring and support systems

National logistics and data management systems like SIGL and DHIS-2 include therapeutic products and could be expanded and strengthened to help manage supplementary products as well. Projects like PROSANI and the USAID Global Health Supply Chain Program—Technical Assistance (GHSC-TA) are working extensively to strengthen supply chains for essential medicines and supplies in DRC and could be leveraged to strengthen these national systems for nutrition inputs as well. GHSC-TA works with USAID Global Health Supply Chain Program—Procurement and Supply Management (GHSC-PSM) and other donors, such as the Global Fund, to support procurement. According to the 2019 GHSC-TA annual report, GHSC-PSM currently procures the following nutrition-related essential medicines: antibiotics, IFA, and oral rehydration solution. However, it is unknown how many of these products are used within nutrition-specific services such as IMAM or related services such as antenatal care (GHSC-TA 2019). In some

#### Box 5. Promising Practice: CMAM Surge

The CMAM Surge approach was developed in recognition of a need for health systems, and particularly health facilities, to better respond to increases in the demand for wasting treatment services. Practitioners had noted that often these increases were seasonal and predictable and that by the time an emergency response was mobilized the opportunity to save the most lives had already been missed (Hailey and Tewoldeberhan 2010).

The CMAM Surge approach supports health facilities to assess their capacity and anticipated demand for wasting treatment services using past data trends and seasonal information and then set thresholds that will trigger additional support responses—such as temporary deployment of human resources or additional delivery of supplies—as previously defined by the health facility staff. CMAM Surge has been implemented in 12 countries with support from both emergency and development actors (Yourchuck and Golden 2021). It has been found to be an effective way to encourage health facility staff to make decisions about their work, strengthen relationships between health facility staff and local authorities, and improve the use and appreciation of data for decision-making (McCloskey, Yourchuck, and Hailey 2021). However, in many contexts the implementation of CMAM Surge actions is still reliant on external, typically NGO, support. The way this support is provided in DRC should be carefully considered, as short-term, piecemeal support has been found to be detrimental to the success of the approach (Golden and Whitney 2021).





PHOTO CREDIT: MOLLY BERGEN/WCS,WWF,WRI

Ensuring the health of women and adolescent girls before, during, and after pregnancy is an important strategy to prevent wasting in young children.

instances, PROSANI procures essential medicines and supplies; however, based on project reports, it is unclear which it procures directly and which it relies on other sources for, including GHSC-TA/GHSC-PSM. Decisions behind when to directly procure and which areas receive procurement support, and for which items, are not well defined either (PROSANI 2019; PROSANI 2020a). If these supply chain projects are able to better coordinate their efforts—especially in direct support of the management of nutrition commodities—it may be possible to overcome some of the health facilities’ supply chain challenges.

#### Explore opportunities to align with the VillageReach Supply Chain Investment Coordination and Advocacy project

Funded by the World Bank, the Global Fund, and the Bill & Melinda Gates Foundation, projects implemented by VillageReach reduced overall immunization supply chain costs by 34 percent by reducing storage, transportation, and management costs. The optimized immunization supply chain sought to reconcile inefficiencies due to ad hoc distribution and collection systems (Thomas et al. 2021). The Leadership in Supply Chain Initiative (LSCI) complemented this work by strengthening supply chain leadership capacity at the operational level (e.g., province and health zone). This work found that leadership and classroom training specific to the supply chain coupled with opportunities for hands-on experience were important elements of success in the LSCI model (Phillips-White et al. 2019).

Lessons from VillageReach’s previous supply chain work seem both promising and applicable to the challenges faced by DRC’s nutrition supply chain. In 2020, VillageReach completed the first phase of the five-year Supply Chain Investment Coordination and Advocacy (SCICA) project. This project builds from VillageReach’s experience supporting the immunization supply chain through its Next Generation Supply Chain Initiative and LSCI. The new SCICA project intends to prioritize programs whose performance is highly dependent on supply chain capacity. SCICA was presented to nutrition actors at the review of the National Multi-Sectoral Nutrition Strategic Plan in February 2021, as the project intends to engage with PRONANUT to ensure the nutrition supply chain is part of SCICA’s activities (VillageReach 2021). It will be important for nutrition actors to coordinate their supply chain activities in support of this initiative.

#### DATA AND INFORMATION SHARING

The availability of high-quality timely data is crucial for program management, planning, and supply forecasting. Many of the challenges cited earlier are linked to a lack of information sharing or poor quality, out-of-date data and data systems. In this section, we examine some of the challenges that stem from poor coordination and collaboration on data collection and management processes and systems.

## FINDINGS AND OBSERVATIONS

### Many nutrition partners do not share project data with other nutrition actors

To ensure that actions can be coordinated and to reduce duplication of efforts, it is important that the nutrition partners share information about their activities and outputs with the government and other partners. This is true for both treatment and prevention elements of the continuum of care.

In the section on planning, we discussed a challenge that arose from the implementation of slightly different community-level care group approaches. This programming disconnect also created a data-related challenge, whereby the DFSA partner implementing the care group approach created a parallel data system for its programming at the community level. Complicating matters, the partner reportedly did not share its data with the health zone, which did not share data from the government system with the partner.

Midterm reviews of all three DFSA projects noted the need to improve coordination and engagement with government structures, particularly for data and information sharing. In Kasai Oriental, the DFSA's failure to share monitoring data with government health officials was cited as a missed opportunity to ensure that project information was integrated into the DHIS-2. In this project, nutrition surveillance data are collected via many platforms at the community level, including care groups, RECOs, and CACs; but no mention was made of sharing these data with the provincial Nutrition Cluster, UNICEF, or WFP, where they could be used to inform decisions about wasting trends and improve product forecasting (IMPEL 2020a). Midterm reviews of the DFSAs operating in Sud Kivu and Tanganyika did not mention anything about sharing wasting data with the government, even though the projects are collecting this information (IMPEL 2020b; IMPEL 2020c).

### There is a general lack of nutrition data available for decision-making

The absence of routine data and information sharing is especially problematic, as there is a lack of information about wasting in general. The most recent national survey to include wasting data was the 2017–2018 UNICEF MICS; the most recent National Demographic and Health Survey was in 2013–2014. UN agencies and partners rely on data provided by PRONANUT and from annual Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys for

a picture of the changes in the number of children who may access services along the continuum of care. However, in areas where SMART surveys have not been completed, UN agencies must rely on data from the 2018 MICS. The 2022 Humanitarian Needs Overview for DRC states that funding for SMART surveys has been decreasing; the number of those conducted has declined approximately 50 percent each year since 2019 (OCHA 2022).

When looking at how the available data are used, it is difficult to determine a pattern that explains the variation in geographic coverage of SAM, MAM, and prevention across the provinces. We compared the 2021 Humanitarian Response Plan (HRP) health zone categorizations for food security and wasting and found that the severity of need did not always result in a comprehensive package of support. For example, in the 2021 HRP, Kasai Oriental is the only one of our four provinces to have two health zones categorized as having catastrophic levels of wasting. Only one of those health zones was receiving a full package of prevention, MAM, and SAM support. The other had no MAM support, despite having MAM rates of over 11 percent (OCHA 2020a; OCHA 2020b). A more transparent process on how these targets are set and clear communication about the necessary trade-offs, especially to health zone level officials, is needed to better understand how these decisions are made so that other nutrition actors, especially non-emergency actors, are aware of where and how they can provide complementary support.

### Data quality is poor all along the data collection chain

We examined wasting data from the DHIS-2 to understand health facility admissions trends and overall performance of UNTA and UNS services. We also reviewed data entered in the health facility UNTA and UNS registers, as DHIS-2 reporting is based on this information.

We found poor-quality anthropometric measurement when we observed UNTA client visits. The low quality of anthropometric data was further verified upon review of UNTA registers and client cards. In the UNTA register, we found that height and z-scores were often recorded incorrectly (e.g., 7,100 cm rather than 71 cm; z-scores for wasted children noted as 3 rather than -3). Entry and exit dates were noted in the registers but the corresponding anthropometric measurements were not included, so we could not confirm whether admissions and discharges were done correctly. Reasons for UNTA exits (e.g., cured, died, defaulted, nonresponse, referred) were

not recorded. Finally, client card records were missing from the summary register. These types of gaps in data are problematic, as this information is one of the ways health facilities and health management teams can check stock records against service use to prevent misuse of stock. On reviewing the UNS registers, we found they did not follow the register format per the DRC national IMAM protocol. Instead, WFP had provided health facilities with registers that followed WFP's format. As with the UNTA registers, information on client exits was inconsistently completed. Further, the WFP register does not include a space for weight-for-height calculations, so we could not tell if children were admitted based on correct anthropometric assessments.

Given the overall poor data quality in the registers, it is not surprising that it was impossible for us to infer anything about service quality using program performance data from the DHIS-2. A review of 2020 IMAM data showed extremely high cure rates, with other program exits (e.g., defaulted, died) almost always listed as zero. For example, one health facility in Cilundu reported a 100 percent cure rate for a monthly total of 229 cases, a rate of performance that seems extremely unlikely given the numerous contextual and operational constraints that we found across our focus health zones. In health facilities that did report deaths, rates often exceed the death rate performance standard of less than 10 percent (Sphere Association 2018).

These findings on data quality, while not directly related to coordination, are important because they have a direct influence on decision-making. The Nutrition Cluster and UNICEF use DHIS-2 data for reporting and, as noted above, these figures are one of the sources of HRP estimates, which in turn influence supply forecasting. These are also an opportunity for nutrition partners supporting these services to coordinate their capacity strengthening efforts to ensure that data quality improves.

## LESSONS LEARNED

Nutrition actors face many challenges to collecting, managing, integrating, sharing, and using nutrition data for decision-making. A fundamental problem is the use of different data collection tools and processes. The multiplicity of processes has produced different indicators for different purposes, which do not always align with the DHIS-2 or PRONANUT indicators of interest. When we consulted partners about this issue,

they expressed frustration. These disjointed systems exist all along the continuum of care, as we have highlighted throughout our findings and observations. SAM and MAM treatment services use different registers and reporting systems; national health and logistics information systems tend to focus only on SAM treatment, excluding MAM treatment and prevention elements; community-level screening and prevention activity data collection systems are not harmonized; and government, health facilities, and nutrition partners do not systematically exchange information.

### There is an ongoing need for improved data quality, analysis, use, and sharing

Although each health zone coordination and collaboration action plan identifies areas in which nutrition actors can improve efforts to align data collection activities and share their outputs, these actions have been undertaken with varying levels of success and many are still partner-driven. Nutrition actors identified joint planning, standardized templates, and activity evaluation coordination as possible ways to strengthen data and information sharing systems and processes. Progress on sharing and gathering community-level nutrition information has been made, with Cilundu, Miabi, and Kalehe all completing data-related activities with their *mamans lumières*, even when additional cost was required to do so. However, more centralized data management activities, such as training health management teams on nutrition data analysis, have not been completed. This is a critical gap, as health zones have noted that there is often misalignment when comparing supervision, nutrition partner, and DHIS-2 data.

Written commitments to support these activities, even if the activities are not always conducted on schedule, are an important first step to enable health zone management teams to follow up with and hold partners accountable for supporting the collection, alignment, and sharing of high-quality data. However, focused ongoing support to data management is required. PROSANI is supporting other health activities as part of its work to improve strategic information gathering and use. This technical capacity could be leveraged to improve strategic use of data for nutrition. This work, if undertaken for nutrition, should be conducted in close consultation with the Nutrition Cluster to facilitate the bridging and sharing of emergency and development intervention data with all partners. It is especially important to share data with the health zone management teams and encourage its use to improve planning and activity targeting.





A woman participates in the Nyalungana swamp reclamation activities, part of the Tuendelee Pamoja (Moving Forward Together) program. The follow-on from this project (Tuendelee Pamoja II) is one of USAID's DFSA programs that USAID Advancing Nutrition documented as part of this learning activity.

PHOTO CREDIT: TANYA MARTINEAU



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## **DISCUSSION AND RECOMMENDATIONS**

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## DISCUSSION AND RECOMMENDATIONS

Our findings, observations, and lessons illuminate the challenges to coordination and collaboration, which have serious consequences for malnutrition and mortality among children under five. Despite partners' and institutions' shared interest in saving lives, these coordination and collaboration deficits create an environment that undermines the continuum of care and puts children's lives at risk.

USAID's efforts to ensure a holistic continuum of care are in line with shifts in global thinking about wasting management and the Government of DRC's efforts to include integrated wasting prevention and treatment services in national nutrition strategies, policies, and protocols. Despite this favorable policy environment, we have found that many of the financing and programming mechanisms to support the continuum of care—especially the treatment component—continue to rely on short-term emergency funding.

This type of ongoing emergency-focused approach to wasting management in DRC is detrimental to overall health system strengthening efforts, as resources are provided and then withdrawn in accordance with short emergency funding cycles. As our documentation has shown, these short-term contracts are plagued by renewal delays, creating gaps in the availability of treatment services that can have repercussions across all aspects of the continuum of care. Many of the health zone nutrition coordination and collaboration action plans identified similar root causes not only to coordination and collaboration but also to service delivery in general. This reflects the fundamental challenges to supply chain reliability and resource availability to ensure continuity of nutrition programs, particularly during periods of contract renewals and project closures. These are important limiting factors for achieving integration, sustainability, and long-term coordinated action.

As we documented coordination and collaboration, it became difficult to talk about certain aspects of the wasting continuum of care without also discussing the implementation of broader nutrition services and multi-sectoral interventions. This led us to another important conclusion: we should be concerned not only with the lack of coordination and collaboration between actors supporting the wasting continuum of care; we should also seek to strengthen multi-sectoral coordination and collaboration for nutrition more broadly.

A holistic approach to the management of wasting must engage a range of treatment, prevention, emergency, and development actors, all of whom contribute to reductions in wasting prevalence but among whom the term wasting may not resonate equally. What may resonate more with these actors is talking about their role in a multi-sectoral approach to improving nutrition outcomes and their contributions to government multi-sectoral nutrition goals and objectives, which reinforces the approach being taken by the government and globally. Achieving these shared, multi-sectoral nutrition outcomes will strengthen the continuum of care for wasting, as so many nutrition programming elements overlap and share interdependencies. Additionally, focusing on wasting coordination and collaboration may reinforce the incorrect impression that wasting is a stand-alone, emergency activity, which can undermine efforts to strengthen its integration into the health system.

Nutrition actors expressed the desire to continue engagement on a wider and more inclusive range of nutrition activities beyond the coordination provided by the Nutrition Cluster. PRONANUT requested support to replicate the coordination and collaboration action planning activity in more health zones and provinces. We presented our planning approach and an initial summary of the outputs to the national Nutrition Cluster, which expressed interest in these participatory approaches. We hope that the recommendations below will help nutrition actors in DRC realize these ambitions and continue to strengthen coordination and collaboration with the goal of providing a high-quality, integrated continuum of care to reduce and ultimately prevent wasting. Furthermore, many of the findings, challenges, and opportunities are not unique to DRC and are likely familiar to those supporting the wasting continuum of care in other countries. We encourage these actors to consider these findings and recommendations in their own implementation contexts as well.

### RECOMMENDATIONS

We have grouped recommendations by those who we believe have the primary responsibility for their implementation. However, the challenges to coordination, collaboration, and wasting service provision will not be overcome through independent action but rather through purposefully coordinated, synergistic, and cooperative efforts.

## RECOMMENDATIONS FOR GOVERNMENT

Government ownership and leadership are essential for the activities along the wasting continuum of care to be scaled, integrated, and sustainable. While external support is required as long as government resourcing gaps remain, government officials retain an important role in directing and coordinating partner support to meet prioritized needs, reduce duplication of efforts, and capitalize on potential efficiencies.

### Integrate nutrition coordination and collaboration activities into provincial and health zone annual plans

The first attempt to develop nutrition coordination and collaboration action plans in late 2020 did not align with the health zone annual planning cycle for fiscal year 2021. We acknowledge this as a weakness in our initial implementation that should be adjusted in future iterations of the coordination and collaboration planning process. Ideally, nutrition coordination and collaboration actions should be identified ahead of health zone and province annual planning cycles so that they can be incorporated and budgeted as part of annual plans.

We recommend that government officials continue to embrace and scale up the nutrition coordination and collaboration action planning process in line with government-mandated multi-sectoral nutrition action planning efforts. To the extent possible, government contributions—either in kind or financial—to implement the actions will be important to ensure sustainability and reduce the uncertainty that comes with reliance on nutrition partner support. We specifically recommend that the DPS prioritize the allocation and timely release of resources to PRONANUT to support these efforts, as good nutrition is central to so many other important health outcomes. Government entities should also consider innovative financing options to support coordination and collaboration for nutrition.

### More clearly define the role of multi-sectoral nutrition committees and invest in strengthening their capacity

The *National Multi-sectoral Nutrition Strategic Plan*, which expired in 2020, mandated the creation of province- and territory-level multi-sectoral nutrition committees but did not define their roles and responsibilities well. The accompanying operational plan did not clarify roles and responsibilities for these entities either. We recognize these committees' potentially critical role in convening multi-sectoral nutrition actors engaged in both emergency and development activities. Without this shared space for dialogue, discussion, and coordi-

ination, progress toward the delivery of a holistic continuum of care for wasting will be impeded.

We recommend clearly articulating the roles and responsibilities of these committees vis-à-vis other existing nutrition coordination platforms, such as the Nutrition Cluster, in the forthcoming *National Multi-Sectoral Nutrition Strategic Plan 2022–2026*. We also recommend that adequate human and financial resources be allocated to establishing and strengthening these committees at provincial and territorial levels.

## RECOMMENDATIONS FOR NGO NUTRITION PARTNERS

Many aspects of the wasting continuum of care depend on partner support yet are hindered by a lack of coordination between partners and government, and sometimes even within single projects or organizations. Nutrition partners—both local and international NGOs—must consider the potential consequences of operating in silos, and instead work to reap greater benefits by taking additional steps to ensure their activities are harmonized with other actors and truly align with government priorities and community needs.

### Ensure coordination and collaboration are integrated into project work plans and activities

The recommendations for government actors cannot be fully realized—at least in the short term—without support from nutrition partners. We recommend that nutrition actors engage with the government in a meaningful and transparent manner to discuss where and how support needs can be integrated into project work plans. Too often, nutrition partners complete their work plans without consulting government authorities or other partners, meaning that opportunities to cross-leverage partner capacities or strategic advantage to improve nutrition programming may be missed.

We documented instances in which emergency and development partners integrated nutrition coordination and collaboration actions into their work plans. For emergency-funded partners, this type of adaptation should be encouraged by the Nutrition Cluster and facilitated by UNICEF and WFP when issuing new awards. The annual duration of these action plans will also likely overlap with development partner annual work-planning cycles at some point throughout the year, providing an opportunity for more purposeful integration of coordination and collaboration support into their next work plans as

well. The longer duration of development projects avails the opportunity for longer-term systems strengthening approaches to support institutionalization of coordination and collaboration actions, and multi-year planning should be encouraged whenever possible.

Projects and implementing partners also need to support government entities, such as DPS and PRONANUT, in their convening roles. When providing capacity strengthening, logistical, and financial support, government partners should lead by calling meetings, developing and approving activities and action plans, and following up with agreed-upon next steps. PRONANUT and DPS, however, need support to delineate their specific convening and coordination roles and responsibilities as laid out in national-level health systems policies. This will also help existing and new partners know which government entities to engage and inform about their nutrition-focused activities. While the DPS and in some cases the provincial governors are the main oversight authorities for planning and budgeting activities, PRONANUT as the nutrition technical arm of the DPS should be prioritized for support, information sharing, and consultation. However, nutrition partners will need to obtain buy-in and support from key DPS officials and the provincial governors to ensure the smooth rollout of activities.

#### **Strengthen multi-sectoral nutrition committees to convene nutrition actors working along the wasting continuum of care**

If the multi-sectoral nutrition committees were strengthened, they would be an appropriate mechanism through which to convene the diverse group of actors supporting the wasting continuum of care. The Nutrition Cluster could share its emergency-focused information and plans, and representatives engaged in other sectoral coordination mechanisms could share similar updates to strengthen prevention programming. Participation in regular meetings through these committees, coupled with ad hoc engagement with other coordination bodies when there is an identified need around specific activities, would promote information sharing without nutrition actors becoming overloaded with meetings. Despite the clear advantages these multi-sectoral committees offer, however, few resources have been dedicated to their setup or capacity strengthening.

The provincial-level multi-sectoral nutrition committees are required to produce multi-year multi-sectoral strategic plans. These have been finalized in five provinces to date (Kasaï Oriental, Ituri, Nord Kivu, Bas Uel , Tanganyika). As more

of these plans are finalized, areas that require capacity and systems strengthening support should be identified.

Our experience highlights the need for dedicated resources to facilitate coordination and collaboration so that these become routine ways of working at the province and health zone levels. Partners supporting this work should integrate transition planning for the financial support of multi-sectoral nutrition committee activities, such as routine meetings and supervision visits, into their work plans, clearly communicate them, and seek agreement from government actors from the outset. Ideally, financing to support multi-sectoral nutrition coordination would be included and financed through the annual province- and health zone-level action plans.

#### **RECOMMENDATIONS FOR UN AGENCIES AND THE NUTRITION CLUSTER**

United Nations agencies like UNICEF and WFP are crucial in the fight against wasting. In complex settings such as DRC, which include areas experiencing protracted ongoing crises and acute emergencies, the Nutrition Cluster also has an important role in coordinating nutrition actors that respond to the resulting needs. Given the important role of UNICEF, WFP, and the Nutrition Cluster—particularly regarding wasting treatment—we recommend ways to strengthen coordination and collaboration between UN agencies and with non-emergency actors.

#### **Contract the same implementing partner to support all aspects of wasting treatment services and align award duration and cycles**

The treatment aspect of the continuum of care is fractured, increasing the possibility that children will not receive lifesaving treatment due to poor operational and administrative coordination between UNICEF and WFP. As they recover, children should be able to seamlessly transition between outpatient services for SAM and supplementary feeding programs for MAM. This is challenging, however, when different implementing partners are contracted to support SAM and MAM services in the same health zone, especially when funding and contracting cycles are misaligned. Although co-location of services provided by different nutrition partners is better than not having services available at all, weak coordination leads to inadequate referral systems that put children at risk as they transition between services. Rather than continuing to prioritize co-location of UNICEF- and WFP-supported programming



elements, which is still not optimal due to funding and targeting constraints, UNICEF and WFP should consider adopting more coordinated approaches, as used by the agencies in other countries. The most important first step is to work toward contracting the same partner to support both SAM and MAM services within a given health zone. UNICEF and WFP should also invest in strengthening the capacity of their local partners to ensure they can efficiently and effectively deliver holistic SAM and MAM treatment.

In addition, UNICEF and WFP should work to harmonize their award durations and cycles with the ultimate aim of giving longer-duration awards to local partners. In a 2020 evaluation, WFP acknowledged the importance of its partners and flagged the need for more strategic long-term engagement with them to improve programming continuity. WFP has also suggested organizing internal planning sessions with partners to agree on activity and payment schedules and provide partners more support with expense and financial reporting (WFP 2020). Despite these recommendations, when new awards were issued in January 2021, they were standardized to a duration of only six months, with the option for a six-month extension. UNICEF awards also tend to be for a six-month period.

#### Add guidance on coordinating and collaborating with non-emergency actors to the Nutrition Cluster Guidelines for DRC

The Inter-Agency Standing Committee, which oversees humanitarian cluster activation, advises that cluster activation be based on an assessment of needs and time-limited (IASC 2015). Yet in DRC the Nutrition Cluster has been activated since 2006. The complexity of emergency response has changed dramatically in the past 10 years with the emergence of many more protracted crises layered with acute emergencies. It is important to determine if the current operating standards for cluster members align with operational realities.

The DRC Nutrition Cluster Guidelines were last updated in 2016. Because much has changed in terms of wasting treatment best practices and the implementation context, an update may be appropriate. While these guidelines already include information on multi-sectoral nutrition interventions, we suggest the inclusion of more information about how emergency actors can coordinate efforts with development actors. Many development actors screen and refer children to health facilities for wasting treatment. However, information sharing on these activities with treatment partners, who are

often also Nutrition Cluster members, is virtually nonexistent. Likewise, Nutrition Cluster members do not actively inform co-located actors about disruptions to treatment services, nor do they work collaboratively to find appropriate, temporary solutions for communities in these circumstances. As we have noted many times in our findings, this situation is not only dangerous for the wasted children in need of treatment but also has detrimental effects on community trust in partners and services. The level of influence that the Nutrition Cluster has over treatment gives it a unique responsibility to take steps to close these coordination gaps.

### RECOMMENDATIONS FOR DONORS

Although our learning efforts have focused on USAID-funded work, all donors have an important role in ensuring that their projects and partners coordinate and collaborate. We have seen that co-location of projects does not always lead to effective coordination, collaboration, or even basic communication. Donors' technical guidance on and sometimes even facilitation of engagement among these entities may be required. However, the extent to which donors can hold their partners accountable for coordination and collaboration actions varies greatly based on the funding mechanism and the type of organization funded. In bilateral development awards, the donor is in a stronger position to influence the level to which its partners coordinate with each other, the government, and coordination structures. For emergency awards, which benefit from reduced reporting requirements under the Grand Bargain (see box 6), the Nutrition Cluster may hold more sway over how these partners interact with other nutrition actors, as these accountability structures are stronger than what donors can impose. We present recommendations for emergency and development awards separately to help identify appropriate strategies for these different systems. We also highlight cross-cutting recommendations for donors to consider regardless of project type and funding modality.

#### Use the GAP DRC Country Operational Roadmap to guide coordination of wasting-related programming

The GAP Country Operational Roadmap for DRC was finalized recently. This document represents the prioritization of the government's and nutrition partners' actions to address the basic, underlying, and root causes of wasting by strengthening health, WASH, social protection, and food systems. This plan, though not comprehensive of issues we highlight here, will facilitate coordination of donor programming priorities for

## Box 6. Grand Bargain Implications on Reporting and Accountability

The Grand Bargain is an agreement between donors and humanitarian organizations that aims to improve the effectiveness and efficiency of the humanitarian action while also increasing accountability to people in need.

It was launched in 2016 at the World Humanitarian Summit in Istanbul; signatories have expanded to include 25 member states, 22 NGOs, 12 UN agencies, 2 Red Cross movements, and 2 intergovernmental organizations. These signatories represent around 84 percent of all donor humanitarian contributions donated in 2019 (OCHA n.d.).

One of the commitments under the Grand Bargain is to harmonize and simplify reporting requirements in order to ease the burden on humanitarian organizations and ensure that more resources can be spent on assisting people in need. While the Grand Bargain commitment reduces the reporting burden on emergency implementing partners to enable them to respond rapidly in emergencies, it also reduces their accountability to donors, particularly in cases where performance is poor. After five years of implementation, some are taking a more critical view of the success of these commitments. Meaningful accountability to affected populations remains poor but is now coupled with limited donor ability to hold humanitarian actors—including UN agencies—to account for results (Van Pragg and Sattler 2021).

wasting and nutrition more broadly. The Inter Donor Health Group (Groupe Inter Bailleurs de la Santé [GIBS]) is another platform that health and nutrition donors can leverage to better coordinate nutrition programming and financing. Donors should be mindful, however, that non-nutrition and non-health actors must be consulted to ensure support for a holistic prevention package.

### Encourage, and when possible require, partner participation in and support for multi-sectoral nutrition coordination committees

Just as we recommend that government actors prioritize the continued scale-up of multi-sectoral nutrition committees and ask nutrition partners to integrate capacity strengthening and leadership support activities into their work plans, we recommend that donors value and prioritize strengthening these committees as well. Dedicated funding, time, and resources are required to overcome the challenges facing their establishment and operationalization. Although it is possible to see short-term improvement through ad hoc support, support will be more effective when strengthening these committees is done through long-term, joint efforts acknowledging that progress may be incremental. Donors should encourage partners implementing multi-sectoral nutrition activities to include capacity strengthening and support to the committees in their work plans and to participate in them. A dedicated project or project work stream may be required to catalyze these efforts. While

opportunities to provide support through emergency mechanisms will likely remain more ad hoc and somewhat limited, donors and multilateral agencies like UNICEF and WFP should, at minimum, plan support in close consultation with development partners to ensure their efforts are complementary, layered, and sequenced.

### Identify opportunities for humanitarian-development nexus programming and financing in DRC

Enhancing engagement between humanitarian and development actors is a crosscutting commitment that is part of the Grand Bargain. While there is much rhetoric from both humanitarian and development actors about the willingness to work together, the ways to do so are less clear. Perhaps even less so is how to implement programs that span the humanitarian and development divide. There are promising approaches for nutrition in this nexus, including the example of PUNC in DRC and CMAM Surge in other countries, as well as that of resilience programming efforts. Donors that fund emergency and development programs need to continue to collaborate to identify appropriate funding mechanisms and create innovative funding opportunities for these types of programs. Although programs like PUNC and CMAM Surge seek to strengthen emergency response capacities within existing systems, they are system strengthening approaches that require multi-year financing. Donors should work with each other, their implementing partners, and the government to strengthen and increase these

types of nexus programming opportunities in DRC, especially given that many operating areas fit this type of context.

The USAID Mission in DRC emphasizes humanitarian-development nexus contexts as a priority for integrated programming in its current *Country Development Cooperation Strategy (CDCS) 2020–2025*. However, there is little mention of the need for partners to coordinate and collaborate on integrating this purposefully into the Mission’s programming. This is an opportunity for strengthening in the next iteration of the CDCS.

#### Recommendations for Emergency Programs

Given their need for administrative flexibility to ensure rapid responses to urgent needs, emergency programs tend to have much lighter reporting requirements than longer-term development programs due to commitments made in as part of the Grand Bargain. Nevertheless, these actors should all strive to adhere to the principles of accountability outlined in the Core Humanitarian Standards and the Sphere Handbook. Emergency

actors working in protracted crises need to think about how to work alongside development actors and local authorities and through existing systems (Sphere 2018). In a changing emergency operating environment, some donors are beginning to adopt longer-term emergency funding formulas.

#### Consider multi-year funding horizons for emergency programs

None of the emergency projects we examined as part of this work exceeded one year; most were six-month awards. As we have highlighted, this continuous, short-term project cycle leads to numerous problems, especially when planning for new contracts tends to create rather than prevent gaps in service delivery. Administrative burdens are higher for both the donor and the local partners, planning alongside government and development partners is made more complex, and children risk not receiving important treatment services. These short, intermittent periods of funding are inappropriate for supporting integrated services and are detrimental to efforts to strengthen service quality and the health system as a whole.

### Box 7. Promising Practice from Niger and Burkina Faso: Dedicated Coordination and Collaboration Support for USAID Partners

USAID’s Resilience in the Sahel Enhanced II (RISE II) program seeks to build the resilience of vulnerable populations in Burkina Faso and Niger, including improving health, family planning, and nutritional outcomes. This multi-sectoral program is made up of multiple projects implemented by different partners. Learning from the previous RISE program highlighted a need for systematic coordination to ensure effective sequencing and layering of activities between implementing partners working to achieve a common higher goal (USAID 2018). For this reason, RISE II includes the Sahel Collaboration and Communication (SCC) Activity. SCC’s purpose is to promote collaboration, learning, and adapting (CLA) for collective impact among USAID, implementing partners, and national government and research institutions, and to build local capacity for learning and adaptation.

SCC coordinates thematic technical workings groups on various cross-cutting topics (e.g., IYCF) to help ensure coordination across partners and interventions in support of achieving the outcomes outlined in the RISE II results framework. SCC collates project information to make it accessible for all RISE II partners, and shares learning through mechanisms including a newsletter that highlights major program activities and achievements. SCC also conducts trainings and other capacity strengthening exercises to enhance CLA. Although Niger and Burkina Faso also have national-level multi-sectoral nutrition coordination mechanisms, having a dedicated entity like SCC, whose purpose is to strengthen coordination capacities and pathways, adds value to the coordination landscape—particularly for USAID’s implementing partners.

Our work in DRC has found a gap in leadership for coordination and collaboration in nutrition and identified several areas for capacity strengthening, which a project such as SCC could be well placed to fill.

USAID/BHA is piloting several multi-year international emergency food assistance awards in alignment with Grand Bargain commitments to increase multi-year emergency planning and funding. A 2020 baseline report on progress and trends toward these commitments found that multi-year funding increased by 75 percent between 2016 and 2018. However, much of this funding was earmarked and channeled to international organizations (Development Initiatives 2020). We recommend that donors explore more of these multi-year funding opportunities, including for local organizations, for use in DRC.

### Recommendations for Development Programs

There are many opportunities for donors to integrate coordination and collaboration into their multi-year development programs. Because these programs often come with contractual agreements that allow substantial involvement and oversight, and more rigorous reporting, monitoring, and evaluation requirements, donors have an opportunity not only to suggest that coordination and collaboration be central to programs but also to hold them more accountable for these actions. In addition to the recommendations below, box 7 presents a promising practice to strengthen coordination of USAID multi-sectoral projects in Niger and Burkina Faso.

### Plan for and integrate coordination and collaboration into every stage of the project cycle

The most effective way for donors to ensure that implementing partners engage in meaningful coordination and collaboration is to integrate them into every stage of the project cycle. Ideally, they are embedded within the project design and results frameworks. Planning for coordination and collaboration from the design phase and holding partners accountable through routine monitoring and project evaluations will help systematize these aspects within and across projects. Donors should consider the following entry points to strengthen coordination and collaboration:

- **Consult internally and with other donors when designing co-located projects.** Donors and their various bureaus, departments, and offices should continue and strengthen efforts to ensure that activities are properly sequenced and layered both within and across projects. They should also be transparent about and coordinated in

defining objectives and expectations. Where appropriate, donors should consider collaborative program design, with clear linkages to complementary activities and shared outcomes. Additionally, they should share information about existing investments in the request for applications so that partners are aware of ongoing activities and more readily able to propose complementary rather than duplicative approaches. Finally, applications could also be scored based on coordination and collaboration criteria, if this is viewed as critical to achieving the program's objectives—especially for cross-cutting areas like nutrition and wasting.

- **Promote common objectives and results frameworks for key activity areas.** Donors could integrate these common requirements into the request for applications, or these could be included during a collaborative workshop with implementing partners after projects have been awarded.
- **Encourage co-located development projects and partners to consult with each other during workplanning.** When complementary projects share an implementation area, donors should encourage, to the extent possible, their partners to consult during their respective workplanning processes. Because development projects tend to be constrained by what is within their annual work plans and corresponding budgets, careful consultation during the workplanning stage will help minimize duplication of efforts and maximize coordinated gap filling and complementarity between project efforts. Ideally, the consultation process would also extend to any emergency-funded entities, including the Nutrition Cluster.
- **Continue to make coordination and collaboration a core component of project evaluations.** The USAID midterm evaluations of the DFSAs and Feed the Future value chains project included specific evaluation questions on coordination and collaboration that prompted meaningful changes in project approaches. Including these questions also led to the generation of valuable learning and recommendations that USAID could share with and apply to current and future projects. We encourage USAID to maintain this evaluation element in future midterm reviews and encourage other donors to adopt this content as well.

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<sup>6</sup> Under the former Office of Food for Peace, three such multi-year emergency food assistance awards were provided to Ethiopia, South Sudan, and Nepal, due to the protracted nature of the crises in these countries and the intends to meet some of the commitments of the Grand Bargain funders.



**Strengthen follow-up, reporting, and data sharing requirements for development projects that conduct community-level screening**

Many development projects have integrated screening for wasting into their community-level activities. Small changes to reporting requirements for these programs could prompt a shift in ways of working that could strengthen the community and health facility linkages needed to ensure a holistic continuum of care for wasting.

As an example, all DFSAs report on the number of referrals made; however, they do not provide information about whether those referrals were followed up, treatment was sought, or those children were enrolled in services. At a minimum, donors should consider requiring or encouraging projects doing screening to report the number of children seeking services or enrolled at the health facility following a referral. Reporting on referral completion would not only prompt development partners to engage directly with health facilities on wasting treatment, but would also create a valuable

information-sharing opportunity with health facility staff. To strengthen reporting mechanisms further, donors should consult with the government and the Nutrition Cluster to identify a common set of wasting-related indicators for partners to report on.

Reporting requirements that necessitate open communication channels with health facilities will not only ensure that projects prioritize these actions, but also lead to a better two-way information flow between projects and the government. Improved communication with health facilities would also provide the opportunity to confirm current IMAM service status, enabling development partners to adjust their referral strategies and potentially repair community confidence in their guidance. This frequent contact with health facilities could also improve overall communication, relationships, and linkages among health facility staff, government officials, and the projects. Much of this information gathering could be integrated into routine supervision visits to the health zones or through phone calls to health facility in-charges or health zone officials.

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## WAY FORWARD

The operating environment and nutritional needs in DRC are complex and will likely remain so for some time. Much of what we recommend will not happen quickly and may require systemic change at levels beyond what is achievable in DRC alone. Our work, however, seeks to underscore the dire consequences for children and families if things do not change.

Coordination and collaboration must improve at multiple levels—between emergency and development actors, between NGOs and government, between sectors—to have any hope of turning back wasting in DRC. We urge nutrition actors in to DRC take these observations, lessons learned, and recommendations into consideration as they continue their work.



PHOTO CREDIT: KATE HOLT/MCSP

Women and children like the ones depicted here at a rural health clinic in DRC stand to benefit tremendously from better nutrition coordination and collaboration between emergency and development actors, between NGOs and government, and among sectors.

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## REFERENCES

- Aburmishan, D., V. Tyler, L. Alamprese, P.B. Nicholas, M.D. Raphael, J. Senesie, A.O. Lawi et al. 2019. "Scaling-up of Care for Children with Acute Malnutrition during Emergency Nutrition Response in South Sudan between 2014 and 2018." *Field Exchange* 60: 73. Accessed August 25, 2022. [www.ennonline.net/fex/60/scalingupofcare](http://www.ennonline.net/fex/60/scalingupofcare)
- ACF (Action Contre la Faim). 2017. *République Démocratique du Congo Modèle du Pool D'urgence Nutritionnelle* (PUNC). New York: ACF.
- Catholic Relief Services (CRS). 2020. *Budikadidi Quarterly Report: Q2 FY20*. Baltimore: CRS.
- Cazes, C., K. Phelan, V. Hubert, H. Boubacar, L.I. Bozama, and G.T. Sakubu. 2022. "Simplifying and Optimising the Management of Uncomplicated Acute Malnutrition in Children Aged 6–59 Months in the Democratic Republic of the Congo (OptiMA-DRC): A Non-inferiority, Randomised Controlled Trial." *Lancet Global Health* 10(4): e510–20. [https://doi.org/10.1016/S2214-109X\(22\)00041-9](https://doi.org/10.1016/S2214-109X(22)00041-9)
- Development Initiatives. 2020. *Multi-Year Humanitarian Funding: Global Baselines and Trends*. Bristol, UK: Development Initiatives.
- DRC Nutrition Cluster. 2022. "20220128 4W Collecte JAN-FEV." Unpublished internal document. Accessed February 10, 2022.
- Emergency Nutrition Network. 2020. *Simplified Approaches to the Treatment of Wasting: Technical Brief*. Kidlington, UK: ENN. [https://www.ennonline.net/attachments/3621/Tech-Brief-31Aug2020\\_Simplified-approach.pdf](https://www.ennonline.net/attachments/3621/Tech-Brief-31Aug2020_Simplified-approach.pdf)
- FH (Food for the Hungry). 2020. *FY 20 Second Quarter Report for Tuendele Pamoja II DFSA in DRC*. Phoenix, AZ: Food for the Hungry.
- GAP (Global Action Plan for Child Wasting). 2021. *DRC Country Roadmap*. New York: United Nations. <https://www.childwasting.org/the-gap-framework>.
- GNC-TA (Global Nutrition Cluster Technical Alliance). 2022. "Webinar: Lessons Learned from Piloting Different Simplified Approaches (for Managing Malnutrition) in DRC." Accessed August 25, 2022. <https://www.nutritioncluster.net/resources/webinaire-lecons-apprises-du-pilotage-de-differentes-approches-simplifiees-pour-traiter>
- Golden, K., and S. Whitney. 2021. "CMAM Surge: The Way Forward." *Field Exchange* 64: 47. Accessed August 25, 2022. [www.ennonline.net/fex/64/cmamsurgewayforward](http://www.ennonline.net/fex/64/cmamsurgewayforward)
- Hailey, P., and D. Teweldeberhan. 2010. "Suggested New Design Framework for CMAM Programming." *Field Exchange* 39: 41. Accessed August 25, 2022. [www.ennonline.net/fex/39/suggested](http://www.ennonline.net/fex/39/suggested)
- IASC (Inter-Agency Standing Committee). 2015. *Reference Module for Cluster Coordination at Country-Level*. Accessed August 25, 2022. <https://interagencystandingcommittee.org/iasc-transformative-agenda/iasc-reference-module-cluster-coordination-country-level-revised-july-2015>
- IMPEL (Implementer-Led Evaluation & Learning Associate Award). 2020a. *Mid-Term Evaluation of the Budikadidi Development Food Security Activity in the Democratic Republic of the Congo (DRC)*. Washington, DC: Implementer-Led Evaluation & Learning Associate Award.
- IMPEL (Implementer-Led Evaluation & Learning Associate Award). 2020b. *Mid-Term Evaluation of the South Kivu Food Security Project (FSP)—Enyanya Development Food Security Activity in the Democratic Republic of the Congo (DRC)*. Washington, DC: Implementer-Led Evaluation & Learning Associate Award.



- IMPEL (Implementer-Led Evaluation & Learning Associate Award). 2020c. *Mid-Term Evaluation of the Tuendelele Pamoja II Development Food Security Activity in the Democratic Republic of Congo (DRC)*. Washington, DC: Implementer-Led Evaluation & Learning Associate Award.
- IPC (Integrated Food Security Phase Classification). 2016. *Democratic Republic of Congo (DRC): Chronic Food Insecurity Situation 2016–2020*. Accessed March 8, 2022. <https://www.ipcinfo.org/ipc-country-analysis/details-map/fi/c/1037095/?iso3=COD>.
- McCloskey, E., A. Yourchuck, and P. Hailey. 2021. “CMAM Surge: Lessons Learned on the Journey So Far.” *Field Exchange* 64: 41. Accessed August 25, 2022. [www.enonline.net/fex/64/cmamsurgelessonslearned](http://www.enonline.net/fex/64/cmamsurgelessonslearned)
- McGrath, M., and J. Shoham. 2019. “Editorial Perspective on the Continuum of Care for Children with Acute Malnutrition.” *Field Exchange* 60: 2. Accessed August 25, 2022. [www.enonline.net/fex/60/extendededitorial](http://www.enonline.net/fex/60/extendededitorial)
- McMillan, D. E., J. L. Seale, Jr., D. Bahati Shamamba, D.M. Salama, P.K. Mupenda, and C. Coffman. 2020. *Mid-Term Performance Evaluation of the Strengthening Value Chain (SVC) Activity in the Democratic Republic of the Congo*. Bethesda, MD: Program Evaluation for Effectiveness and Learning (PEEL) for USAID/DRC.
- MSH (Management Sciences for Health). 2014. *DRC LMIS Assessment (Draft)*. Submitted to USAID by the SIAPS, SCMS, IHP, and USAID | DELIVER PROJECT programs. Arlington, VA: MSH.
- MSP (Ministère de la Santé Publique). 2020. *Liste Nationale des Médicaments Essentiels Edition 2020*. Kinshasa: Secretariat Général.
- MSP (Ministère de la Santé Publique). 2016. *Manuel des procédures d’organisation et de fonctionnement des structures de participation et approches communautaires*. Kinshasa: Secretariat Général.
- MQSUN+ (Maximising the Quality of Scaling Up Nutrition Plus). 2020. *Final Report for Real Time Learning Review on Nutrition Response in the Democratic Republic of the Congo*. Washington, DC: PATH
- Ngwenyi, E., M. Jenkins, N. Joannic, and C. Patricia. 2019. “Addressing Acute Malnutrition in Cameroon during an Emergency: Results and Benefits of an Integrated Prevention Programme.” *Field Exchange* 60: 96. Accessed August 25, 2022. [www.enonline.net/fex/60/acutemalnutritioncameroon](http://www.enonline.net/fex/60/acutemalnutritioncameroon)
- Ntambi, J., M. A. Abdirahman, D. Nabiwemba, et al. 2019. “Bottleneck Analysis for the Integrated Management of Acute Malnutrition Services in Somalia.” *Field Exchange* 60: 56. Accessed August 25, 2022. [www.enonline.net/fex/60/bottleneckanalysissomalia](http://www.enonline.net/fex/60/bottleneckanalysissomalia)
- OCHA (Office for the Coordination of Humanitarian Affairs). 2020a. *Aperçu des Besoins Humanitaires République Démocratique du Congo*. New York: United Nations/OCHA.
- OCHA (Office for the Coordination of Humanitarian Affairs). 2020b. *Chiffre Humanitarian Response Plan 2021*. New York: United Nations/OCHA.
- OCHA (Office for the Coordination of Humanitarian Affairs). 2021a. *Aperçu des besoins humanitaires République Démocratique du Congo: Cycle de programme humanitaire 2022*. New York: United Nations/OCHA. <https://reliefweb.int/report/democratic-republic-congo/r-publique-d-mocratique-du-congo-aper-u-des-besoins-humanitaires-3>
- OCHA (Office for the Coordination of Humanitarian Affairs). 2021b. *République Démocratique du Congo Plan de Réponse Humanitaire 2021*. OCHA Financial Tracking Service. New York: United Nations/OCHA. <https://fts.unocha.org/appeals/1026/flows?f%5B0%5D=destinationClusterIdName%3A5926%3ANutrition>
- OCHA (Office for the Coordination of Humanitarian Affairs). n.d. “About the Grand Bargain.” Accessed March 23, 2022. <https://interagencystandingcommittee.org/about-the-grand-bargain>.



- Phillips-White, N., E. Motomoke, F. Nkosi, F. Nkosi, J. Crawford, B.P. Magadzire, 2019. "Leading from All Levels: Building Supply Chain Leadership Capacity in Equateur Province, Democratic Republic of Congo." *BMJ Global Health* doi.org/10.1136/bmjgh-2019-001756
- Sphere Association. 2018. *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. 4th ed. Geneva: Sphere Association. [www.spherestandards.org/handbook](http://www.spherestandards.org/handbook)
- State of Acute Malnutrition. n.d. "Simplified Approaches across the Continuum of Care: An Introduction." Accessed March 14, 2022. <https://www.acutemalnutrition.org/en/Simplified-Approaches-Introduction>.
- Tamarack Institute. 2017. Tool: *The Collaboration Spectrum*. Waterloo, Ontario, Canada: Tamarack Institute.
- Thomas, D., E. Motomoke, J. Crawford, J. Crawford, O. Defawe, A. Makaya, J. Willy Ngwato et al. 2021. "Optimized Supply Chain Model Reduces Health System Costs in DRC." *Vaccine* 39(30): 4166–72. <https://doi.org/10.1016/j.vaccine.2021.05.083>.
- UNICEF (United Nations Children's Fund). 2019. *Plan de mise à l'échelle de la prise en charge de la malnutrition en République Démocratique du Congo*. Draft. New York: UNICEF.
- USAID (U.S. Agency for International Development). 2018. *Resilience in the Sahel Enhanced (RISE) II Technical Approach Working Paper*. Washington, DC: USAID. [https://www.usaid.gov/sites/default/files/documents/1860/RISE\\_II\\_Technical\\_Approach\\_Working\\_Paper\\_May\\_20181.pdf](https://www.usaid.gov/sites/default/files/documents/1860/RISE_II_Technical_Approach_Working_Paper_May_20181.pdf)
- USAID (U.S. Agency for International Development). 2021. "Democratic Republic of the Congo—Complex Emergency Fact Sheet #3, Fiscal Year (FY) 2021." Accessed August 25, 2022. <https://reliefweb.int/report/democratic-republic-congo/democratic-republic-congo-complex-emergency-fact-sheet-3-fiscal-8>
- Van Pragg, N., and M. Sattler. 2021. "Everyone's Doing Stuff but Nobody's Accountable—Will Grand Bargain 2.0 Set Us Right?" Accessed March 23, 2022. <https://odihpn.org/publication/everyones-doing-stuff-but-nobodys-accountable-will-grand-bargain-2-0-set-us-right/>.
- VillageReach. 2021. *Supply Chain Investment Coordination and Advocacy (SCICA) Présentation Générale. Presentation at the Review Meeting of the National Multi-sectoral Nutrition Strategic Plan*. Kinshasa: VillageReach.
- WFP (World Food Programme). 2020. *Evaluation of Democratic Republic of the Congo Interim Country Strategic Plan 2018–2020 Evaluation Report*. Vol. I. Rome: WFP Office of Evaluation.
- WHO (World Health Organization). 2020. *Global Action Plan on Child Wasting: Framework for Action to Accelerate Progress in Preventing and Managing Child Wasting and the Achievement of the Sustainable Development Goals*. Geneva: WHO.
- WHO (World Health Organization). 2022. "Democratic Republic of the Congo: WHO Coronavirus (COVID-19) Dashboard With Vaccination Data." Accessed June 30, 2022 <https://covid19.who.int/region/afro/country/cd>
- World Bank. 2021. "Population, total—Congo, Dem. Rep. | Data". Accessed August 27, 2021. <https://data.worldbank.org/indicator/SP.POP.TOTL?locations=CD>.
- Yourchuck, A., and K. Golden. 2021. "The 'CMAM Surge' Approach: Setting the Scene." *Field Exchange* 64: 19. Accessed August 25, 2022. [www.ennonline.net/fex/64/cmamsurgesettingscene](http://www.ennonline.net/fex/64/cmamsurgesettingscene)

## ANNEX I. LEARNING AGENDA AND LEARNING QUESTIONS

Learning Objectives	Learning Questions
<p>1 Document partners' experiences collaborating to deliver the SAM/MAM continuum of care</p>	<p>1. What lessons learned from other parts of the DRC or other countries may be applicable to improving coordination and collaboration on the delivery of the continuum of care at the provincial level, including lessons from other types of emergencies?</p> <p>2. What processes and practices do implementing partners in target health zones use to coordinate and collaborate along the continuum of care for acute malnutrition? What are the successes and challenges of those specific approaches, including in the new context of COVID-19?</p>
<p>2 Co-design and initiate actions to strengthen coordination and collaboration</p>	<p>3. Of the initiated actions, which are most effective in improving a targeted aspect of coordination and collaboration between co-located partners within the continuum of care for acute malnutrition in target health zones?</p> <p>4. What are the lessons learned about how to strengthen information sharing and learning across stakeholders and mechanisms to improve coordination and collaboration on the delivery of the continuum of care for acute malnutrition at the provincial level, including consideration of COVID-19 complicating factors?</p>
<p>3 Develop recommendations for how collaboration to deliver the continuum of care can be strengthened in the future</p>	<p>5. What are lessons learned and recommendations for USAID on how to support or facilitate a coordinated, layered, and purposeful co-location of partners working along the continuum of care at the health zone level?</p>





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## **USAID ADVANCING NUTRITION**

Implemented by:  
JSI Research & Training Institute, Inc.  
2733 Crystal Drive  
4th Floor  
Arlington, VA 22202

Phone: 703-528-7474  
Email: [info@advancingnutrition.org](mailto:info@advancingnutrition.org)  
Web: [advancingnutrition.org](http://advancingnutrition.org)

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