ACTION AGAINST HUNGER

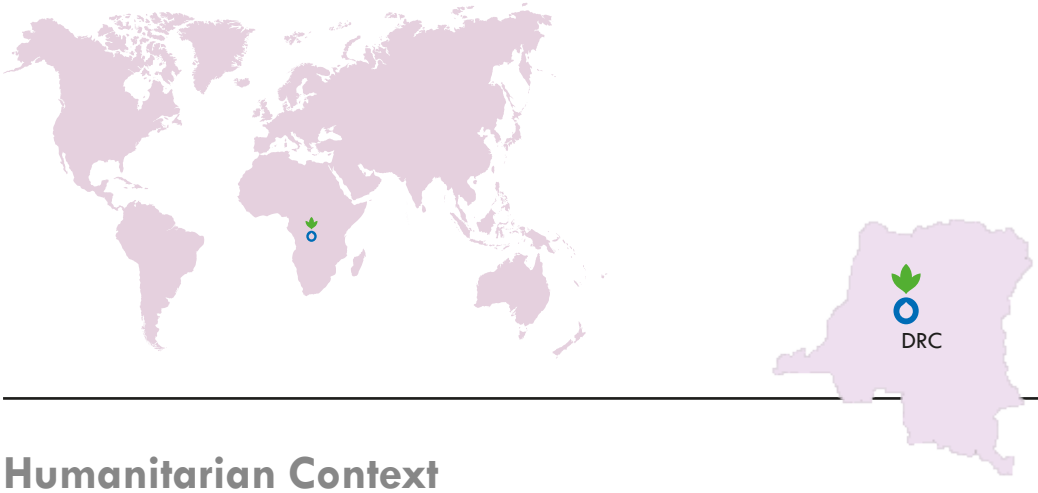
DEMOCRATIC REPUBLIC OF CONGO

NUTRITION EMERGENCY

POOL MODEL

The fight against malnutrition and hunger in the Democratic Republic of Congo (DRC) is a challenge that Action Against Hunger has worked to address for close to ten years. The Action Against Hunger's DRC nutrition emergency pool is the mission's flagship and longest-running program, thanks to UKAid, EU Humanitarian Aid and UNICEF. The pool works in close collaboration with the Ministry of Health (MoH) and its division, PRONANUT, to confirm nutrition crisis alerts through rapidly deployed SMART surveys and respond to confirmed crisis through emergency intervention teams. The pool's response capacity covers the entire country, over 2,345 million square miles and one of the continent's largest. The teams' emergency activities are integrated within MoH structures, contributing to streamline integrated management of acute malnutrition (IMAM) policy and reinforce the health system's capacity for nutrition crisis response.

The Action Against Hunger's DRC nutrition emergency pool has evolved over the years, and some key findings and lessons learned are presented in the following case study.



Humanitarian Context

Background

One out of ten children dies before the age of five years old in the Democratic Republic of Congo (DRC), representing one of the highest rates in the world[1], and estimates suggest that almost half of these deaths are due to malnutrition.[2]

Over 3.6 million children under five are affected by acute malnutrition annually in the country, of which 2 million suffer from its most severe form (Severe Acute Malnutrition or SAM).[3]

In 2014 and 2015, humanitarian partners' surveys consistently show global acute malnutrition (GAM) rates above alert (10%) and emergency (15%) thresholds in health zones across the country, with many districts falling into cyclical patterns of crisis.[4]

The three immediate causes of high malnutrition rates in DRC include household food insecurity, poor maternal and child health (complicated by inadequate child care and feeding practices), and a lack of access to safe water and sanitation.

An estimated 50% of undernutrition cases in the DRC are linked to diarrhea, microbial infections, and/or waterborne pathogens caused by poor water quality, poor sanitation or insufficient hygiene.[5]

Chronically understaffed and often poorly trained, health authorities face significant challenges in responding to this systemic emergency. Only 15% of the country's alarming SAM caseload had access to adequate therapeutic treatment in a health facility in 2014[6], and national SAM treatment coverage remains extremely low.

Limited financial and material resources as well as serious logistics challenges related to supply and access compromise the government's ability to implement its integrated management of acute malnutrition (IMAM) protocol.

The recurrence of nutritional crises in the DRC is fundamentally linked to chronic structural poverty[7], exacerbated by repeated epidemics or cycles of violent conflict, resulting in a chronic emergency context.

Considering the emergency GAM thresholds in a country-wide crisis, the complex contextual factors impacting both prevention and treatment, as well as the protracted nature of the humanitarian emergency; the DRC government, humanitarian partners, and donors have developed a unique and evolving model for nutrition surveillance and emergency intervention in which Action Against Hunger plays a historical and driving role.

Program Overview and Implementation

Action Against Hunger's DRC nutrition emergency pool began in 2008, the same year that the country's first IMAM national protocol was rolled-out by the Ministry of Health (MoH) and PRONANUT, a specific division within MoH responsible for nutrition. Over time, Action Against Hunger's nutrition emergency pool was financed in several phases[8] including both annual and multi-year funding arrangements, and has seen a significant evolution in its approach.

The global objective of Action Against Hunger's nutrition emergency pool is to contribute to the prevention of morbidity and mortality linked to malnutrition in the DRC through identification and emergency response to nutrition crises. This includes strengthening both national and community level surveillance systems as well as integrated interventions; streamlining the process from alerts to SAM admissions' intake in close coordination with the government and other partners.

With a team of over fifty rapidly deployable staff, the pool is one of the largest and most reactive of its kind in-country[9], including some of the most remote and hard to reach communities in crisis.

Nutrition Emergency Pool

Action Against Hunger's emergency nutrition pool includes stand-by teams of rapidly deployable cells of SMART survey and intervention units. Based on alerts from the National Surveillance System (SNSAP), the Integrated Food Security Phase Classification (IPC), clusters and other humanitarian partners, Action Against Hunger deploys a team to determine malnutrition rates in the health zone at risk through a SMART survey.

This task is shared with other survey actors in the country, mainly PRONANUT or COOPI, and coordinated at the national-level through the Coordination Committee (CC). If crisis threshold[10] is confirmed and findings are validated by the CC, the decision is made for intervention.

Once the decision is made, Action Against Hunger immediately mobilizes one of its units to launch a response. On average, the pool deploys 8-10 SMARTs and 6-9 interventions per year.

Activities include training of local health authorities and community health volunteers (CHV), in-kind support to health facilities for quality treatment of SAM at health centers and hospital-level.

These activities are complemented by a community-level nutritional surveillance through Community Health Volunteers (CHVs) and "Mother-MUAC"[11], sensitization campaigns and support groups.

Close Cooperation with Government and Partners

A key aspect of the model is Action Against Hunger's close involvement with government. Surveys and interventions are coordinated and conducted in total integration within the MoH. Action Against Hunger promotes active PRONANUT involvement in supervision and support to nutrition activities by systematically organizing joint supervision visits of all Action Against Hunger's DRC Emergency Pool interventions for PRONANUT authorities, at both provincial and national levels.

Action Against Hunger has consistently supported the government in refining the IMAM and survey protocol over the years, and ensuring mass dissemination via training and materials' support to local health authorities across the country.

Action Against Hunger has also actively contributed to the development and revisions of the national nutrition survey protocol, as well as our technical feedback to other partners in CC validation meetings.

Finally, Action Against Hunger plays an important role in Nutrition and WASH clusters, as leads of the Wash in Nutrition (WiN) technical working group, and has streamlined WiN into PRONANUT IMAM training modules at all levels.

Program Results

Program Outcomes

To date, the Action Against Hunger's DRC Nutrition Emergency pool has conducted 39 surveys, 41 interventions, supported 309 health structures, and admitted 55,722 SAM cases for treatment in 41 health zones stretched across the country. 3,653 community health workers, 1,774 local health staff, and 397 government health zone management officials have been trained on IMAM protocol, including key messages in Infant and Young Child Feeding and WiN adapted per level. In addition, over 2000 MUAC moms were trained in household-level surveillance.[12]

Recommendations

Some key recommendations emerging from the model are summarized below.

• One of the key strengths of the model is investment in Action Against Hunger staff, present in the pool from its inception. Their experience is invaluable to assure quality within the rapid deployments. Kick-off workshops and regular training, taking the time necessary for lessons learned, and encouraging staff members with long-term commitment to the organization and the program are key elements. Many evolutions to the model are thanks to team recommendations based on their experience with field reality over the years.

• Multi-year funding is optimal for this kind of intervention model. One-year funding timeframes significantly limit response capacity, as there is often not enough time to complete a 6-months intervention cycle before the end of the project.

• The lack of a contingency stock creates delays in procurement in every annual cycle. Pre-positioned stock is essential for the streamlined operation of such a model, allowing for deployment within the first days of a confirmed nutrition crisis.

• Finally, there are limits to what can be done within an emergency intervention. There have been some successes with multiplying effects of support groups, but attempts to try and address resilience factors have always been limited by the emergency nature of the intervention.

While the model works best when its emergency scope remains clearly defined, links should be made to longer-term development programs to avoid the recurrence of crisis.

Lessons Learned

SMART Surveys

• Action Against Hunger's team size maximizes overall pool deployment capacity while still ensuring quality survey data. The optimal team consists of three people (one manager and two team leaders for four survey teams).

• Increasing SMART survey training to eight days and including staff with a community mobilization background improved quality and resulted in 90% of 2016 SMARTS with an "excellent" score.

• Survey data entry from hard copy questionnaires to ENA software is one of the greatest constraints to publishing rapid survey results. The pool is piloting the use of tablet computers and Open Data Kit (ODK) for faster data processing, removing the need for data entry and minimizing errors.

Interventions

• Action Against Hunger adapted the intervention model to evolve with changing national policy (which now promotes 100% health catchment area[13] or AS coverage) and operational context by increasing coverage to 15-20 AS per zone[14], where average health zone size in the country varies between 10-28 AS.

This improved geographical coverage and targeting (minimum coverage of 54% AS under PUNC and 71% under RRCN), allows Action Against Hunger to mitigate issues of accessibility bias as noted following a 2015 external evaluation when interventions were limited to only 5 AS per health zone.

• The diversity of contexts across DRC requires an adaptive intervention cycle timeframe to ensure sufficient control of a nutrition crisis while optimizing resources. Following 2015 DFID evaluation recommendations, Action Against Hunger shifted from a three-month to a six-month intervention cycle. These improved admission trends, including a 19% increase at the 3-month mark[15] (N=409) compared to previous interventions closed at the end of the third month (N=332), as well as more significant drops between peak admission months and intervention closing months, suggesting a more complete resolution of the crisis before pool phase-out.

In addition, knowledge uptake of MoH health staff increased by 30% thanks to more time for training and on-site support. One challenge with the extension of the intervention cycle is less flexibility in deployment capacity. Action Against Hunger has now established a flexible cycle[16] allowing adjustment of resources according to the severity on the nutrition crisis.

• Reinforced community mobilization efforts was not enough to increase referrals to the Stabilization Center (SC) in the General Reference Hospital as transport and food are key inhibiting factors for most families. When addressed, admissions remained around 6% of the total SAM caseload (as in MSF[17] intervention in Ankoro health zone), which contrast with the typical 1%[18] observed in Action Against Hunger intervention where such support was not present. Although not sustainable, Action Against Hunger decided to incorporate these services to its intervention model given their immediate life-saving impact in a crisis context[19].

• The addition of the WiN package improved health centers' service delivery (increased hygiene, potable water availability, integrated sensitization, etc.), while the phased distribution over the course of SAM treatment for WiN household (HH) kits contributed to a "pull" factor and helped mitigate defaulter rates. Distribution was done by health centre MoH staff during patient intake. While this approach strengthened integration, it did complicate monitoring compared to a direct distribution by Action Against Hunger staff.

• The merging of PRONANUT IMAM registry and the Ministry of Health general admissions registry into one registration book improved

passive screening of arrivals to health facilities and reduced nurses' reporting time.

• The incorporation of a performance-based joint monitoring (health zone/Action Against Hunger) for monthly follow up of key indicators has been an important step to help local authorities better appropriate their supervision responsibilities and link financial support to performance-based results.

• Continuity of IMAM remains a significant challenge in DRC and activities often stop once the buffer stock left by Action Against Hunger is finished. Incorporating Action Against Hunger phase-out as part of induction workshops with local authorities allowed for joint exit-strategy planning streamlined over the course of the intervention cycle. 37% (N=15)[20] of health zones covered by the pool secured longer-term support post-Action Against Hunger intervention either through PRONANUT, UNICEF, other NGOs or pooled funding programs.

[1] Cited from a 2014 UNDP Report in the 2015 DRC Humanitarian Needs Overview (HNO), OCHA/HCT, p11.
[2] An estimated forty-five percent, as cited from Lancet, 2013 in the 2015 DRC HNO, p11.
[3] DRC Humanitarian Action Plan 2016, OCHA.
[4] 2016 DRC HNO, p17.
[5] WASH in Nutrition Strategy, DRC WASH Cluster 2015.
[6] "Plan stratégique national multisectorielle en Nutrition", February 2016 (PSNMN), p12.
[7] DRC consistently scores among the lowest for various country wealth and development ranking indices, 186 out of 187 on the 2014 UNDP Human development Index and 178 out of 179 on the Save the Children International State of the World's Mothers 2015 Report, to give two examples.
[8] Financed by UNICEF from May 2008 to January 2010. UKAid joined UNICEF in co-financing the PUNC Phase One from July 2010 to June 2012. PUNC Phase Two (November 2012- October 2015) included three years, extended for two annual cycles, until October 2017 all under UKAid's financing. Action Against Hunger received renewed support from UNICEF in October 2015 via RRCN (Réponse Rapide aux Crises Nutritionnelles/Rapid Response to Nutrition Crisis), and now receives direct ECHO funding for RRCN since October 2016 in consortium with COOPI, set to finish at the end of 2017. Today, the Action Against Hunger's DRC Nutrition Emergency Pool is supported by UKAid through the PUNC program and the ECHO-financed RRCN.
[9] In terms of an emergency pool dedicated to nutrition response. Doctors without Borders (MSF) - Belgium also has an extensive and long-standing emergency pool in the country, called PUC (Pool Urgence Congo). While nutrition treatment is streamlined in their overall activities, this is focused on emergency health response at hospital level and disease outbreaks, and usually last less than 6 months.
[10] Nutrition cluster guideline, DRC, September 2016: SAM>5% and/or GAM>15% without aggravating factors or SAM>2% and/or GAM>10% with aggravating factors.
[11] Mother-MUAC teaching mothers to screen for Malnutrition, Guideline for Training of Trainers, ALIMA, July 2016.
[12] All figures in this paragraph are the accumulation of PUNC Phase II from 2012 to-date.

Contact Details and Further Reading

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To learn more about Action Against Hunger's programs in DRC, please visit our website at www.actionagainsthunger.org.

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The views expressed in this document are the responsibility of Action Against Hunger and should not be taken, in any way, to reflect the official opinion of its partners and donors.

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[13] "Aires de Santé"/Health Catchment Areas.
[14] 15 AS per zone under UKAid financing and 20 AS per zone under ECHO financing.
[15] Data is extracted from three out of 6 intervention zones where admission rates are available through the third month of SAM intake.
[16] As per Action Against Hunger international standards and on-going discussion with national PRONANUT to fix minimum intervention periods at 6 months.
[17] Médecins sans Frontières (Doctors without Borders).
[18] Statistics of RRCN intervention in Ankoro, AAH 2015/2016, financed by UNICEF/ECHO.
[19] Most recent intervention launch in Kahemba health zone is showing similar figures than the ones of MSF's in Ankoro with 21 SC cases in just the first four weeks of response.
[20] 12 interventions in 2012-2015 programming, 3 interventions in 2016 to date.

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