CMAM 2021

22-25 March

VIRTUAL CONFERENCE

CASE STUDY 8

DEMOCRATIC REPUBLIC OF CONGO

Scaling Up Management of Wasting in the Democratic Republic of Congo: A Case Study

Irish Aid
An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

1.

Context

Context

The Democratic Republic of Congo (DRC) is the second largest country in Africa. With abundant natural resources and a young and very diverse population, it is home to some 84 million people[1].

Low government revenues continue to be a major constraint on the investment needed to provide basic social services to the population. Health financing in the DRC (14%) relies mainly on external aid and direct payments by households.

The nutritional situation in the DRC is worrying despite the efforts made in recent decades to improve the nutritional status of children under five. According to the Multiple Indicator Cluster Survey (MICS-Palu 2018), 42% of children under five are stunted, i.e. almost one child in two; 2% of children under five suffer from severe acute malnutrition, representing at least one million children under five.

Malnutrition situation in Tanganyika

The province of Tanganyika, although considered the breadbasket of the former Katanga, is among the most malnourished provinces in the country. The prevalence of chronic malnutrition is currently over 40% and the provincial average prevalence of global acute malnutrition is 4%. (National Institute of Statistics, MICS, 2018). Although below the 10% threshold, this hides significant disparities from one health zone to another (Ankoro's GAM is 12.5%, Kabalo's is 4%, Kalemie 3.3%, Kansimba 6%, Kiambi 11.3%, Manono 12.5%, Mbulula 7%, Moba 6%, Nyemba 3.3% and Nyunzu 6.8%). Although decreasing (see Table 1), the number of GAM cases remains a significant burden for the province (see table below for cases admitted in 2020).

Number of new admissions for acute malnutrition in 2020			
Organisation unit / Data	**Number New admissions to UNTI**	**Number New admissions to NSU**	**Number New admissions to UNTA**
Ankoro ZS	116	25 386	4 642
Kabalo ZS	59	16 221	7 116
Kalemie ZS	229	17 634	6 322
Kansimba ZS	102	23 828	13 857
Kiambi ZS	128	14 568	2 397
Kongolo ZS	41	5 337	3 769
Manono ZS	169	16 054	4 941
Mbulula ZS	110	1 151	2 205
Moba ZS	43	12 686	7 769
Nyemba ZS	176	11 606	5 233
Nyunzu ZS	114	18 896	2 883
Province Tang	**1 287**	**163 367**	**61 134**

Table 1. Number of new admissions for acute malnutrition in 2020

1 The State of the World's Children, UNICEF, 2019

Malnutrition is the second leading cause of mortality (after malaria) and the third leading cause of morbidity (after malaria and acute respiratory infections) (PAO-DPS/Tanganyika, 2021).

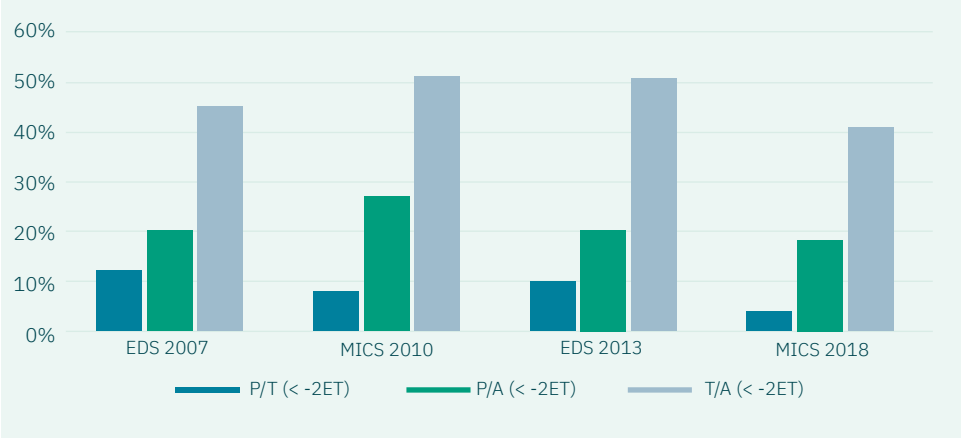

Table 1. Prevalence of malnutrition in Tanganyika

State of play of IMAM in Tanganyika

Over the last 20 years, the Integrated Management of Acute Malnutrition (IMAM) has been implemented in 135 health centres for the management of moderate acute malnutrition (MAM) and 108 health centres for the provision of the severe acute malnutrition (SAM) package, out of the 264 health areas in Tanganyika province. This corresponds to a geographical coverage of 51.1% for MAM (Supplementary Nutrition Units, SNUs) and 40.9% for SAM (Therapeutic Nutrition Units, TNUs), as shown in Table 2. Although there are some dysfunctions, IMAI remains integrated both in the health structures and at the community level. Among the elements that are not effectively integrated, we can cite the reporting system, which has not yet been fully integrated into the health information system and still requires parallel data collection systems, and the low motivation of community actors, which reduces their participation in IMCI activities.

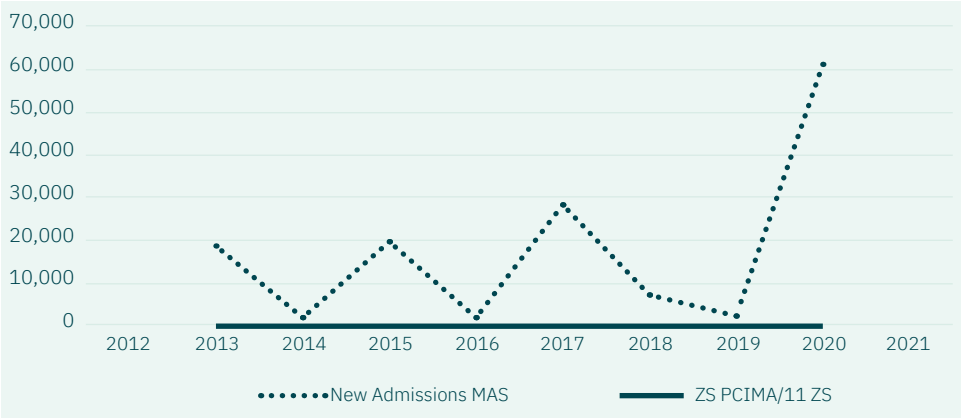

Table 3. Evolution of new SAM admissions

In the table above, the evolution of news has been up and down from 2013 to 2020. This is due to the fact that the health zones implementing IMAI increased and decreased according to the duration of the projects implemented there. There have been years when there has been more support from partners and years when supporting partners have disengaged from the health zones or the province leaving the health zones orphaned. And the year 2020 broke the record because there were several projects in most health zones and the minority of orphaned health zones benefited from inputs from the UNICEF donor.

Interventions	Number of Health Areas	Number of Health Areas covered	Coverage rate
GAM	264	135	51,1%
SAM	264	108	40,9%
IYCF	264	70	26,5%
IYCF-U	264	4	1,5%

Table 4. Coverage of nutrition interventions in 2020

2.

Main lessons learned

Low national ownership is a risk to the sustainability of care programmes

Although the involvement and commitment of both the provincial and national government is of great importance in the sustainability of PCIMA, the cooperation between the NGO partners and the provincial authorities in Tanganyika province is very weak. The state contribution is almost zero, which results in :

- A lack of exit strategies or disengagement from PCIMA partners on the government side,
- A lack of government funding for nutrition outside of the country-level standards for implementing partners in nutrition),
- Poor sustainability of IMCI activities in health structures: after the disengagement of the implementing partner, health areas/zones remain orphaned (without inputs or any other support). Sometimes the trained nurses have left the structure/area in search of something better and eventually the health area/zone becomes non-integrated again.

This also means that the geographical coverage of services varies over time.

The multi-sectoral approach is insufficient to reduce wasting prevalence

Increase the involvement of actors from other nutrition-sensitive sectors. Multiple causes, multiple solutions it is said, cannot be better managed by the health sector alone in the province. We will need to involve other nutrition sensitive sectors such as education, agriculture, the Wash, protection, etc. to curb this scourge in our province.

Advocate for making projects in other sectors more nutrition sensitive (agriculture, wash, education, etc.). Projects in other related sectors should be able to integrate some aspects of nutrition, so that some of the underlying and structural causes can be overcome and the occurrence of new cases (incidence) of acute malnutrition reduced.

Increase funding for preventive nutrition activities in all SIAs that have integrated IMCI. Preventive activities are poorly funded in Tanganyika province in view of the emergencies. To put an end to this super-fire brigade work, a package of preventive activities is important in all health areas that have already integrated PCIMA in order to reduce the incidence and prevalence of acute malnutrition in Tanganyika province.

Main points of intensification of IMCI

For the increase and maintenance of the geographical coverage of PCIMA, it would be necessary to advocate with the government (national and provincial) for:

- The inclusion of certain PCIMA costs in the state budget (purchase and delivery of inputs for the management of acute malnutrition), especially after the disengagement of implementing partners.
- Motivation of health centre staff and community actors to improve their loyalty to PCIMA activities.
- A well-trained, motivated staff with inputs for management

3.

Enablers and barriers to the scaling up of wasting treatment

Enablers

Case detection

Screening for wasting is done routinely

In the community, community relays/mothers-PB screen households for malnutrition for the target groups (under-fives, pregnant and lactating women). At the level of the health centre, the screening is done systematically in all under-fives and pregnant and lactating women who consult the health facilities.

Cases management

Case management is integrated into the health system

All cases detected within the community and in health facilities (severe and moderate cases) are automatically managed in the appropriate facilities (UNS, UNTA, UNTI). No cases of acute malnutrition are managed outside the health system facilities. The wasting management system

The nutrition information system is integrated into the national system

Health information are collected through the health information system established by the Ministry of Health. The Ministry has made remarkable efforts by integrating the major PCIMA information into this system. Other complementary data (notably the management of PCIMA inputs) are collected in the parallel framework.

Barriers

Provision of services :

GAM and SAM services are part of two separate programmes that operate independently. Some health areas may offer SAM services only in the health facilities and sometimes it is only SAM case management.

The problem of implementing the protocol by the supporting partners: The specific medical treatment is poorly respected by the interveners: especially specific medicines are not delivered by the different projects (especially UNTI).

Low coverage of IMAI across the province: less than half of the province's health areas have integrated IMAI and are sustaining it.

Weak integration of IYCF-U activities in emergency interventions (PCIMA): All PCIMA projects carried out in recent years have integrated IYCF/IYCF-U activities in the design phase. But in implementation, partners attach little importance to these activities.

Low funding for monitoring of IYCF activities where they are implemented: Although funded, there is little monitoring of IYCF activities because monitoring has not been integrated into planning.

Weak monitoring of community activities: as with previous activities, there is little monitoring of community activities because monitoring has not been integrated into planning

Health staff

› Non/weak alignment with the state payroll of care providers;

› Low presence of qualified personnel in most health facilities

› Low motivation of community actors

Health information systems :

The comprehensive integration of nutrition information into the health information system could end the use of parallel tools in health facilities.

Access to essential medicines :

Lack of an incomplete kit of essential generic drugs for the management of malnutrition cases at health facilities.

Shortage or absence of inputs for the cases management of acute malnutrition in health zones not supported by a humanitarian project (emergency health zones are well supplied with nutritional inputs; on the other hand, developing health zones are constantly short of nutritional inputs).

Financing :

The support projects are of short duration, making management too intermittent: the end of a project usually corresponds to the end of the management of cases of malnutrition because the health zone will no longer receive the inputs for the continuation and sustainability of the management of acute malnutrition.

Input supply highly dependent on external funding

Leadership / governance

› Lack of a line item in both the national and provincial government budgets for the purchase of therapeutic nutritional inputs

› Low ownership of nutrition activities by political actors

4.

Next steps

1. What are the planned investments that the country/area will make to ensure access to wasting treatment?

PRONANUT and its partners are exploring local alternatives to ensure universal access to wasting treatment in the event of a shortage of conventional inputs (ready-to-use therapeutic foods).

The simplified PCIMA protocol is being tested in the DRC to limit the over-consumption of inputs by beneficiaries.

The PB-Mère approach is being developed in the province to allow early detection of GAM by household members (this approach solves the problem of motivation of the community relay and limits the spread of Covid-19 in the community).

2. What resources or support do you need from the global community to scale up waste treatment in your country/region?

Institutional support at the intermediate and peripheral level :

› For example, logistical support is needed to enable the field activities to be monitored independently

3. What are the main policy changes you would like to see in your country/region to allow for scaling up wasting treatment?

› Inclusion of a line item for nutrition activities in the state budget

› The Congolese state pays the salaries of state service providers in due course in order to encourage their retention in their posts.