People in Need

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Applying a community-based nutrition approach in humanitarian and protracted crisis

Lessons learned from the Democratic Republic of Congo (DRC)

March, 2023

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List of Abbreviations

CAC	Cellule d'Animation Communautaire
CODESA	Comité de Développement de l'aire sanitaire
CODEV	Comité de Développement
CPS	Consultation Préscolaire
DPS	Division Provincial de Santé
FGD	Focus Group Discussion
IYCF	Infant and Young Child Feeding
PCIMA	Prise en Charge integrée de la malnutrition aiguë
PLW	Pregnant and lactating women
PRONANUT	National Nutrition Programme.
RECO	Relais communautaire
SAM	Severe Acute Malnutrition
UNTA	Unité Nutritionnelle Thérapeutique Ambulatoire
UNTI	Unité Nutritionnelle Thérapeutique Intensive
WASH	Water, sanitation, and hygiene
WRA	Women of reproductive age

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Applying a community-based nutrition approach in humanitarian and protracted crisis

1 Executive summary

Good nutrition is a fundamental driver of a wide range of development goals. Nonetheless, in many low- and middle-income countries, a myriad of system bottlenecks and barriers limit programming efficiency, effectiveness, and scalability, excluding many children in need. Contexts that are fragile and affected by protracted crisis experience persistent acute and chronic malnutrition with higher than average levels.[1] The Democratic Republic of Congo (DRC) is not exempt. The DRC, the fourth most populous country in Africa, has been marred by conflict over the past two decades. This has led to population displacement (over 5 million Congolese people are internally displaced) and instability, which in turn results in the abandonment of agriculture, disrupted health, market, and other systems, food insecurity and severe malnutrition.[2] According to the 2022 Global Report on Food Crises, DRC is one of 15 countries most severely impacted by the global crisis[3]. These 15 countries[4] account for 8 million children with severe wasting and 40 million children living in severe food poverty. Food, fuel, and fertiliser shocks have collectively increased the cost of a healthy reference diet. Rising prices and falling incomes have caused diet quality to worsen for many households and more than 2.2 million people have become deprived in at least one additional food group.[5]

Child stunting – an indicator of chronic undernutrition – remains high at 41.8%[6]. Although the national prevalence of wasting (acute undernutrition[7]) has significantly decreased from 16% in 2011 to 6.5% in 2018, the rates are still of concern. In periods following civil unrest, rates of paediatric severe acute malnutrition (SAM) in DRC have climbed as high as 23%.[8] Some children experience multiple bouts of wasting during a given year, putting them at a mortality risk that is 11 times higher than those who are not malnourished. Infant and young child (IYCF) feeding practices remain suboptimal. Recent data indicates that only about 8% of infants 6-23 months have a minimum acceptable diet. [9] [10] Children are fed diets that include at most 2 food groups, as opposed to the minimum 5 food groups that children need to grow, develop, and thrive in early childhood. Compared with men, women are often economically and socially disadvantaged for a range of interrelated, social, economic and institutional reasons. This affects their access to and control over food and nutritional resources, and in turn the nutrition security of their households. The nutrition situation is hindering the country's potential for

[1] MQSUN+, 2020. Strengthening the Humanitarian Development Nexus for Nutrition in Protracted Crises. A Synthesis Report, June 2020.
[2] Nachigera, G.M., et al. 2016. Building the Evidence Base on the Agricultural Nutrition Nexus: Democratic Republic of Congo. CTA Working Paper 16.
[3] The combined effects of conflict – including the war in Ukraine, climate-induced drought, and the socio-economic impacts of the COVID-19 pandemic – are driving a devastating global food and nutrition crisis. (UNICEF, 2022. Child Food Poverty. A Nutrition Crisis in Early Childhood).
[4] Horn of Africa: Ethiopia, Kenya, Somalia, South Sudan and Sudan.
Central Sahel: Burkina Faso, Chad, Mali, Niger and Nigeria.
Countries in Crisis: Afghanistan, Democratic Republic of the Congo, Haiti, Madagascar and Yemen.
[5] IFPRI, 2022. DRC- Impacts of the Ukraine and Global Crises Poverty and Food Security. IFPRI, Country Brief 17.
[6] UNICEF, WHO Joint child malnutrition estimates. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-jme-country-children-aged-5-years-stunted-(-height-for-age--2-sd)
[7] The WHO defines severe acute malnutrition as a child with a MUAC of <115mm, or Weight for Height Z-score of <-3, or oedema; moderate acute malnutrition is a child with a MUAC between 115 mm and <125 mm or a WHZ score between -3, and <-2.
[8] ENN, 2015. Efficacy of a community-embedded RUTF programme to treat childhood malnutrition in Kapanga, DRC
[9] World Bank, 2019. DRC Multisectoral nutrition and health project.
[10] Global Nutrition Report Country Profiles 2020.

human and economic development. Malnutrition costs the DRC one quarter (1/4) of its annual budget, which is an economic loss for the DRC of US$ 1.174 billion US$ each year.[11].

The different forms of malnutrition are linked to chronic crisis and longstanding structural causes. Communities in DRC are affected by ongoing civil conflict and high rates of displaced persons, as well as limited health system capacity, inadequate diets, poor water, sanitation and hygiene (WASH) service, and gender inequalities. In such communities, a locally-embedded model provides a key strategy to prevent and address undernutrition. Through the National Nutrition Program (PRONANUT), the government of DRC adopted a model for the delivery of community nutrition, called *Nutrition à Assise Communautaire* (NAC) in 2002. The approach is designed to maximise local ownership and sustainability.[12] It involves a system of volunteer community health providers (*relais communautaires - RECOs*) who provide a package of nutrition services targeting pregnant and lactating women (PLW), and children under the age of 5 years. RECOs are selected by and are part of the key community governance structures, including the CAC *(Cellule d'Animation Communautaire*) and the community health development committee (*Comité de développement de santé* [CoDeSa]). The experience to date underlines the potential of a community model as an effective service delivery modality. Furthermore, the approach has the potential to sustainably develop capacity at the local level to ensure more effective, inclusive and sustainable solutions for nutrition through mobilisation and capacity strengthening. However, due to capacity constraints within the health system, it has only been rolled out on a small-scale, largely driven by external donor assistance through short-term programmes[13].

There is ample opportunity to embed a community approach to enable greater nutrition security in DRC by:

a) ***applying and scaling the integrated management of acute malnutrition***. Guided by the *Prise en Charge integrée de la malnutrition aiguë* (PCIMA)[14], the integrated management of acute malnutrition encompasses three components: (i) community outreach and mobilisation; (ii) outpatient management of MAM, and SAM without medical complications; and (iii) inpatient management of SAM with complications[15]. PRONANUT is considering the simplified approach, focusing on the community management of malnutrition[16]. Fundamental to the approach is the community engagement in the prevention, early detection, and monitoring of malnutrition cases. The recent 2023 World Health Organization (WHO) guidelines includes an updated recommendation on community health workers (CHWs) i.e. "Assessment, classification and management or referral of infants and children 6-59 months of age with wasting and/ or nutritional oedema can be carried out by community health workers as long as they receive adequate training, and regular supervision of their work is built into service delivery."[17]

b) ***investing in longer term interventions focused on the underlying and basic causes of undernutrition*** (figure 1); and the risks and vulnerabilities to which populations are exposed in protracted crises. Greater programming efficiency and effectiveness can be realised if both forms (wasting and stunting) of undernutrition are jointly tackled in settings that experience shocks. Building resilience, particularly at the local level, may seem obvious but it warrants

[11] Cartographie des Intervenants et des Interventions en Nutrition République Démocratique du Congo Résultats au niveau national - Année 2017
[12] ENN, 2015. Efficacy of a community-embedded RUTF programme to treat childhood malnutrition in Kapanga, DRC
[13] World Bank, 2019. DRC Multisectoral Health and Nutrition Project.
[14] National Protocol, Integrated Management of Acute Malnutrition Acute, Edition 2016.
[15] Inpatient care at UNTI (Unité Nutritionnelle Thérapeuthique Intensive), for individuals with medical complications and all infants <6 months of age), outpatient care at UNTA (Unité Nutritionnelle Thérapeuthique Ambulatoire).
[16] DRC Ministry of Health, 2020. National Nutrition Programme. Organisation generale de l'approche simplifiee prise en charge de la malnutrition aigüe module.
[17] WHO, 2023. WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years.

time and a radical shift in how programmes are coordinated, planned, implemented, and financed.

Over the previous decade, People in Need (PIN) DRC has been implementing a community approach to the management of acute malnutrition[18]. To build evidence on the community embedded approach, and to better understand the key lessons learnt from implementing a community nutrition model in fragile and protracted crisis and its potential to manage both acute and chronic malnutrition, PIN DRC conducted a study in South-Kivu province between November 2022 and January 2023. The findings are summarised in this report.

2 Introduction

Efforts to implement multisectoral actions and to build a comprehensive nutrition policy agenda in DRC have been under way since the early 2000s. Recognising the impact of malnutrition on human development and economic growth, the country's government identified the fight against malnutrition and, more broadly, the investments in the early years, as priorities in the national strategy for poverty reduction and economic development. In 2000, the Government adopted a national nutrition policy and created the PRONANUT within the Ministry of Health (MoH). In the early 2000s both the policy and the programme focused on nutrition-specific curative interventions, but this was expanded to a multi-sectoral approach, with the adoption of the second National Nutrition Policy in 2013, in the same year as DRC joined the Scaling-up Nutrition (SUN) movement, and followed by the adoption of the National Multisectoral Strategic Nutrition Plan in 2017. PRONANUT, which serves as the SUN platform's executive secretariat, is mandated to oversee and coordinate the implementation of the Plan. UNICEF and other international NGOs, including PIN, assist PRONANUT by providing support to nutrition programmes, including PCIMA. PRONANUT is the co-facilitator of the national Nutrition Cluster, with UNICEF in the lead. At the sub-national level, PIN facilitates the cluster in Sud-Kivu.

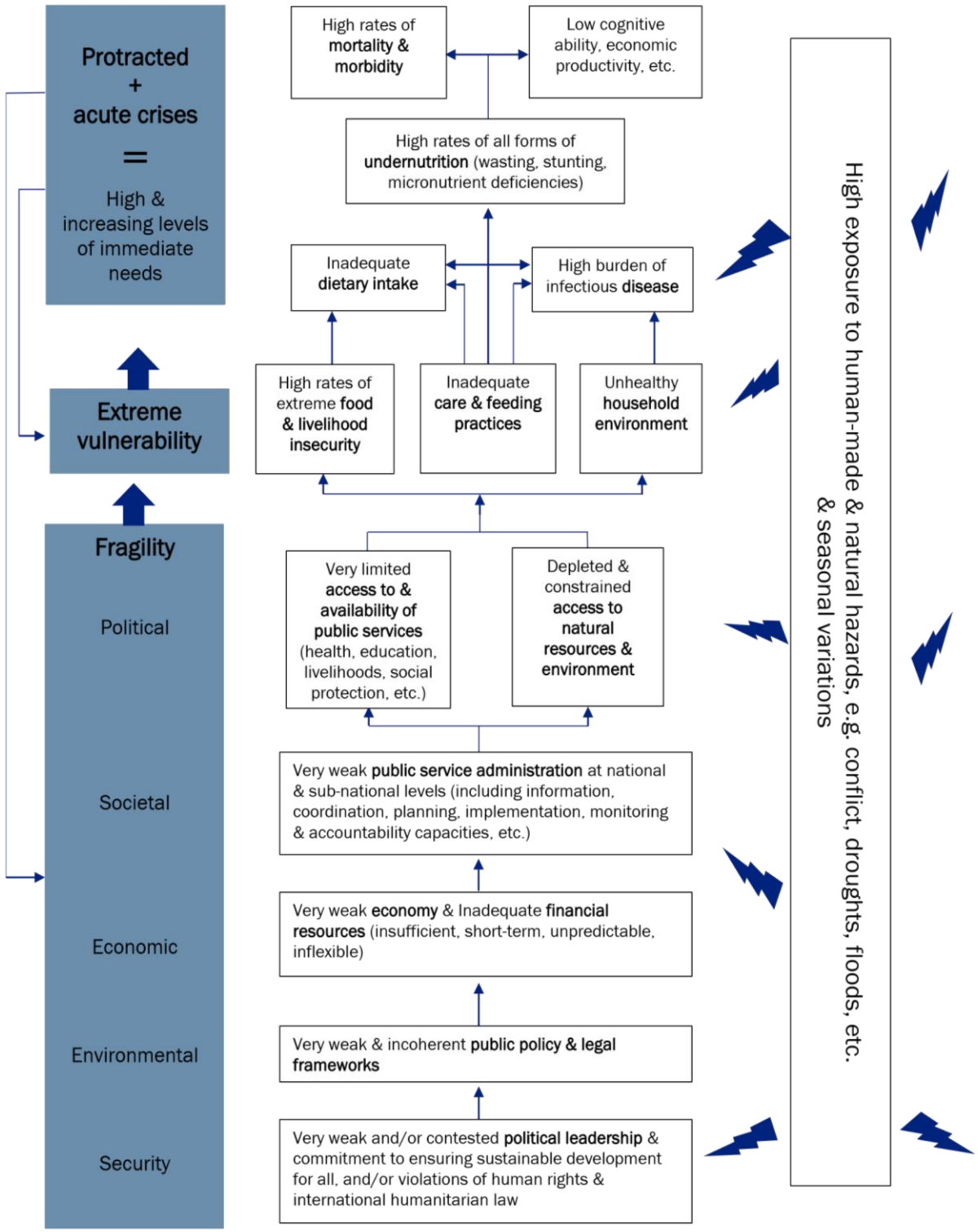
Despite the commitment and positive development at the policy level, systemic bottlenecks constrain the sustainability and scale-up of evidence-based actions aimed at reducing malnutrition. Services are inadequate to meet basic needs in areas such as health, water, sanitation, education, nutrition and food security. Efforts to combat malnutrition in the DRC have largely focused on curative/treatment actions within the health sector. These are bringing encouraging results in addressing acute malnutrition, but they remain insufficient in the face of the challenges and require stronger mobilisation of other contributing sectors to sustainably tackle all forms of malnutrition (e.g. wasting, stunting, anaemia).

In DRC, there are two types of interconnected approaches needed to enable greater nutrition security:

i. **Immediate lifesaving interventions for children who are wasted and/or ill.** The PCIMA covers these types of interventions. However, the impact of PCIMA is often limited by low coverage (which varied between 25-48% for SAM from 2016 to 2019).[19]
ii. **Longer-term interventions focused on the underlying and basic causes of undernutrition.** While key policies and guidelines regarding community-level mobilisation and service provision have been developed in DRC, the community based preventive approach (NAC), has only been rolled out on a small scale[20]. Hence, there is also limited research on this approach.

[18] For example, PIN implemented the Community-Based Nutrition approach in the Minova health zone / Kalehe territory in South Kivu province in 2016 and in the Punia health zone / Punia territory in Maniema province in 2018.
[19] UNICEF. Module organisation generale de l'approche simplifiee prise en charge de la malnutrition aigue
[20] The strategy has only been rolled out on a small scale (covering only 36 out of 516 [6.7 %] health zones (HZ) in DRC) (World Bank, 2019)

Figure 1: Conceptual framework of undernutrition in protracted and acute crises[21]



[21] MQSUN, 2020. Strengthening the Humanitarian Development Nexus for Nutrition in Protracted Crises A Synthesis Report.

3 Methodology

This is a qualitative study, involving primary data collection, and supported by a literature review. The survey was carried out in 2 health zones in Sud Kivu:

1. Itombwe-Minembwe health zones, where PIN has been active for 2 years, is a remote and volatile area.
2. Lemera health zone, where PIN is entering its second phase.

The survey considers intersectionality, i.e. factors related to caregivers' knowledge, attitudes, and practices (micro-level); community and healthcare factors (meso-level) and structural factors (macro-level) (e.g. poverty, gender inequality, education, employment and social protection).

Using purposive sampling, data (see Table 1) was collected over 3.5 weeks[22] from :

- In-depth interviews with carers/mothers of malnourished children, religious leaders, traditional practitioners, and village chiefs;
- Focus Group Discussions (FGDs) with community members (male and female). The female group included grandmothers and the male group included fathers;
- Key informant interviews (KIIs) with health centre staff and RECOs;

Table 1. Categories of respondents

Region	Sex	Mothers/ caregivers	Community Members	RECO	Health staff	Village leader/chief	Religious leaders	Traditional practitioners	Total
Itombwe	♂	0	17	2	3	3	1	1	27
	♀	10	19	2	1	0	1	1	34
Lemera *Bwegera, Langala	♂	0	18	4	4	3	2	2	33
	♀	20	19	4	1	0	0	0	44
Total		30	73	12	9	6	4	4	138

The adapted UNICEF causal framework on undernutrition in fragile and protracted crises (see figure 1) was used as a lens through which to design the methods, and interpret the data. The data from in depth interviews was triangulated with KIIs and FGDs in order to reduce bias, and a thematic analysis was carried out.

[22] Between November 2022 and January 2023.

4 Findings

The analysis produced a number of key themes, as highlighted in the following pages.

Theme 1: Community's understanding and perceptions of malnutrition

"Malnutrition causes generational problems, because the child's intelligence is affected, and maybe their ability to work, leading to lack of money" RECO, Bwegera, Lemera.

Causes

- All interviewed mothers/caregivers of malnourished children(who participated in PCIMA had a good understanding of acute malnutrition, including the symptoms, immediate, and underlying causes.
- At the immediate level, poor diet (including lack of diversity of food) is the main reason, following by disease. At the underlying level, food insecurity, poor sanitation and hygiene and poor care practices were cited, and at the basic level, poverty and insecurity were commonly cited.
- The village chiefs in Itombwe indicated that the main causes are instability and conflict that has displaced people (*'malnutrition is largely related to trauma'*), as well as poverty, poor diets *'sometimes we are without food. We just heat the water, and drink it to have a little warmth in the body'*.
- In Lemera, the same causes were listed, although insecurity was mentioned to a lesser extent compared to Itombwe. Notably gender related issues were mentioned by women in surveyed areas i.e. limited decision-making power, and workload which affect women's capacity to participate in trainings.
- The women's FGDs demonstrated a higher understanding of the causes compared to the men's FGDs. Two RECOs highlighted the intergenerational cycle- *'malnutrition during pregnancy leads to a malnourished baby*'. In Bwegera, one RECO stated that '*malnutrition comes when the pregnant mother has been malnourished and the child will be affected by this malnutrition after birth'.*

Symptoms

- Some mothers/caregivers, considered malnutrition to be a disease, rather than a state or condition, and some members of the community thought it was a communicable disease.
- In both Lemera and Itombwe, the main symptoms of acute malnutrition mentioned by the mothers, women's FGDs , the RECOs, village chiefs, religious leaders, and traditional practitioners were:-i) Presence of oedema, ii) Weight loss. iii) Discolouration of skin and/or hair
- Lack of appetite and fatigue were also cited by the interviewed mothers and women, although to a lesser extent.
- Some caregivers, women and RECOs also recognised the chronic implications, i.e. poor nutrition can negatively affect brain development, growth and intelligence.
- Two RECOs highlighted the intergenerational cycle- *'malnutrition during pregnancy leads to a malnourished baby*'. In Bwegera, one RECO stated that '*malnutrition comes when the pregnant mother has been malnourished and the child will be affected by this malnutrition after birth'.*

Consequences

- The main consequences mentioned by mothers in Itombwe and Lemera were death, followed by chronic implications (e.g. *'the child is not growing well compared to his little brothers'…. 'there are problems with intelligence, at school, and repetition of grades'……. 'even a 7 or 8 year old can look like a 3 year old').* The women's FGD in Itombwe mentioned that malnutrition can results in chronic malnutrition where the *'5 years old can look like a 1-year old child'.*
- The men's FGD (in Lemera and Itombwe) highlighted that the consequences include tension, and stigmatisation, as well as death.

Perceptions

- According to the majority of respondents, there is a negative community perception and stigmatisation of the parents of the malnourished children, particularly from other parents. '*Instead of giving advice, they criticise*' said one mother in Lemera. Sometimes they don't want to approach the child, and they are suspicious of him/her, and keep them away from other children. For example, some mothers in Itombwe felt judged- '*the community said that the parents don't give food to their children, because the parents are poor and they don't take care of the child*'. Sometimes the malnourished child was prevented from playing with other children or eating from the same plate, as some believed that malnutrition is a communicable disease.
- Associations with witchcraft were also mentioned. According to a RECO in Itombwe, the community perceives that the child has received the 'mulonga' (bad spell) if the child has swollen legs, but if the belly is swollen, the community sometimes thinks that the child has consumed poison. Another RECO said that the community perception is that the parents are negligent- *'they are called orphans because children who have parents should not suffer from malnutrition*'.
- According to the religious leaders, the community perceptions vary from stigmatisation to indifference.

Theme 2: Social and environmental influences

"My children have never eaten an egg ……..We don't eat any animal products like meat, a year can pass without eating meat."
Caregiver's Interview, Itombwe

Enablers and barriers

- Notably gender-related issues were considered to be the main barriers according to women, and the main enablers were factors related to their own empowerment.
- The effectiveness of RECOs was highly regarded by the mothers, and the RECOs also acknowledged the importance of good quality services (supply side) and commitment of leaders (community influencers).
- The root causes of malnutrition were also cited (insecurity/instability, conflict, and poverty).
- According to the health centre staff in Itombwe, the main obstacles are insecurity, mistrust from the community, and lack of availability of inputs.

Nutritious food access

- Food access, particularly of animal source foods is a challenge, particularly for those who have been displaced.
- The women's , men's FGD, and the RECOs indicated that the main cultivated crops in the community are potatoes, sweet potatoes, maize, amaranthus, cabbage, cassava (for foufou), beans and these are the main foods consumed. However, not everyone has access to land to grow crops.
- Most foods are available in the market, but are not accessible/affordable to all. One RECO highlighted that food are often imported.
- There are indications that the frequency of consumption is low (varying between once or twice a day).
- In general there are no food taboos. The restriction of consuming chicken by the daughter in law were mentioned as an old taboo in Lemera and Itombwe.

WASH

- All actors noted the lack of improved water sources, and latrines, apart from those available in health centres supported by the project
- Notably the women knew the critical handwashing moments, which is in line with the recent end line evaluation (PIN, 2022. Endline ECHO Report Lemera Health Zone/ Uvira Territory) , where at the end of the project, 89% children aged 0-59 months' mothers or caregivers knew at least three of five key handwashing moments which is an increase of 21% from the baseline (68%). However, there was limited knowledge in the men's FGD on the critical handwashing times.

Gender equality

- Traditionally, nutrition is seen as a domain of women, in which men should not be involved. Although the team has observed that this perception has been changing in some areas. The persistence of this traditional role division was confirmed by many respondents, including male caregivers, community leaders, teachers, traditional healers, and religious leaders.
- The respondents (caregivers, female FGDs, RECOs, village chiefs, religious leaders, TPs) indicated that women in Itombwe have a lot of responsibilities, including working in the field, going to the market, housework, and food preparation; and the men are primarily involved in field work.
- The men are primarily the decision makers in both regions. The RECO said that *'in the family the last decision is the man's because they have been blessed by the Gods. If women can make decisions, it is in their professional environment and they have studied'*. One of the religious leaders that that *'the bible says that the man is the pillar of the house'*. In the absence of his wife, the man may take care of the child.
- There are however some indications of positive gender role models in Lemera. One woman said that both her and her husband make decisions together. However, the majority of women said that the man is the one who decides,.
- Men are not usually involved in taking care of the children. Some men fear that they would be mocked.

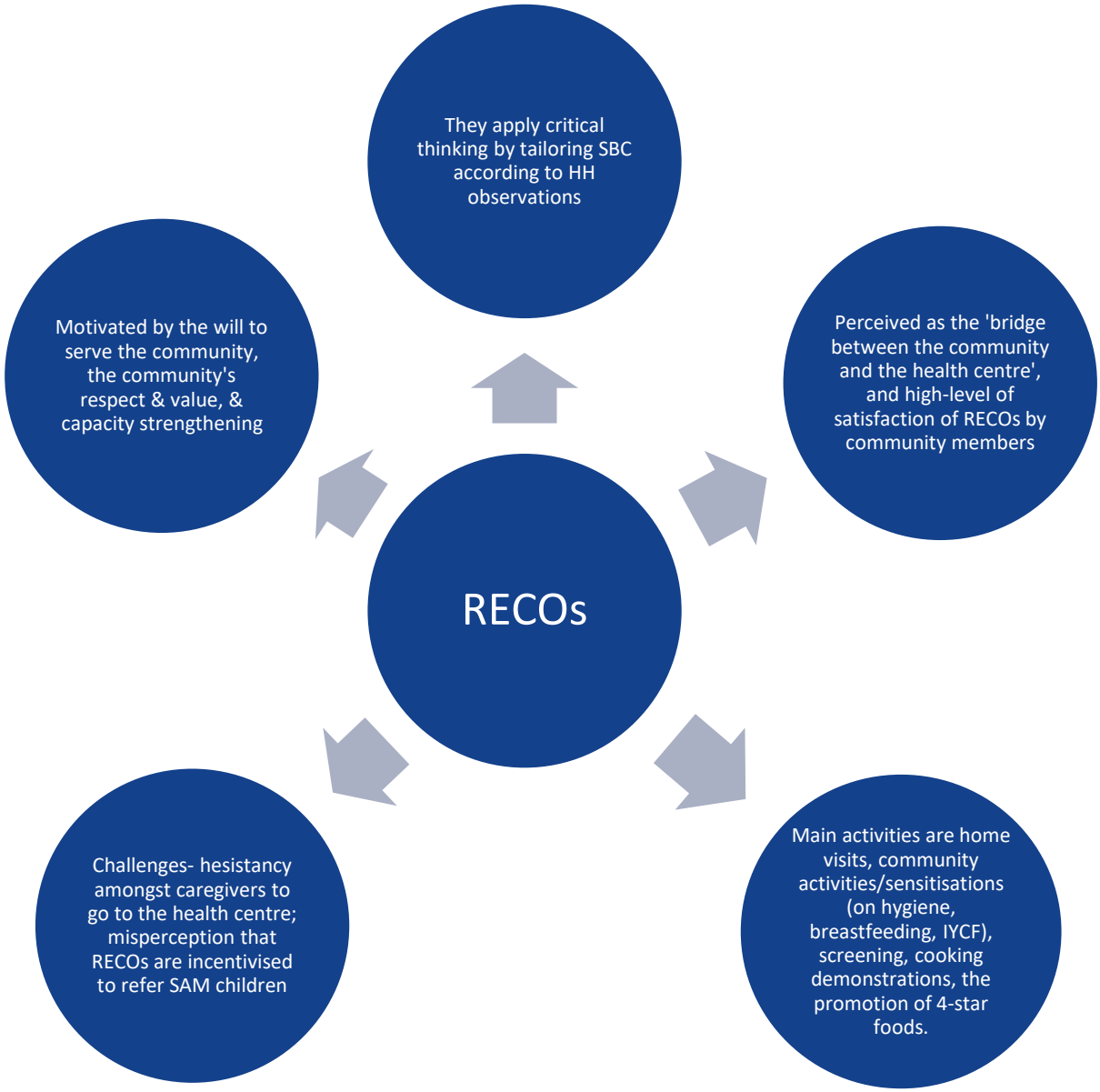
IYCF

- The respondents (mothers' interviews, FGDs, RECOs) recognised that colostrum strengthens immunity, mitigate risk of disease, *'it's the first vaccine the child receives to protect him from different diseases such as intestinal worms'*….
- All actors were familiar with the recommended breastfeeding practices, however there were gaps regarding the introduction of complementary feeding and the frequency of meals/snacks. it wasn't clear if this was related to food access issues, or the social behaviour change (SBC) communication.
- The diversity of meals using 4 star foods was well understood by community members.

"The woman is very busy because she takes care of the work in the field and after the harvest the man decides what to do with the products- which ones to eat and which ones to sell."
Mother, Itombwe

"The man can take care of the children even when the woman is not busy, but we must be careful so that the woman does not consider it a habit, because even in the presence of friends she will ask you to take care of the children and this can bring shame to the man."
Village Chief, Itombwe

"The decision-maker is the man because he is the head of the family, although the woman may make decisions around meal preparation. Men rarely take care of the children because they think they will be mocked by their friend."
Female RECO, Lemera



Health staff

- Designated health staff are responsible for coordinating PCIMA, including supervision of RECOs. Interviewed health staff appreciated the trainings from PIN/MdM on PCIMA.
- Good understanding of the treatment protocol (although some consider it to be complicated)
- The highlighted challenges, included poor salary, heavy workload, and lack of materials in the health centre. Sometimes the SAM treatment does not work as RUTFs are sometimes redistributed within the household.
- No current support for MAM

Religious leaders

- Perceived positively, and have an influential role in the community
- According to the health centre staff in Langala, '*we are in a society where religious beliefs are strong. If these religious leaders already know the signs and symptoms of diseases, they can help us to sensitise the community.*
- A religious leader (Lemera) said '*during the mother's pregnancy, we make sure that the mother has a good diet before giving birth, and we promote diversification of food with vegetables*'

Village Chiefs

- Their role includes community mobilisations and provision advice to the community regarding the importance of agriculture, disease prevention, good feeding practices, security, and other issues
- Encourage households to do preventive activities, such as cultivating crops, and business to generate income

Traditional Practitioner

- The interviewed TPs believe that malnutrition can be cured by traditional means.
- They perceive that they '*defend the community by treating malnourished people and other diseases'.*
- One TP said that they treat malnutrition with local products (Kijingi: using crushed bark and water; Mugimbu, bark is ground and mixed with maize based porridge, and Ambindula, the leaves are boiled). One TP said *'We should also be involved in the programme because people believe in us because of what we do for them.'*

" I act as a bridge between the population and the health centre. Sometimes parents refuse to send their children to the health facilities, some refuse to screen their children because they are not informed. I encourage respect for healthcare structures."

Chef de Village, Langala

"I didn't know if my child was suffering from malnutrition and thanks to mother MUAC I found out that my child was sick."

Mother, Langala

"There is already a decrease in the malnutrition rate, and the mortality rate in children under 5 years has decreased. It is also good that maternity expenses are covered."

Religious leader, Lemera

Theme 3: Perception of PCIMA and other community nutrition activities

'The RECOs help us a lot, especially in screening and when they do the house visits, and cooking demonstrations. They teach us a lot of things but we only lack the means to put them into practice', Mother, Itombwe

Theme 4: Stakeholders' recommendations and opportunities for programming

Increase the number of cooking demonstrations and community education sessions

Expand the programme to other areas (e.g. Aleba, Kanogo)

Extend the duration of the programme beyond one year, because the needs are high (due to conflict and displacement).

- Recommended by mothers/caregivers (Itombwe, Lemera), women's FGD (Itomwbe), RECOs (Lemera), chef de Village (Itombwe, Lemera), health staff, men's FGDs

Provide support on inputs (food) (e.g. vegetable gardens)

Provide support on income generation

- Recommended by mothers/caregivers (Itombwe, Lemera), women's FGDs (Itombwe, Lemera) RECO (Bwegera, Langala), men's FGD (Itomwbe, Lemera), religious leaders (Itombwe, Lemera)

Continue to provide free health care

Provide inputs to health centre (RUTFs)

- Recommended by mothers/caregivers (Itombwe, Lemera), Chef de Village (Itombwe), health centre staff, men's FGD

To Increase the number of RECOs and further strenghten their capacity

Continue to strengthen capacity of health staff to manage malnutrition

- Recommended by RECOs (Bwegera), womens FGDs (Lemera)

Target and engage men in nutrition (e.g. during mass)

- Recommended by RECOs (Bwegera, Langala), Chef de Village (Lemera), health staff (Itomwbe, Lemera)

Support WASH

- Recommended by RECOs (Lemera), men's FGDs (Itomwbe, Lemera), religious leaders (Lemera)

Engage religious and local leaders in sensitisation sessions

- Recommended by RECOs

Include women under 18 years of age because of issues regarding early marriage

- Recommended by religious Leaders(Itombwe), health staff

5 Discussion

Historically in DRC, the nutrition sector has adopted a somewhat 'siloed' approach towards programme, policy and financing, with wasting viewed as predominantly occurring during emergency contexts while stunting is seen as a longer-term development issue. There is a need for greater coherence amongst development and humanitarian actors. It is no longer acceptable to focus on just one form of undernutrition (i.e. wasting) in these complex and high-risk contexts, nor to focus only on treatment when the burden of undernutrition is disproportionately high, and both prevention and treatment approaches are needed. Longer-term development approaches addressing underlying vulnerability—in combination with necessary lifesaving humanitarian interventions—help to build resilience to future shocks and to minimise the impact of current crises.[23]

This study reveals the opportunities in bridging the humanitarian-development divide through a community-based approach, which can ensure demand for, continuation and utilisation of nutrition services, and ultimately strengthen resilience against all forms of malnutrition. The findings of the study indicate that the PIN programme has strengthened the community's understanding of malnutrition in Itombwe and Lemera. In some interviews (with mothers of malnourished children, RECOs, women's FGDs) the respondents were also aware of chronic malnutrition, and the impact on long-term growth, development, and cognition. The men were less familiar with recommended nutrition and hygiene practices, which is to be expected as women tend to be the primary target group of nutrition programmes. Gender-related issues (division of responsibilities, women's heavy workload, and poor decision-making power) were regularly mentioned by female interviewees as the main barriers to achieving good nutrition. It was reported that men do not want to be seen as weak by showing they support their wives, or feed their children. It might be possible to change this social norm gradually by identifying what men are willing to do, and then promoting smaller doable actions that can over time have a big impact. Among the main barriers to greater engagement of men are that many men do not see themselves as being responsible for doing nutrition-related tasks; and some men fear that by doing 'women's tasks' they would look like 'weak men' in the eyes of their peers. Men also seem to have limited understanding of IYCF and do not necessarily know exactly what they can do to support their children to be well-nourished. However, there are positive potential male change agents which can be leveraged, particularly those who have an influential position, such as village chiefs and religious leaders. The main enablers of good nutrition were factors related to women's own empowerment.

Community platforms can act as a gateway to providing an integrated and multi-sectoral service package and are an effective approach for bringing about reductions in child malnutrition.[24] Community participation in nutrition:

- increases a sense of ownership, and thus can contribute to sustainability of the project;
- supports the promotion of nutrition, and regular attendance in activities;
- may decrease dependence on external assistance; and promotes local solutions through the strengthening of community structures and leadership.

In this study, community involvement and engagement were identified as potentially key factors in the success and sustainability of the programme's implementation. It was flagged by respondents (e.g. the RECOs) that it is important to engage village chiefs, and religious leaders, considering their influential positions.

[23] MQSUN, 2020. Strengthening the Humanitarian Development Nexus for Nutrition in Protracted Crises A Synthesis Report.
[24] Shrimptom, R., 2017. Community Based Nutrition Programs – Critical design elements and Research needs Article in World Nutrition.

Research evidence on community management of acute malnutrition has shown that about 80% of children with SAM who have been identified through active case finding, or through self-referrals, can be treated at home. Where treatment is decentralised to community health workers or community relays coverage rates have been reported to improve. With basic community training, mothers can use MUAC tapes which is becoming a stand-alone practical tool for screening children to monitoring recovery.[25] CHWs/RECOs are often able to continue providing services during acute and protracted crises, including prolonged periods of conflict and insecurity and during population displacement. Female CHWs/RECOs carry social capital within communities of intervention and act as role models for others. Although attitudes on gender[26] can make it difficult to attract and retain female CHWs/RECOs, having the opportunity to serve in this role is seen as empowering for women, allowing them to gain skills, improve their social status, and prioritise women's nutrition in communities. [27]

In this study, the effectiveness of RECOs was listed as one of the main enablers of good nutrition, and overall, they are perceived positively and respected by the different respondents. The RECOs indicated that they are motivated when they feel valued by the community. They also appreciate the capacity building in the management of acute malnutrition, and nutrition/hygiene education. However, respondents did also note challenges related to the misperception that RECOs are incentivised and paid to refer SAM cases. This can cause tension within the community. RECOs indicated that they would like more support and involvement from health staff from DPS and PRECODESA. Notably the RECOs demonstrated 'critical thinking' in how they carry out their activities. They reflect on the issues at the household/community level, and use these observations to tailor and inform the nutrition education topics.

In this study, the PCIMA and nutrition activities were mostly perceived positively in the community. Different actors acknowledged that they witnessed improvements in SAM cases. It was noted that most of the SAM cases are currently identified by the RECOs, suggesting that further support on self-referrals through 'Mother's MUAC' is needed to also ensure early detection and treatment of malnutrition and ideally, to reduce the number of children who go on to become severely malnourished. Cooking demonstrations were also regularly cited as the preferred nutrition activity, followed by screening and community sessions. A common thread is that activities which empower females through education are perceived positively. It was recommended to also expand the target group to adolescent females because of issues with early marriage and pregnancy.

Adherence to the programme, social acceptance and the strong involvement of the target groups are key facilitating factors in the success of the programme. This was particularly noted in Lemera where the programme has been in place for a longer period. There are some persistent issues regarding the stigmatisation of malnutrition in the community, and also the resistance by some caregivers to bring their child to the clinic when referred. The persistence of certain traditional beliefs about the treatment of malnutrition is an obstacle to seeking treatment. Again, the role of religious and local leaders is important in this regard, particularly in organising community dialogue to address stigmatisation, and negative traditional beliefs. Mobilising the community using the NAC approach, to reiterate the root and underlying causes of malnutrition, could remove negative beliefs. There are

[25] Cazes, C., et al., 2022. Simplifying and optimizing the management of uncomplicated acute malnutrition in children aged 6-59 months in the DRC (OptiMA-DRC): a non-inferiority, randomized controlled trial. The Lance, E510-E520.
[26] For example, it can be difficult for women to become CHWs and/or supervisors because of literacy, cultural, and safety concerns.
[27] Raven, J. et al. Supporting community health workers in fragile settings from a gender perspective: a qualitative study; Perry, H., et al., 2014. Developing and Strengthening Community Health Worker Programs at Scale A Reference Guide and Case Studies for Program Managers and Policymakers; Exemplar Research, 2021. Do women make the most effective community health workers? Why women CHWs are critical to delivering primary health care.

some conflicting messages being promoted by the traditional practitioners (e.g. that local products such as tree bark can be used to treat malnutrition).

There are barriers related to food security[28] and health service delivery, as well as systemic causes (poverty, conflict), which are outside of the scope of the project. At the health sector level, the staff turnover, disruption of input supplies, and absence of MAM services were highlighted. The lack of financial resources to cover the needs of the entire population with an entire integrated package is a constraint observed by the health service, and local leaders. MAM and SAM services are not integrated, and in the surveyed areas, the SAM programme is being implemented but with limited geographic coverage. Building the capacity of implementing health actors in PCIMA, and NAC is important. To successfully prevent malnutrition, the successful operationalisation of multisectoral programmes and actions is needed. Increased coverage of PCIMA and NAC must be accompanied by quality training and supervision particularly of RECOs to carry out their expanded role effectively. Community selection of RECOs, and engagement of respected local leaders are crucial for community trust and acceptance and high utilisation of services. [29]

PRONANUT has intensified its engagement as a coordinator of the national multisectoral nutrition efforts. At the provincial level, provincial health directorates (DPS) often do not have capacity to perform their oversight, management, and supervisory functions due to a lack resources. Similarly, the capacity at the local levels (*zones des santé aires, de santé*) is constrained by limited resources. While key policies and guidelines regarding community-level service provision and mobilisation have been developed in DRC, to date the model has only been rolled out on a small scale, largely by external donor programs. The coverage of the essential nutrition interventions on the ground remains very limited. [30]

Nutrition-sensitive interventions are limited, particularly in agriculture and WASH, which can contribute to relapsed cases of malnutrition and chronic malnutrition. The limited access to and affordability of diverse foods, particularly ASFs, were regularly mentioned as challenges in the study, and it is not clear if this is the reason why complementary foods and frequency of meals are not as per the recommendations. For the future, macro-level factors also look set to maintain upward pressure on food prices, affecting the affordability of food. The integration of nutrition-sensitive interventions can form the backbone of multi-sectorality.

6 Conclusion

The challenges to implementing community nutrition services in a humanitarian setting can be daunting. Beyond implementation challenges usually faced in stable low-income settings, programme implementers in fragile contexts must also cope with challenges such as insecurity (particularly noted in Itombwe), large-scale population movements, destruction or theft of infrastructure and commodities, and even greater shortages of health/nutrition workers. The insecurity necessitates the development of new innovative strategies to ensure that people have access to integrated multisectoral nutrition services. These include the mobile health clinics and leveraging local resources. In these settings the community-based approach can contribute to sustainable impact through

[28] From an earlier vulnerability study, IDPs and returnees were less likely to eat twice a day. Hungry season is March, June, July, Aug, Sept. PIN, 2022. Report on the analysis of vulnerabilities carried out in the health zone of Lemera and Nyangezi- South Kivu Province. August 2022.
[29] ENN, 2015. Efficacy of a community-embedded RUTF programme to treat childhood malnutrition in Kapanga, DRC
[30] World Bank, 2019. DRC Multisectoral nutrition and health project

community ownership, nutrition education, women's empowerment and overall, changes in practices. Community resilience strategies are important, however their implementation at scale is needed.

7 Recommendations

Consider multi-year funding for emergency programs. Flexible and longer-term funding arrangements that allow smoother transitions between humanitarian and development programming facilitate rapid emergency response and achievement of longer-term development objectives. Short, intermittent periods of funding are inappropriate for supporting integrated services and are detrimental to efforts to strengthen service quality and the food and health systems as a whole. They can lead to gaps in service delivery and create a higher administrative burden for both the donor and local partners, adding complexity to planning processes. Financing for system strengthening and surge capacity (health, social protection) is important.

Improve multi-sectoral coordination among different administrations, ministries and local leaders for more successful comprehensive prevention and treatment strategies. Nutrition is not a matter of health alone, and if it is only looked at from this perspective, interventions are often too late, focused on the cure and not on prevention. As a SUN country, there is an opportunity to promote the SUN model of integrated action on nutrition – action which addresses both acute and chronic undernutrition, by incorporating interdependent interventions in health, food security and agriculture. The model lends itself to the scale-up of the NAC approach.

Support community-based SBC integrated package to address the underlying and root causes. Strengthening community capacities and resources, community participation, and ownership across sectors is critical. This involves community SBC to address the barriers and enablers to good nutrition.

Strengthen a holistic continuum of care for prevention, early detection, and treatment of acute malnutrition. Enhancing the life cycle approach involves inclusion of adolescents, pregnant women, breastfeeding women, infants under six months and children 6-59 months in prevention and treatment. Families should be integrated as the target for increased uptake of continuum of care approaches, linking treatment to prevention with an emphasis on sustaining recovery, preventing both relapse and all forms of undernutrition.

Prioritise gender-transformative approaches to nutrition. To date, some efforts have been made to "integrate" or "mainstream" gender into nutrition programmes, but wide gender disparities persist because these efforts have not addressed the root causes of the problem. An effective response requires that **gender equality becomes the central foundation upon which multi-sectoral responses to nutrition are built.** Traditional power holders and influencers, particularly men, must be engaged in this process. They are important potential gender champions, and agents of change.

Expand the evidence base through adaptive programming and operational research
Considering how quickly situations in fragile and conflict affected areas can change, it is important for mechanisms to be easily adapted. It is important to build the evidence based for community-based nutrition approaches.

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