



**Implementation of the simplified
approaches as recommended in the
management of malnutrition in the
context of COVID-19 in DRC**

Disclaimer

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Executive summary

Many countries all over the world have been affected by the COVID-19 pandemic. Despite the preventive measures put in place, the Democratic Republic of Congo (DRC) was affected as of March 10, 2020. Up until May 2020, 1,455 cases and 61 deaths were recorded. To respond to the spread of the epidemic, the Ministry of Health (MoH) through the national nutrition program (PRONANUT) in collaboration with the Nutrition Cluster developed and disseminated a guidance manual (April 2020) providing recommendations for adjustments that could be made in routine nutrition programs. Initiating simplified approaches by volunteers in areas where it is possible, and resources are available is one of the recommendations. The PRONANUT in collaboration with the Nutrition Cluster decided to pursue the recommendation on simplified approaches outlined in the guidance manual. A consultation process was carried out to determine the most appropriate package of the simplified approaches.

The overall objective of the consultation was to provide a forum for all stakeholders including partners directly implementing IMAM activities to review the key aspects on the different simplified approaches including pros and cons and share their views and opinions to determine the most suitable adaptations to use considering the COVID-19 context in each of the selected health zones.

All activities and support were carried out remotely. Qualitative methods were used to gather information. Participants included representatives from the IMAM technical working group (TWG), PRONANUT, UNICEF, WFP and NGOs including national NGOs. The process entailed consultative discussions, an individual questionnaire, a prioritisation matrix and a final discussion on the selected package of simplified approaches by a taskforce.

The following were the key outcomes of the consultation:

Experiences with the simplified approaches. Results showed that 37.5% of the respondents to the individual questionnaire had some level of experience in one or more of the adaptations. There is more experience with 1) using of a single product for the treatment of MAM and SAM, 2) the family MUAC and 3) reducing follow-up visits. The adaptation least familiar with was the treatment of acute malnutrition by the community health workers or volunteers.

Feasibility of the approaches. Overall all the adaptations were considered relevant to the organisations. Based on the six thematic areas that were looked at; the family MUAC, use of MUAC-only including oedema to admit, follow up and discharge and combined treatment of SAM and MAM under one program were the top three adaptations considered feasible. Treatment of acute malnutrition including medical treatment by community health workers was considered the least feasible.

The agreed upon package includes the following adaptations: 1) Family MUAC 2) Use of MUAC and Oedema as the criteria for admission, follow-up and discharge 3) Combined treatment of SAM and MAM as one program 4) Use of a single product (RUTF) for the treatment of both SAM and MAM 5) Modification of the amount of RUTF provided by giving SAM cases 2 sachets and all MAM cases 1 sachet per day 6) Reduced frequency of follow-up visits and 7) Use of CHWs to treat acute malnutrition including medical treatment.

Introduction

In December 2019, China declared an epidemic caused by a new coronavirus (SARS-CoV-2), called Coronavirus disease 2019 or COVID-19. To date, all continents are affected with the epidemic. Given the severity of the situation, the Executive Director of the World Health Organisation (WHO) declared on January 30, 2020 this epidemic “a public health emergency of international scope” (USPPI), then since March 11, 2020 as a pandemic.

Like other African countries, the DRC was under-prepared to deal with the COVID-19 pandemic. Despite the preventive measures put in place, the country was affected as of March 10, 2020. From this day to May 16, 2020, the country has recorded 1,455 cases with 61 deaths. Currently (May 18, 2020) 7 provinces are affected (City of Kinshasa: 1,356 cases; Kongo Central: 72 cases; Haut-Katanga: 11 cases; North Kivu: 8 cases; South Kivu: 4 cases; Ituri: 2 cases and Kwilu: 1 case). The provincial city of Kinshasa remains the epicenter of the epidemic.

To respond to the spread of the epidemic, the Ministry of Health through the national nutrition program (PRONANUT) in collaboration with the Nutrition Cluster developed and disseminated throughout the country a guidance manual¹ providing recommendations for adjustments that could be made in routine nutrition programs (including in and outpatient treatment of acute malnutrition in children under 5, IYCF-E, and treatment and prevention of malnutrition amongst pregnant and lactating women). This manual gives practical recommendations to minimize the risk of nutrition programmes becoming sources of transmission for COVID-19.

This guidance manual goes into further detail in different areas of programming in a series of annexes (anthropometry, wasting, messages for health workers and communities and IYCF-E). The annex on wasting recommends that Integrated Management of Acute Malnutrition (IMAM) programmes should integrate further adaptations to treatment of acute malnutrition to reduce opportunities for transmission of COVID-19. The adjustments are community-based (such as Family MUAC and behaviour change communication for IYCF-E) and initiating simplified approaches by volunteers in areas where it is possible, and resources are available. Simplified approaches include a range of modifications to the standard IMAM approach such as the use of mid-upper arm circumference (MUAC) as the main criterion for admission, follow-up and discharge, expansion of the MUAC cut-offs, adjustment to the quantity of RUTF given, treating both SAM and MAM under OTP, use of volunteers to treat uncomplicated SAM, and reduction in the frequency of follow ups.

The Ministry of Health (MoH) in collaboration with the Nutrition Cluster decided to pursue the recommendations on simplified approaches outlined in the guidance manual in April 2020. A (as yet undefined) package of simplified approaches for the management of acute malnutrition was piloted in five different health zones. The five health zones (Gombe, Binza Ozone, Bonza Meteo, Manono and Nyankunde) were selected for this pilot as they represent some of the most affected districts by COVID-19 (Gombe, Binz Ozone and Binza Meteo have most cases of COVID-19 and Manono and Nyankunde (from Kalemie and Ituri provinces respectively represent rural contexts).

¹ [Manuel d'orientation sur la Nutrition et la pandémie de COVID-19 en République Démocratique du Congo, 1 Avril 2020, République Démocratique du Congo Cluster Nutrition et Ministère de la Santé Publique et les annexes](#)

Purpose

At country level, there was no firm decision as to what the package of the simplified approaches would entail. A consultation process was carried out in order to determine the most appropriate package of the simplified approaches. Consultation was carried out to consider the challenges involved in certain approaches (e.g. using MUAC as the sole admission, monitoring and discharge criteria) and assess measures to mitigate those risks (e.g. using expanded admission criteria). The purpose of the consultation process was to avail a platform for dialogue on the simplified approaches. Different aspects were appraised to determine the most appropriate package of simplified approaches to be implemented in the selected zones.

Overall objective

To provide a forum for all stakeholders including partners directly implementing IMAM activities to review the key aspects on the different simplified approaches including pros and cons and share their views and opinions to determine the most suitable approaches to use considering the COVID-19 context in each of the selected health zones.

Specific Objectives

1. Provide participants with an overview of the various simplified approaches
2. Collect information on the insights and concerns the partners have about the simplified approaches and the feasibility of? their implementation.
3. Understand the partner's needs in terms of knowledge and support in order to implement adaptations.
4. Agree on the appropriate package of simplified approaches to implement in the current context.

Methodology

All activities and support were carried out remotely. Qualitative methods were used to gather information. A list of 37 persons (see list in annex) compiled by the nutrition cluster coordinator from the DRC TWG on IMAM, PRONANUT, UNICEF, WFP and NGOs including national NGOS was used as the stakeholder database for the consultation process. The process entailed consultative discussions, an individual questionnaire, prioritisation matrix and a final discussion on the selected package of simplified approaches by a small taskforce.

Consultative meetings. A series of meetings were carried out. The first meeting had 37 participants (see list in annex). During this meeting, the overall purpose of the Terms of Reference for the Tech RRT support and objectives of the consultation were shared. The process was discussed in detail including the matrix. At the same meeting a brief presentation was given by the Tech RRT Advisor on the various simplified approaches and their advantages, disadvantages, potential challenges during implementation and suggested solutions. In the same meeting, the methodology to complete the prioritisation matrix was discussed.

The activities undertaken during the consultation process were:

- Online group discussions: 2 group meetings were held online with the audience to discuss the approaches, the advantages and disadvantages and potential challenges during implementation and suggest solutions. Bilateral discussions were held with the partners key NGOs, UNICEF and WFP.
- The prioritization matrix: was an opportunity for assessing capacity, preparedness and willingness at organisation level for the various adaptations. A list of contributing (or blocking) factors was established. Using a scale from 1 to 5 (5 for very strongly and 1 not at all), a given factor was scored for how much it contributed to or impacted the implementation of the adaptations. The information captured in the matrix encompassed structures in place, ease of implementation, willingness of partners and resources; and will be used to determine and prioritise which approaches are best suited in the current context. The thematic areas looked at the following:
 - Overall contribution of the approaches to the organisational strategy
 - Health structure and infrastructure in place at field level
 - Human resources
 - Operations including logistics
 - Aspects specific to COVID-19 (additional supplies, PIC, PPE, challenges e.g refusal of workers to provide services, refusal of community members etc)
 - Community engagement including a gender sensitivity component.
- **Online Questionnaire for participants using monkey survey:** The online questionnaire was sent to all the 37 participants to get their views and opinions based on their knowledge of the current context and where possible, their experiences on the use of simplified approaches in the context of COVID-19. The questionnaire focused on the participants experiences and knowledge on the approaches, feasibility on ground based on current programming and potential quality challenges.
- **Continued dialogue and communication during the process:** As the various organisations were compiling the matrix, communication was maintained to ensure that the different partners understood what was required. Additional discussions were held with some of the partners when the completed matrices were reviewed to get clarification on some of the information reported.

Data collection

The whole consultation process took place remotely led by the Tech RRT Advisor with support from the Cluster Coordinator. A brief on the simplified approaches was shared in advance so that the participants were informed. The prioritisation matrix and individual questionnaire were aimed at getting the participants to share opinions and concerns about the approaches and the way forward were used. The whole process took 14 days.

Methods used were:

1. Facilitation of discussions during the meetings.
2. Conference calls for the bilateral discussions with the partners.
3. One-on-one interviews. The number of interviews carried out were determined by the outcome of the group and bilateral discussions. In total 3 interviews were held.
4. Individual questionnaire
5. Listing of the key prerequisites for the selected package during the training on the simplified approaches.

Risks and limitations

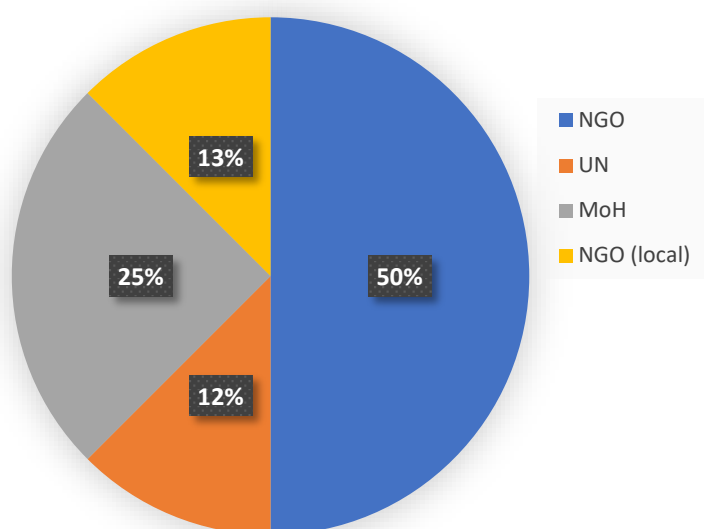
Table 1: Risk and limitations

<i>Limitation</i>	<i>Mitigation</i>
Challenges working virtually (poor connectivity, limited knowledge of platforms/applications, limited coordination).	Provision of various online platforms including some that utilise low internet bandwidth or could be accessed via both computers and smart phones. There was also the option to make telephone calls. Coordination from the nutrition cluster coordinator was also very helpful.
Limited participation.	Using various tools to keep the participants engaged, use of video as much as possible and ensuring good facilitation.
Unrealistic expectations given the timeframe, technology available and method of support.	The TechRRT advisor ToR was shared with UNICEF and PRONANUT. During the introductory meeting, the purpose and objectives of the consultation and overall support were clearly explained.
Competing priorities among some of the participants.	Proper identification of participants, clear communication of the objective of the consultation and sharing in a timely manner all relevant information including dates when various activities will be carried out, time.
Finding a common ground on the most feasible package of simplified approach to pilot.	Structured discussions and ensured participants understood well the prioritisation matrix that was used. Ensured an atmosphere is cooperation and mutual respect during discussions.

Results

Participants

The consultation process was participated in by various MoH staff, UN and organisations represented by a total of 37 participants. These included: Unicef, PRONANUT, representatives from the IMAM, iCCM department, nutrition monitoring and surveillance and the IYCF-E TWGs, Caritas-Congo, INTERSOS, IRA national program, ADRA, ALIMA, SDC, COOPI, SCI, MDA, WFP, MSF and ACF. All the 37 persons attended the 2 key meetings (initial meeting and the results sharing meeting), while 9 organizations completed the prioritization matrix and 19 people responded to the Individual questionnaires.



Of the 19 individual questionnaires received, 50% of the responses were from INGOs followed by the MoH, the UN and national NGOs. To note is that 3 of the 19 questionnaires were incomplete and so were not included in the analysis.

Experiences with the simplified approaches.

Overall 37.5% (6) out of the 16 respondents to the individual questionnaire have experience in one or more of the adaptations. PRONANUT Staff had very limited experience that they did not score themselves as “having experience” in general. Participants had more experience with 1) using a single product for the treatment of MAM and SAM, 2) the family MUAC and 3) reducing follow-up visits. The adaptation they were least familiar with was the treatment of acute malnutrition by the community health workers or volunteers. For most of the respondents, their experience comes from the pilot projects currently ongoing in DRC and some from other countries such as Niger and South Sudan. For most of the participants from the MoH side, their experience is from interacting with partners that are piloting the adaptations in the country.

Table 2: Experiences on the various adaptations

Adaptation	No experience	A little experience	Experience
Detection and treatment of both SAM and MAM in one programme and at delivery-point.	56% (9)	19% (3)	25% (4)
Using a single product to treat SAM and MAM	50% (8)	19% (3)	31% (5)

Using MUAC and Oedema as the admission and discharge criteria	63% (10)	0% (0)	37% (6)
Modifying the quantity of RUTF: a) amount given not based on weight (2:1 for SAM: MAM).	62.5% (10)	25% (4)	12.5% (2)
Modifying the quantity of RUTF: b) Progressive reduction of dosage of RUTF, either for SAM patients or for all acutely malnourished children as they recover.	56% (9)	31% (5)	13% (2)
Reducing frequency of follow-up visits	44% (7)	19% (3)	37% (6)
Use of CHWs to manage malnutrition without complications including medical treatment (SAM and MAM)	81% (13)	6% (1)	13% (2)
Family MUAC approach	43.7% (7)	12.5% (2)	43.7% (7)

Feasibility of the approaches.

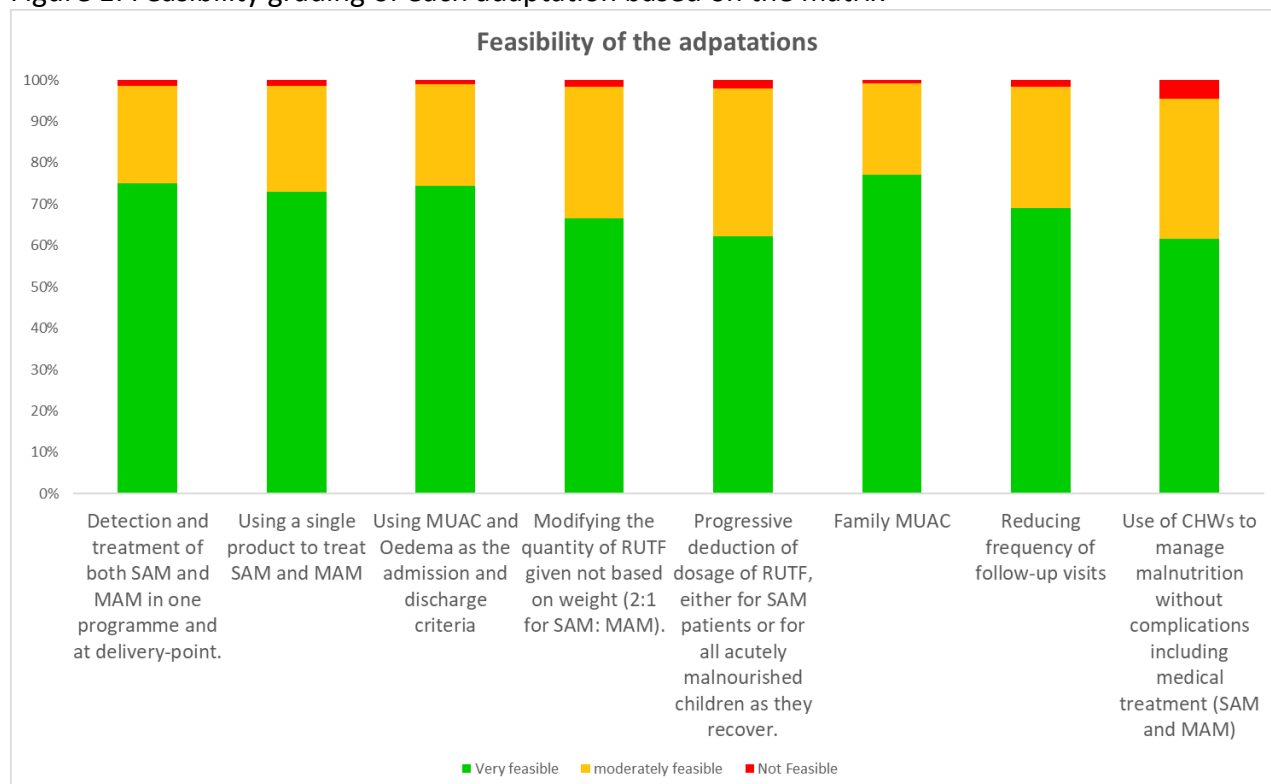
All organisations reported the various adaptations being relevant to their overall organisational strategy, with each adaptation being given a score of 5 on average in the prioritisation matrix. Based on the six thematic areas that were looked at; family MUAC approach, use of MUAC-only including oedema to admit, follow up and discharge and combined treatment of SAM and MAM under one program were the top three adaptations considered feasible.

The scoring from the individual questionnaires was similar to what was presented in the matrix. Although the top 3 were the same, the top in the individual questionnaire was the use of MUAC-only including oedema to admit, follow up and discharge followed by use of one product to treat both SAM and MAM and thirdly the family MUAC approach.

The reasons for the prioritizing of family MUAC included:

- Existing capacity among partners
- More experience with the MUAC approach as it has been implemented longer than the other adaptations
- The quality component is still the responsibility of health workers
- Availability/easy access to MUAC tapes
- Potential to cover villages that are very remote

Figure 1: Feasibility grading of each adaptation based on the matrix



From the prioritisation matrix, treatment of acute malnutrition including medical treatment by community health workers was considered the least feasible. This was followed by Progressive reduction of dosage of RUTF either for SAM patients or for all acutely malnourished children as they recover and reducing frequency of follow-up visits. The same ranking was deduced from the individual questionnaires. The major concerns for considering the mentioned adaptations as the least feasible included:

- Quality issues e.g. concerns that Community Health Workers would not manage the complex care involved especially in administering the medication.
- Limited engagement of the health works with community actors including the CHWs.
- Supplies challenges including irregular pipelines, distribution especially in hard to reach villages, storage and safety of supplies at community level.
- Limited capacity to incentives Community Health Workers effectively.

Prioritisation by thematic area.

The term prioritisation was used to mean how feasible a given adaptation would be. The feasibility was ranked from most feasible to least feasible denoted as option 1 for most feasible through to option 6 for the very least feasible. Each adaptation was analysed against each of the six individual thematic areas. This was done to find which adaptation would be considered most suitable given the available resources, capacity and health system structure in place. Family MUAC and use of MUAC as the only criteria for admission, follow-up and discharge were the most prioritised adaptations. When the simplified approaches were analysed individually for each thematic area, Family MUAC was chosen as the first option in 5 out of 6 thematic areas. The use of MUAC only for admission,

screening and discharges was chosen as the first option in 3 out of the 6 thematic areas. To note is that although the use of CHWs to manage malnutrition without complications including medical treatment was scored the least feasible/preferred adaptation, it ranked second most feasible option when analysed against the community thematic area. The other adaptations received varied scores from second to fourth options as shown in the table below. There was no 5th and 6th options as some approaches were ranked the same position for 2 or more thematic areas.

Table 3: Simplified approaches prioritisation based on individual thematic area.

Examples of the approaches	Composant						
		Current organisational program strategy	Health system structure at field level	Human resources	Operational aspects/implementation including logistics.	Specific to COVID-19	Community
	Detection and treatment of both SAM and MAM in one programme and at delivery-point.	Option 3 (14%)	Option 2 (13%)	Option 1 (13%)	Option 1 (13%)	Option 4 (11%)	Option 2 (13%)
	Using a single product to treat SAM and MAM	Option 4 (12%)	Option 3 (12%)	Option 1 (13%)	Option 2 (12%)	Option 3 (12%)	Option 3 (12%)
	Using MUAC and Oedema as the admission and discharge criteria	Option 2 (15%)	Option 1 (14%)	Option 1 (13%)	Option 1 (13%)	Option 2 (13%)	Option 2 (13%)
	Modifying the quantity of RUF given not based on weight (2:1 for SAM: MAM).	Option 4 (12%)	Option 2 (13%)	Option 1 (13%)	Option 1 (13%)	Option 2 (13%)	Option 3 (12%)
	Progressive deduction of dosage of RUTF, either for SAM patients or for all acutely malnourished children as they recover.	Option 5 (11%)	Option 3 (12%)	Option 1 (13%)	Option 1 (13%)	Option 2 (13%)	Option 3 (12%)
	Family MUAC	Option 1 (16%)	Option 1 (14%)	Option 2 (12%)	Option 1 (13%)	Option 1 (14%)	Option 1 (14%)
	Reducing frequency of follow-up visits	Option 4 (12%)	Option 1 (14%)	Option 2 (12%)	Option 1 (13%)	Option 2 (13%)	Option 2 (13%)
	Use of CHWs to manage malnutrition without complications (SAM and MAM) including medical treatment.	Option 6 (9%)	Option 4 (6%)	Option 3 (11%)	Option 3 (11%)	Option 4 (11%)	Option 2 (13%)

Selection of a package of the simplified approaches to implement.

Following the analysis and presentation of the results from the prioritization matrix exercise and the individual questionnaires, it was agreed to create a task force to look at the resources currently available for the piloting to begin. The task force included the CMAM TWG, UNICEF, WFP and PRONANUT. During the discussions that took place in one day, 7 adaptations were agreed upon and key prerequisites listed for each adaptation. The agreed upon package includes the following adaptations:

1. Family MUAC
2. Use of MUAC and Oedema as the criteria for admission, follow-up and discharge
3. Combined treatment of SAM and MAM as one program
4. Use of a single product (RUTF) for the treatment of both SAM and MAM
5. Modification of the amount of RUTF provided not based on weight (SAM cases 2 sachets and MAM cases 1 sachet per day)
6. Reduced frequency of follow-up visits
7. Use of CHWs to treat acute malnutrition without complications including medical treatment

During the same meeting it was agreed to find ways in which children that are likely to be left out when using the MUAC-only approach would be catered for. One of the suggestions included distribution of PlumpyDOZ to all children found to have a MUAC from 125mm to 130mm.

The prerequisites for each adaption from the taskforce are indicated in the table below in addition to prerequisites that were obtained during the trainings that took place soon after the consultation. The prerequisites from the training were based on in-depth understanding of the different adaptations. The trainings took place in 3 phases between the 15th and 30th of July 2020

Table4: Prerequisites for each adaption as proposed by the taskforce and from the trainings

Analysis of the feasibility of the adaptations within the framework of piloting the simplified approaches for the management of MAM and SAM without complications in the context of COVID-19	
Adaptation	Prerequisites
Family MUAC	<ul style="list-style-type: none"> • Strengthened monitoring of the community actors • Motivation • Improved availability of MUAC tapes • Training of mothers on the family MUAC approach • Feedback mechanism
Using MUAC and Oedema as the admission, follow-up and discharge criteria	<ul style="list-style-type: none"> • Implementation of preventive interventions (IYCFE, PlumpyDoz for children at risk etc) to provide an alternative to children who will be excluded from admission by applying this criterion • Increase the MUAC-cut-off point
Detection and treatment of both SAM and MAM in one programme and at delivery-point.	NONE
Using a single product to treat SAM and MAM	<ul style="list-style-type: none"> • Ensure adequate availability of RUTF for both SAM and MAM cases • Proper orientation of all actors (health workers, CHWs, community) • Good mechanisms for supplies management up to community level
Reducing frequency of follow-up visits	In zones affected by COVID-19
Modifying the quantity of RUF given not based on weight (2:1 for SAM: MAM).	<ul style="list-style-type: none"> • Strengthen medical and nutrition monitoring • Implement individual follow-up and documentation
Use of CHWs to manage malnutrition without complications including medical treatment (SAM and MAM)	<ul style="list-style-type: none"> • In health zones where IMCI and iCCM are active • CHWs are active and receive motivation. • Trained staff to orient the CHWs • Strengthened supervision and monitoring at community level • Development of appropriate monitoring tools for the CHWs.

Conclusion and recommendations.

Simplified approaches are recommended not only to help with reducing the risk of transmission of COVID-19 but also have the potential to contribute to overall improvement of the CMAM strategy. Simplified approaches are meant to increase the simplicity of prevention and treatment of acute malnutrition by improving quality, cost, coverage and continuity. The selected package of approaches was based mainly on resources available and capacity on the ground. Each organisation had varying scoring of feasibility (very feasible, moderately feasible and not feasible) for a given adaptation but globally it was accepted that the 7 adaptations are possible to implement in the selected zones.

The selected adaptations:

1. Family MUAC
2. Use of MUAC and Oedema as the criteria for admission, follow-up and discharge
3. Combined treatment of SAM and MAM as one program
4. Use of a single product (RUTF) for the treatment of both SAM and MAM
5. Modification of the amount of RUTF provided not based on weight (SAM cases 2 sachets and MAM cases 1 sachet per day)
6. Reduced frequency of follow-up visits
7. Use of CHWs to treat acute malnutrition without complications including medical treatment

The prerequisites as discussed by the taskforce will be key in ensuring effective piloting of the approaches. It is therefore critical that all nutrition cluster partners together with the PRONANUT collectively ensure that these prerequisites are adhered to as the minimum requirements to ensure a strong foundation for implementing the adaptations.

It is important that the simplifications should not be seen as a magic bullet to the inherent health system challenges but rather as opportunity to further tackle the already existing weaknesses and an avenue to continuously find ways to improve nutrition programming in the country. Therefore, the cluster should ensure to create a platform for discussions on the need for a shift in the way the CMAM program is implemented, the existing challenges and solutions; these discussions should also include the donors.

Annexes

Annex 1: Agenda for the group meetings

- Presentation of a brief on simplified approaches
- Presentation of information on the consultation process (objectives, approach, outcomes)

- Discussion of the pros and cons of the approaches
- Feedback session on opinions, concerns and of the potential challenges during implementation.
- Discussion on how to complete the prioritisation matrix of the approaches
- Question and answer session.

Annex 2: List of participants

List of participants in the consultative meeting on the simplified approaches.			
#	Name	Position	Institution/Organisation department
1	Kalil SAGNO	Nutrition Cluster Coordinator	UNICEF
2	BUMBA N'LOSI Nono	Président GTT	GTT PCIMA -RDC
3	Tusuku Toussaint	Chef division, formateur PCIME	Pronanut
4	Georges Alain Tchamba	Point focal prévention et prise en charge MA, section nutrition	UNICEF
5	Patrice BADIBANGA	Nutrition spécialiste	PAM
6	Brigitte KINI	Co-présidente	GTT-Nutrition COVID 19 (OMS)
7	DIAMFU MONGALA	Caritas	Caritas-Congo
8	Moussa ISSA	Nutrition Programme Manager	INTERSOS
9	Fidèle Ilunga	Formateur PCIME	Programme National IRA
10	Macky Kyusa	Nutrition Technical Advisor	ADRA
11	Kalala Danny	Coordonnateur cluster Nutrition-Mbujimayi	
12	Moise KABONGO	Nutrition officer	Bureau UNICEF région Ouest
13	Vanessa Cimpaka	Membre GTT	GTT PCIMA- RDC
14	Kambale Sabuni Damien		Pronanut
15	Viviane Malembasabuni	Chef service	Pronanut
16	Rosette Mbanza Tshiende	Point focal urgences, section nutrition	UNICEF
17	Ines LEZAMA	Cheffe section Nutrition	UNICEF
18	Milca BORAMWEMA	Nutrition specialist	PAM
19	JuanCarlos MARTINEZ	Chef nutrition	PAM
20	KENGE Eunice	Deputy Nutrition Technical Advisor	ADRA
21	Victoire Hubert	Resp. Recherche Optima	ALIMA
22	Allain Chikuru	IM cluster Nut	East Hub
23	Dr. Mbuyi Kazambu	Nutrition Programme Manager	SDC
24	Kévin PELLE	IMO cluster nutrition	GTT-SIN
25	Marie Petry	Responsable sante-nutrition	ACF
26	Annie MITELEZI	Présidente	GTT-ANJE-U

27	Beatrice Kalenga Tshiala	Directrice adjointe	Pronanut
28	Nelly Malela	Nutrition Manager, section nutrition	UNICEF
29	Mr. Jungkeun Lee	Nutrition Officer	PAM
30	Daouda Mbodj	Coordinateur Nutrition	COOPI
31	Matenda Mulonda Kalalu	Responsable sante-nutrition	SCI
32	Cecile CAZES	Chef de Projet scientifique d'OPTIMA RDC	ALIMA
33	Bienvenue MUTU	Point focal Nutrition	MDA
34	Dr. Primitive	Point focal MSF inter sections	MSF
35	Constant Mopaya Mbavumoya Shabani	Coordonnateur cluster nutrition	Cluster Ituri
36	Marie Petry	Responsable sante-nutrition	ACF
37	Izie Bozama Lievin	Coordonnateur cluster Nutrition-Kalemie	UNICEF

Annex 3: Simplified approaches prioritisation matrix



Microsoft Excel
97-2003 Worksheet

Annex 4: Individual consultation questionnaire.



Microsoft Word 97 -
2003 Document