

Project: Emergency response to the nutritional crisis among children aged 6 to 59 months in the Mongbwalu health zone in Ituri province, DRC.

Context and justification:

For several years, Ituri province has been experiencing a multifaceted humanitarian crisis characterized by persistent insecurity, intercommunal conflicts, armed violence, and massive population displacements. As of June 30, 2025, there were 1.56 million internally displaced persons (IDPs), a figure that is constantly rising and reflects the extent of the security volatility. In June 2025 alone, approximately 9,300 additional people were forced to flee their villages in Djugu territory following deadly attacks. These ongoing population movements profoundly disrupt livelihoods, limit access to agricultural land, disorganize markets, and increase dependence on humanitarian assistance (OCHA, 2025). This protracted situation significantly impacts food security. The 2024–2025 IPC analysis indicates that 33% of Ituri's population, nearly 1.5 million people, are experiencing acute food insecurity at level 3 or higher, a level that alone reflects the scale of the humanitarian needs. Surveys conducted in the most affected areas show that 40–55% of households have insufficient food consumption and that more than 60% resort to negative coping strategies such as reducing the number of meals per day, a mechanism that disproportionately affects children and pregnant or breastfeeding women.

The nutritional consequences of this prolonged vulnerability are particularly concerning. Recent data show that global acute malnutrition (GAM) in Ituri generally ranges between 7% and 12% depending on the health zone, often exceeding the alert thresholds defined by the SPHERE standards. Severe acute malnutrition (SAM) ranges between 1.5% and 3%, with higher rates in areas heavily affected by insecurity or that are isolated. In addition to these nutritional vulnerabilities, there is a high prevalence of childhood illnesses: malaria accounts for nearly 50% of consultations, diarrhea approximately 20%, and acute respiratory infections 15%. In 2024, 34,128 children suffering from severe acute malnutrition (SAM) were admitted to nutritional units in the province, despite limited and insufficient capacity to meet the actual needs.

According to the SMART Territorial survey conducted from June 18 to August 18, 2025 by the NGO GRAINES with funding from UNICEF in five territories of Ituri (Aru, Djugu Irumu, Mahagi and Mambasa), the nutritional situation observed among children aged 6-59

The prevalence of severe acute malnutrition (SAM) in the five territories of Ituri is very low in Irumu (1.8%), precarious in Aru (7.3%) and Mahagi (7.2%), and concerning in Djugu (4.3%) and Mambasa (14.1%). The prevalence of underweight is precarious in Djugu (17.8%), Aru (19.9%), and Mahagi (15.8%), and concerning in Irumu (20.5%) and Mambasa (24.9%). However, chronic malnutrition is at the critical threshold in all five territories, ranging from 40.1% to 46.6%.

The Mongbwalu health zone, located in the Djugu territory, is at the heart of this crisis. With an estimated population of 183,222, including a significant number of displaced households, it has particularly alarming rates of acute malnutrition: 11% for acute malnutrition and 2.5% for severe acute malnutrition, according to the SMART survey conducted by PRONANUT and ACF (2025). These figures exceed emergency thresholds and reflect an advanced state of vulnerability. Furthermore, large parts of the zone remain difficult to access, mainly due to persistent insecurity and the rainy season, which makes travel to health facilities extremely complicated, slows down screening activities, and increases the number of children arriving in critical condition. Approximately 40% of health areas are considered difficult to access, a factor that directly impacts the effectiveness of the malnutrition treatment program.

Operational constraints are numerous. Roads are in poor condition, making the delivery of nutritional supplies and essential medicines irregular. Prolonged stockouts have been recorded in several facilities, compromising continuity of care. Healthcare staff suffer from a lack of specific training in Integrated Management of Childhood Illness (IMCI), and formative supervision remains irregular, leading to significant variations in the quality of services. In some facilities, dropout and attrition rates reach 10 to 15%, exceeding international standards. At the same time, community screening coverage remains low: in some health areas, fewer than one in three children is screened each quarter. This low early detection rate increases the proportion of children arriving in critical condition or with medical complications.

Nutritional vulnerability is exacerbated by seasonal, economic, and epidemiological factors. During the rainy season, some areas become virtually inaccessible, leading to a drop in consultations and hindering the referral of complicated cases. Food price inflation, sometimes reaching 20 to 40% in a single year, further reduces households' ability to access nutritious food. Moreover, outbreaks of malaria, diarrhea, or measles, combined with limited access to safe drinking water and poor hygiene, contribute to the development of waterborne diseases, major aggravating factors in acute malnutrition.

It is crucial to emphasize that the Mongbwalu health zone currently has no support partners for the IMCI program. The lack of technical, logistical, and operational support constitutes a critical gap that exposes children to an increased risk of morbidity and mortality related to severe acute malnutrition (SAM). It significantly compromises the continuity and quality of services in a context already marked by a high prevalence of acute malnutrition and humanitarian pressure. constant.

In the absence of technical, financial, and logistical support, health facilities operate with limited capacity, both in terms of staffing and the supply of essential nutritional inputs. Community screening activities remain irregular, the availability of therapeutic milk and Plumpy'Nut is frequently disrupted, and training supervision mechanisms are not fully operational. This situation increases the risk of morbidity and mortality among children under five, who are already particularly vulnerable in this context of chronic instability.

The lack of a nutritional partner also undermines the integration of the Integrated Management of Acute Malnutrition (IMAM) program into the minimum package of activities for the Health Zone. Management teams find themselves without support to strengthen staff capacity, ensure monitoring and evaluation, improve data collection, or implement prevention measures at the community level. Furthermore, the absence of logistical support limits the capacity of facilities to refer complicated cases to functional stabilization units, thus exacerbating delays in treatment and increasing the risk of clinical deterioration.

In this context, the implementation of an emergency project to address severe acute malnutrition in the Mongbwalu health zone is an urgent humanitarian necessity. Priority needs include improving community screening, strengthening care structures, ensuring a regular supply of nutritional inputs, building the capacity of healthcare personnel, supporting the referral and counter-referral system, and integrating preventive interventions. The actions proposed by RUPFA are fully aligned with the priorities of the Nutrition Cluster in the DRC, the guidelines of the Ituri Provincial Health Division, and the needs explicitly expressed by the Mongbwalu health zone. They meet the requirements of international standards and are consistent with national strategies for the integrated management of acute malnutrition.

The well-coordinated intervention proposed by RUPFA will not only reduce mortality and complications related to SAM, but will also sustainably improve the capacity of the local health system to manage nutritional emergencies in a context of prolonged crisis.

Implementation strategy and technical guidelines:

RUPFA's implementation strategy for this project aims to ensure effective care for children suffering from severe acute malnutrition, both in hospital settings (UNTI), outpatient settings (UNTA), and at the community level, in accordance with the adapted IMCI modules, 2025 version. Simultaneously, it aims to strengthen the health system's capacity by building on the six pillars defined by the WHO: financing, supply, governance, human resources, health information systems, and quality of services. This strategic approach promotes the sustainable integration of IMCI into the minimum package of activities for health facilities, while taking into account accountability mechanisms and community engagement.

The strategy adopted in this project is based on an innovative, integrated, and community-centered approach that combines an adapted IMCI approach, decentralized care, and active family participation. This approach is distinguished by several major innovations adapted to the complex humanitarian context of the Mungwalu health zone:

1. PCIMA approach adapted with a single product (ATPE)

One of the project's key innovations lies in the adoption of the adapted IMCI approach, which combines the use of a single nutritional product (RUTP) to treat both severe acute malnutrition (SAM) and moderate acute malnutrition (MAM), with the decentralization of care to the community level. Within this framework, Outpatient Therapeutic Nutrition Units (OTNUs) located in health centers will provide care for children with SAM without medical complications and children with MAM living within a 5 km radius, including those referred by Community Action Centers (CACs). Children residing more than 5 km from health facilities will be cared for directly within the CACs by community health workers. Intensive Therapeutic Nutrition Units (ITNUs), on the other hand, will manage cases of SAM with complications at the general referral hospital. Admissions will be organized continuously, every day of the week, in order to consider malnutrition like any other pathology requiring rapid care and not constrained by consultation days.

RUPFA also plans to strengthen the capacity of healthcare personnel and community health workers in applying the adapted IMCI protocol, with a particular focus on managing medical complications. The technical facilities of the Infection Prevention and Control Units (INCUs) will be reinforced to improve the quality of care and maximize the survival chances of hospitalized children.

This simplification:

- reduces input shortages and classification errors;
- facilitates the work of service providers and RECOs;
- accelerates the admission and monitoring process;
- reduces the risk of children with MAM progressing to MAS.

In a context of insecurity, where travel is difficult and resources are limited, this approach allows for a more effective and consistent continuum of care.

2. Decentralization of care by the CACs

The project strengthens Community Animation Cells (CACs) so that they become advanced care points. Children living in remote villages (more than 5 km from the health facility) or in hard-to-reach areas can receive screening, monitoring, and first-line treatment there.

This decentralization:

- brings services closer to households located more than 5 km from health centers;
- reduces dropouts due to distance and security constraints;
- relieves pressure on health facilities;
- improves community-level nutritional monitoring.

The RECOs thus become key players in the detection and regular monitoring of children.

3. “Family brachial circumference” (FB family) approach

This strategy gives caregivers a direct role in the early detection of malnutrition. This approach relies on their ability to quickly detect the first signs of malnutrition and their participation in improving their children's health. Training caregivers and family members will increase screening coverage and promote early detection, thus reducing the risk of death and medical complications. Thanks to simple and reliable tricolor MUAC bracelets, families can regularly measure their children's mid-upper arm circumference at home. When the PB bracelet indicates a yellow or red color, the caregiver will go to the RECO (Regional Nutrition Observatory) for confirmation. If the child's nutritional status is

If confirmed as having severe acute malnutrition (SAM), the screening will be recorded on the reference token, mentioning the guardian. If the child is screened directly by the RECO (Regional Early Intervention Center), the admission will be assigned to the latter.

In addition to the PB-Family approach, systematic screening will be conducted for all children presenting at health facilities. Specific columns will be added to consultation registers to record anthropometric measurements. Given the ongoing outbreaks, staff will verify whether the caregiver has been trained in the PB-Family approach, whether they have screened the child themselves, and whether there is consistency between the color of the wristband, the presence of edema, and the measurements taken by healthcare personnel. In case of inconsistency, immediate retraining will be provided for the caregiver. Every opportunity will be used to ensure that each child has completed their vaccination schedule.

Each month, staff will assess the work of the community health workers (CHWs) and community health workers, take necessary corrective actions, and compare admissions resulting from active and passive screening, as well as the number of children referred by CHWs with those actually admitted and vaccinated. Random household testing will assess the workers' ability to correctly use the MUAC strip, ensuring ongoing monitoring and continuous skills development for staff and community health workers. The effective implementation of the mid-upper arm circumference (MUAC) approach will identify children at an early stage of acute malnutrition, before complications develop. This early detection will reduce the amount of adult-to-child diet (ATCD) needed for treatment, shorten the length of stay in the program, and allow for the treatment of more children than anticipated due to savings on inputs.

Innovation is based on:

- continuous monitoring by families;
- early detection before the onset of complications;
- reducing the time between the appearance of symptoms and treatment;
- empowering parents in their children's health.

This approach is particularly relevant in the context of recurring crises, where children often seek medical help late at a health center.

4. Integrated community monitoring and pre-registration of children

Each RECO maintains a pre-registration register for children, including those:

- delayed vaccination; -
- zero doses; -
- living in households that are difficult to access.

This innovation facilitates the link between nutrition and vaccination, especially in the context of a measles outbreak and other epidemics. The RECOs quickly direct children to fixed or advanced vaccination sites, thus improving vaccination coverage.

Passive monitoring in health centers is compared to screenings carried out at home or in community health centers, which allows for:

- to assess the consistency and quality of the measures;
- to adapt the training of RECOs and families;
- to identify gaps in screening;
- to strengthen the community system over the long term.

5. High-impact nutritional preventive interventions

The prevention component of this project will be implemented through several key interventions:

Promoting infant and young child feeding in emergencies (IYCF-E) is essential for saving lives and preventing malnutrition in all its forms. Within this framework, mothers and children will be educated at both healthcare facilities (antenatal care, maternity wards, primary care centers, primary healthcare centers, curative consultations) and community levels (IGF-E, mass awareness campaigns, home visits, community health center meetings, cooking demonstrations, etc.). This promotion will focus on breastfeeding from the first hour after delivery, exclusive breastfeeding, continued breastfeeding, and complementary feeding, including nutrition for pregnant and breastfeeding women. At each contact, the mother and child will undergo a rapid assessment to determine the necessary follow-up actions. The project will also emphasize hygiene practices, particularly handwashing and water treatment at home, along with the establishment of breastfeeding sites.

in facilities to facilitate mothers' privacy and encourage breastfeeding. The main objective is to improve the population's knowledge and attitudes regarding infant and young child feeding (IYCF).

Cooking demonstrations will be used to show mothers how to prepare nutritious meals using local produce. These demonstrations will include tasting and educational sessions held at health centers, schools, and within the community to reach both malnourished and well-nourished children. Healthcare providers and community health workers, accompanied by NGO teams, will analyze the foods available, accessible, and culturally acceptable in the area and select two to three recipes from 21 existing ones for demonstration and community adoption for children under five.

To strengthen **the revitalized preschool consultation (RPC)**, the focus will be on individual counseling to prevent chronic malnutrition and other serious childhood illnesses. RPC, deployed as an outreach strategy with the support of community health workers, will enable parents to bring their children to the Early Childhood Center (ECC) once a month until age 2, and then once a quarter until age 5, for monitoring of their health, growth, and development. Promotional interventions will include growth monitoring, promotion of infant and young child feeding (IYCF), and other family practices such as the use of insecticide-treated bed nets, handwashing, and the use of hygienic latrines. Preventive measures will include vaccination of children aged 0 to 11 months, vitamin A supplementation at 6 months, and deworming with mebendazole.

The provision of nutrient-rich infant foods will be targeted to all healthy children aged 6 to 23 months to prevent malnutrition. Each child will receive a one-month supply of 15 sachets of nutrient-rich infant foods, to be consumed at a rate of one sachet every two days, with the goal of using all 15 sachets within 30 days. Distribution will preferably be carried out at the community level by local organizations (CODESA, CAC, RECO); where RECO is not active, distribution will take place during community health centers (CPS), but the two strategies will not be used simultaneously within the same health area.

Early childhood stimulation (ECD) will be integrated for children admitted to the Intensive Care Unit (INT) to promote mental and emotional development and accelerate recovery. A facilitator and social worker will receive capacity building and material support to organize 30 minutes of stimulation activities daily (games, language, motor skills), prioritizing locally made toys. A fixed budget will cover snacks, supplies, and necessary materials. At the community level, community-based organizations (RECOs) will accompany mothers and caregivers during home visits and organize workshops to teach children how to make local toys using available materials (fabric, rope, cardboard, branches), thus ensuring the continuity of cognitive and emotional stimulation for the child within their home environment.

At the community level: RECOs will accompany mothers and caregivers on home visits to ensure that early childhood stimulation techniques are being applied correctly. They will also organize mass awareness sessions and practical demonstrations on how to play and communicate with children according to their age. In addition, RECOs will train mothers to make local toys from simple, readily available community materials such as fabric, rope, cardboard, or branches, to reinforce children's learning and development at home.

6. Quality assurance of the intervention

The project's quality assurance system aims to ensure that the services provided meet the standards and norms for malnutrition management. To this end, a quality assurance framework for Integrated Management of Acute Malnutrition (IMAM) will be used during joint missions with PRONANUT to strengthen the quality of interventions in the field. This framework will be shared with all partners of the Nutrition Cluster, thus enabling comprehensive analysis and exchanges between the different intervention areas.

To ensure the quality of implementation, management of funds and inputs made available to NGOs, several activities will be carried out:

- **PRONANUT central and provincial:** guarantor of standards, it will ensure the quality assurance of interventions, ensuring the correct application of the protocol, the quality of ECZS supervision, accountability and input management, while providing technical support;
- **Health Zone Management Team (ECZS):** will provide technical support, monitor compliance with the protocol in the management of SAM, manage inputs, co-manage with the community and implement the selected community interventions;
- **Donor:** will monitor project activities, provide financial support and ensure the security of the program. Its missions will include programmatic visits, bilateral meetings on project progress and financial controls;
- **RUPFA technical supervisors:** will ensure daily and close monitoring of activities in the structures and the community, control the use of resources, monitor the quality of care and ensure reporting;
- **Health inspection:** will conduct control missions on the management of inputs in order to guarantee their proper use.

7. Combating Input Fraud

- Establishment of anti-fraud committees:

At the community level, anti-fraud committees will be established in each health area to oversee the management of nutritional inputs. These committees will participate in co-management, stock monitoring, and reporting any cases of sales or diversion of inputs. They will be involved in each supply delivery to healthcare facilities by jointly signing the input receipt. Unannounced inspections will also be conducted in markets to ensure the absence of illicit sales of inputs. The NGO will support the implementation of a functional information-gathering system, promoting community participation in monitoring cases of theft or diversion.

- Setting up suggestion boxes:

Suggestion and complaint boxes will be installed in all health areas and at the BCZS (Basic Health Zones), in locations accessible to all beneficiaries. Members of the anti-fraud committees will be trained on the importance of these boxes, and awareness campaigns will be conducted by community radio stations to encourage the community to report thefts or to express complaints and suggestions. The boxes will be reviewed monthly by the anti-fraud committees, the IT department, NGO supervisors, and the CODESA (Committee for the Development of Social Action) during participatory meetings.

- Involvement of the Provincial Health Inspectorate:

The NGO will work in collaboration with the Provincial Health Inspectorate, which will have access to all documentation related to the management of supplies (shipping slips, distribution plans, receiving slips, usage reports, etc.). Two quarterly inspection missions will be carried out to verify the proper use of supplies for the benefit of the end beneficiaries. In cases of proven misappropriation, disciplinary measures will be taken.

- End User Monitoring (EUM):

EUM activities will be conducted weekly to verify the correct use of inputs by the end beneficiaries. RUPFA will randomly select ten beneficiaries per week from health facilities and conduct home visits to monitor anthropometric parameters and input use. Tokens will be used to track each beneficiary and ensure accurate follow-up in the Integrated Management Units (IMUs) and Integrated Management Units (IMUs). The EUM will provide reliable information on the availability, quality, and use of RUTFs by beneficiaries.

- Beneficiary satisfaction survey:

The EUM surveys conducted at the beginning and end of the project will be combined with beneficiary satisfaction surveys to assess the impact of the interventions on households and the community. The questionnaires will be administered to the same beneficiaries at the same time as the EUM surveys.

- Nutrition Cluster and Technical Working Group on Inputs (GTT Inputs):

As a member of the National Nutrition Cluster and the Provincial Sub-Cluster, RUPFA will rely on the Technical Working Group (TWG) on inputs, which will facilitate the sharing of information on inputs used in health zones, the monitoring of early warnings in case of stock shortages, as well as coordination between partners involved in the management of severe acute malnutrition (SAM).

8. Improvement of the information system

- DHIS2

The project will facilitate support for encoding nutritional data in DHIS2 at the BCZS level and will support its analysis during monthly monitoring. The ECZS will be informed of the integration of this data into the National Health Information System (SNIS), via the supplementary module, and of its systematic analysis. The data entered into DHIS2 will be consistent with that transmitted by NGOs to the donor, thus ensuring the harmonization and reliability of the information.

- Data encoding

The project will support the monthly encoding of data from all individual monitoring forms for children in intensive care units (UNTA and UNTI) at the health facility level. Information concerning malnourished children will be entered upon their discharge from the program. This data will allow for the evaluation of the quality of implementation of the Integrated Management of Acute Malnutrition (IMAM) protocol, as well as the impact of the family-based approach on the early detection and management of severe acute malnutrition.

9. Strengthening cross-cutting protection and integrating PSEA/GBV

RUPFA will ensure the strengthening of cross-cutting protection, integrating gender, prevention, and the reduction of gender-based violence (GBV) into the implementation of project activities. The organization will apply its PSEA (Protection against Sexual Exploitation and Abuse) and GBV policy, with 100% of staff trained and adhering to the corresponding code of conduct.

Integrating PSEA/SGBV aspects into the malnutrition control program:

The project includes training and support for staff (online PSEA courses, briefing at the project's launch), briefing for healthcare providers on the prevention of abuse and gender-based violence, and raising awareness among community health workers (Reco and CAC) to detect and report cases in the community through suggestion boxes and an anonymous helpline. Information collected will be treated confidentially, and survivors will be referred to appropriate services.

In parallel, the project will encourage men's participation in child nutrition, through reflection and support groups, recognizing their crucial role in preventing malnutrition within the home and community.

The NGO will produce and distribute posters, stickers, and leaflets on the prevention of sexual exploitation and abuse (SEA) and gender-based violence (GBV). These tools, including the toll-free number for reporting cases, will be displayed in all UNTA and UNTI units in the targeted health zones, and leaflets outlining the code of conduct for humanitarian actors will be distributed to the community and staff.

Environmental and social safeguards

- **Protection of children and workers:** Children, whether accompanied or not, will enjoy all their rights and will never be used as labor. Workers will enjoy their rights, including a safe working environment and the proper use of the equipment provided;
- **Environmental protection:** The following measures will be applied to reduce environmental impact: responsible use of vehicles, drying laundry and equipment in the sun, reuse and recycling of objects, and raising awareness of environmental protection;
- **Waste management:** ATPE sachets will be destroyed by incineration or buried in secure pits to avoid any contamination.

Capacity building:

RUPFA will see its capacities strengthened through the project, covering technical, logistical, and administrative aspects. For the operational and financial monitoring of activities, management software will be implemented. The organization will also benefit from the implementation of

provision of a motorcycle and the coordination office in Bunia, as well as 7% of the project funds, which will allow, as far as possible, for the improvement of the daily lives of staff through the purchase of office equipment and necessary materials.

RUPFA staff will receive a one-week induction at the start of the project, covering a general understanding of the project, the PCIMA protocol, infant and young child feeding, revitalized preschool consultations, early childhood stimulation, and activity reporting. Weekly technical briefings will be held at the health zone level based on points identified during supervision visits, while the project manager will conduct monthly on-site coaching sessions. Quarterly, and based on the conclusions of monitoring and evaluation meetings, the program coordinator may provide training to RUPFA staff on specific topics or on certain stages of the project cycle.

Support staff will also receive induction and training tailored to their roles, including financial management, procurement and distribution, and the application of RUPFA's internal policies, particularly those related to human resources, the prevention of sexual exploitation and abuse, gender equality, and the fight against fraud and corruption. Upon completion of this training, each staff member will sign the code of conduct and related documents. Staff evaluations, conducted at the end of the probationary period and every six months thereafter, will identify and address any training needs in a targeted manner to ensure a competent and effective staff throughout the project.

Other partners involved:

It should be noted that all activities will be integrated into the health system, supported by RUPFA at each intervention.

- The project will also involve the National Nutrition Programme, both at the provincial and national levels (PRONANUT/DPS and national), for the management and technical monitoring of the project, as well as for the signing of the PCA;
- Daily coordination will actively involve the BCZS, local authorities and community leaders. The BCZS will supervise the care of children with SAM, screened by community relays, and will ensure regular monitoring of the project through formative supervision missions and strict control of the application of the PCIMA protocol;
- Health centers and health areas will form the basis of the project, concentrating the majority of activities within the framework of this emergency intervention;
- The CODESA of each health area will be revitalized and will support community relays, benefiting from the supervision of the health center and RUPFA;

- Community relays, members of IYCF support groups and journalists from community radio stations will be mobilized for the promotion of IYCF-U/PFE, cooking demonstrations, home nutritional monitoring and the dissemination of essential messages;
- RUPFA will strengthen coordination between all partners and actors under the leadership of the BCZS;
- The provincial nutrition cluster will provide support for sector coordination and gap analysis.

10. Gender, equity and sustainability

RUPFA systematically integrates gender and age considerations at every stage of the project, ensuring a participatory, inclusive, and active approach involving women, men, girls, and boys, while respecting the minimum commitments for cross-cutting protection of the Protection Cluster and the recommendations of the Nutrition Cluster. Gender equality is promoted in all activities, with effective representation of all segments of the population. The project encourages the genuine participation of children, women, men, and people with specific needs in decision-making, access to resources, and the expression of their interests, and guarantees equal opportunities in recruitment. Access to nutritional care is ensured without discrimination, regardless of age, sex, religion, social class, or sexual orientation. During training sessions and follow-up meetings, service providers are reminded of their obligations to protect beneficiaries and reduce waiting times at facilities. Home visits and random surveys of ten households per health area will be used to verify the quality of reception and services. The initial project analysis will examine the food access situation, the distribution of roles and responsibilities between men and women, as well as dietary habits, resource decision-making, and specific vulnerability factors according to gender and age. At the community level, men and women will be involved in the assessment, prioritization, planning, and implementation of activities. Focus groups with mothers and girls will be organized at the beginning, midpoint, and end of the project to gather their perspectives, ensure their specific needs are addressed, and reduce the risks of gender-based violence/child abuse. Furthermore, the project will strengthen men's awareness to actively involve them in child nutrition through dedicated discussion and support groups, recognizing their strategic role in combating malnutrition within households and the community.

Therefore, RUPFA commits, within the framework of this project, to systematically analyze the impact of the humanitarian situation on the food and nutrition of women, men, girls and boys, by identifying the obstacles to access to care.

The organization will ensure that service providers and structures are provided with appropriate tools to collect data disaggregated by sex, age, and type of disability, while taking into account specific vulnerability factors. Beneficiaries, RECOs, and the

Trained healthcare staff will also be disaggregated by sex and age, and training teams will be composed equally of men and women. Community consultations will systematically involve both women and men to adjust service hours and days according to their availability. Nutrition education activities will target both mothers and fathers, encouraging their involvement in managing malnutrition and providing food for women and children. RUPFA will analyze nutritional vulnerabilities, particularly affecting boys, and implement appropriate corrective measures, including awareness campaigns on their specific nutritional needs.

11. Equity Assessment

- **Screening and dosage:** Healthcare providers and community health workers responsible for screening and care will be systematically trained on the principle of equity in nutritional care. The aim is to ensure that each child receives the dosage that corresponds exactly to their nutritional status, without favoritism or discrimination.
In some contexts, irregularities are observed in the application of admission criteria or the distribution of nutritional supplies, with some children being favored over others. RUPFA will ensure strict adherence to admission criteria, as well as the allocation of quantities of supplies proportional to each child's actual needs. Furthermore, a special effort will be made to educate mothers on the early detection of severe acute malnutrition using the mid-upper arm circumference (MUAC) approach, utilizing all opportunities for contact with mothers and caregivers. Each admitted child will receive treatment aligned with their weight, clinical condition, and current protocols.
- **Stay in Intensive Care Units (ICUs) and physical accessibility:** In ICUs, where children are hospitalized, the program will support the mother or caregiver by guaranteeing them a daily meal for the entire duration of the therapeutic stay. Furthermore, upon referral, the project will cover the transportation costs for the patient and their caregiver, thus removing the economic barriers often responsible for delays or refusals of referrals. These measures aim to ensure genuine equity between children living near ICUs and those residing in remote or hard-to-reach villages. The most isolated and highly vulnerable areas will be integrated into the service delivery through the implementation of the CPSr's outreach strategy, which will improve access to remote households.
- **Children living with disabilities:** As part of this project, access to nutritional care will be guaranteed for all girls and boys, including children living with disabilities, without distinction or restriction related to their physical, sensory or cognitive condition.

- **Awareness-raising:** Women, who play a central role in feeding and caring for young children, will be the primary beneficiaries of nutrition education activities. They will receive tailored messages on nutrition, infant and young child feeding (IYCF), early childhood development (ECD), child health and development, and water, hygiene, and sanitation (WASH). Awareness-raising will promote the adoption of practices that support child health and prevent waterborne diseases, contributing to a sustainable reduction in morbidity and mortality related to undernutrition. Sessions organized at health facilities and within the community will be contextualized according to the specific needs and constraints of each beneficiary, household, or village. Particular attention will also be paid to fathers, who are often the main decision-makers regarding family expenses and responsibilities; they will be a priority target for certain support groups and awareness-raising activities. RUPFA will ensure an equitable distribution of available resources, taking into account the number of children targeted as well as the necessary equipment and tools. During awareness sessions as well as during training sessions, the questions and concerns of each participant will be welcomed, addressed and integrated as much as possible into the activities.

12. Sustainability Assessment

At the project's inception, RUPFA plans to strengthen the technical and operational capacities of the health zone, drawing on the six pillars of health system strengthening. The objective is to ensure the sustainable integration of nutritional interventions into the minimum package of activities. Simultaneously, particular attention will be paid to strengthening community participation in the prevention and management of malnutrition. These capacity-building efforts will enable local structures and the Central Health Zone Office (BCZS) to progressively achieve autonomy in managing nutritional activities, both in emergency situations and in stable contexts.

To strengthen local resilience, a buffer stockpile will be pre-positioned in the area to ensure the continuity of operations in the event of a security crisis or natural disaster that temporarily renders RUPFA teams inaccessible. The management of this stockpile will be organized jointly with the BCZS and the CODESA to ensure transparency, traceability, and optimal use.

All the measures put in place aim to ensure that the project's achievements continue to be used after its completion. Several levers will contribute to this sustainability. The PB-family approach, which strengthens the skills of mothers and caregivers in the nutritional monitoring of children under five, will become a sustainable practice within households. The project will also support the strengthening of CPSr (Community-Based Nutritional Support) at the health facility level, thereby improving the provision and use of nutrition services. Capacity building for service providers, through training, formative supervision, and...

Ongoing support will contribute to a lasting improvement in the quality of care and the performance of facilities after the project's completion. Active community participation will also be a key pillar of sustainability, fostering local ownership of interventions and continued engagement around nutrition. The gradual adoption of good food and nutrition practices by communities will further strengthen this dynamic.

The strategy for preventing and combating fraud or theft, implemented by village complaint management committees, with the involvement of the DPS and community actors, will facilitate the transfer of local skills to ensure continuous monitoring and strengthened governance after the end of the project.

13. Risk analysis and proposed mitigation measures

The implementation of the program is likely to face several risks that could affect the quality, acceptability, or continuity of the interventions. Identifying these risks and defining appropriate mitigation measures will guide program design, anticipate constraints, and ensure rigorous monitoring throughout the project.

- Social and environmental risks

A primary risk concerns beneficiaries' reluctance to adopt new dietary or hygiene practices. To address this, intensive awareness sessions will be organized, systematically involving community leaders and political and administrative authorities to strengthen community buy-in and participation. The lack of acceptance of certain activities by local leaders will also be mitigated by creating a supportive environment based on the active participation of community structures and the local nutrition committee. Furthermore, poor waste management, particularly of EAT sachets, poses an environmental risk. The project will encourage the safe disposal of packaging using available incinerators or, failing that, by constructing pits for waste disposal.

Physical access to intervention areas remains a major challenge, particularly during the rainy season when roads become impassable. To minimize disruptions to service delivery, supplies will be pre-positioned at remote facilities before the onset of the period of inaccessibility.

- Financial risks

The project could be exposed to cases of fraud, corruption, or embezzlement. To mitigate these risks, RUPFA implements a strict policy against fraud, corruption, and conflicts of interest. Financial and logistical processes will be jointly supervised by the financial administrator and the PEAS officer, and staff will be trained on fund management, logistical procedures, and the quality of supporting documentation. All project transactions will be conducted through a dedicated, secure sub-account, and funds will be held in a vault. Cash payments will be minimized in favor of bank transfers or mobile money.

The limited number of service partners in the province also poses a risk. In this case, RUPFA will seek donor support for appropriate measures, including the implementation of exceptional procedures.

Fluctuations in the dollar and the high cost of certain equipment remain persistent risks. Close coordination with the donor and monitoring of regional markets will help mitigate their impact.

- Operational risks

The limited availability of local products could restrict their use in awareness-raising activities. Therefore, teams will prioritize the most readily available seasonal products. The risk of delays in training will be mitigated by sharing a provisional schedule with PRONANUT as soon as the ProDoc agreement is signed, in order to guarantee trainer availability.

The delay in the release of funds could disrupt the start of operations. To address this, RUPFA will request authorization to pre-finance certain essential actions. Furthermore, the request for inputs will be sent immediately after the signing of the ProDoc to reduce supply delays; the inputs received will be stored in secure warehouses at the BCZS or the RUPFA office.

The risk of diversion, theft, or loss of supplies is significant in unstable areas. To address this, close collaboration with the Provincial Health Inspectorate will be established, including the reporting of quantities received, unannounced inspections, and the application of sanctions. Health facilities will sign letters of commitment, and community management mechanisms (reporting, monitoring committees, end-user monitoring tools) will be implemented. Supervised transport, regular inventories, and continuous consumption analysis will strengthen the protection of supplies.

The late entry of data into DHIS2 represents a risk, which the project will mitigate by regularly reminding healthcare facilities of deadlines and providing support. Frequent staff rotations will be managed through rapid skills transfers and systematic onboarding of new service providers by the technical teams.

- Organizational risks

Improper storage of inputs can jeopardize activities. RUPFA already has detailed logistics procedures and facilities that meet standards. A main warehouse will be established in Bunia to store all project inputs, under the responsibility of the logistics officer. The BCZS will participate in the shared management of stocks, and a post-distribution monitoring system will verify that the inputs actually reach the beneficiaries. A regular stock report will be submitted to the donor and PRONANUT.

The supply chain can be disrupted by poor organization. Specialized logistics personnel will closely monitor and receive inputs delivered by CADIMÉBU, as well as ensure their secure transport to the BCZS. Permanent security will be in place to protect the stock.

The risk of delays in staff recruitment will be reduced thanks to the rapid activation of the database of qualified candidates held by RUPFA.

- Political risks

Risks related to Protection against Sexual Exploitation and Abuse (PSEA/EAS) are addressed through the implementation of a strengthened institutional policy. Staff are trained by UN agencies, and a PSEA focal point ensures the mainstreaming of protection into nutrition activities. Posters, messages, and awareness-raising tools will be deployed in all supported facilities, and at least one staff member from each health facility will be trained to serve as a focal point.

- Strategic risks

Failure to achieve the results constitutes a major strategic risk. This risk will be mitigated by the rigorous application of the approaches described in the implementation strategy and by close partnership with all stakeholders: community, local leaders, donors, BCZS, nutrition cluster, and DPS. In the event of delays, a catch-up plan or a request for an extension at no additional cost may be proposed to the donor.

Uneven implementation of the PB-family approach will be avoided by training all households in the intervention area and ensuring continuous availability of MUAC strips.

- Security risks

The security situation remains volatile in the targeted areas and may hinder the implementation of activities. RUPFA regularly updates its security plan, validated by the logistics officer, which specifies the measures to be followed in the event of a deterioration. Team movements are authorized after security clearance, and vehicles are subject to strict monitoring. Communication resources will be available, and a satellite phone will be considered for areas without network coverage. The medical evacuation plan is operational, and a designated physician is mobilized to coordinate emergency cases. In the event of a worsening security situation, activities may be relocated to safer areas after consultation with the donor.

14. Logical framework

Result	Description of the result	Location	Target Reference	Verification methods	Location
Product program, country, performance indicator(s)					
Product prog. 2.2. Children, teenagers, pregnant women and breastfeeding women have access to diets nutritional as well as interventions prevention and management of malnutrition through the use services	2.2.1. Number of children Children aged 6 to 59 months with SAM/AM admitted for treatment (new cases) MAS/MAM UNTA+UNTI)	ZS Mungwalu 360	750 (390 girls and 360 boys) AS CECA 20: 202 (105 girls and 97 boys) AS Mongbwalu: 190 (98 girls and 92 boys) AS Pluto: 188 (96 girls and 92 boys) AS Saio: 170 (91 girls and 79 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu

quality nutrition on a large scale via the key systems contributing to the nutrition (Systems) Food, Health, EHA, Education and Social Protection).	2.2.2. Percentage of healthcare facilities reaching over 75% of the treatment's cure rate for the MAS/MAM	ZS Mongbwalu 100		100% (5 healthcare facilities): AS CECA 20, AS Mongbwalu, AS Pluto, AS Saio and HGR Mongwalu	UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	2.2.3. Percentage of children aged 6 to 59 months with Acute malnutrition patients admitted for treatment and recovering (Cured)	ZS Mongbwalu 85		95% (371 girls and 342 boys) AS CECA 20: 192 (100 girls and 92 boys) AS Mongbwalu: 181 (94 girls and 87 boys) AS Pluto: 179 (93 girls and 86 boys) AS Saio: 162 (84 girls and 78 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	2.2.4. Percentage of children aged 0 to 59 months with acute malnutrition cases are admitted for treatment and whose The treatment is failing.	ZS Mongbwalu 15		5% (19 girls and 18 boys) AS CECA 20: 10 (6 girls and 4 boys) AS Mongbwalu: 9 (5 girls and 4 boys) AS Pluto: 9 (5 girls and 4 boys) AS Saio: 9 (3 girls and 6 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	2.5.5. Percentage of children aged 0 to 59 months with acute malnutrition cases involving admission for treatment and subsequent death	ZS Mongbwalu 5%		0%	UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu

Product 1: Children under 5-year-old malnourished severe cases are treated in health areas CECA 20, AS Mongbwalu, AS Pluto, AS Saio	Number of new cases MAM admitted to the CAC	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	450 (234 girls and 216 boys) AS CECA 20: 127 (66 girls and 61 boys) AS Mongbwalu: 115 (59 girls and 56 boys) AS Pluto: 113 (58 girls and 55 boys) AS Saio: 95 (51 girls and 44 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of new cases MAS without complications admitted to UNTA	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	150	300 (160 girls and 140 boys) AS CECA 20: 79 (42 girls and 37 boys) AS Mongbwalu: 76 (40 girls and 36 boys) AS Pluto: 75 (40 girls and 35 boys) AS Saio: 70 (38 girls and 32 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of new cases MAS with complications admitted to the UNTI	HGR Mongbwalu	30	100 (52 girls and 48 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of equipped and functional CACs	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu	0	20 CAC	UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of structures Health facilities (UNTI and UNTA) equipped and operational	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu	5	5 (1 UNTI/HGR and 4 UNTA/CS)	UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu

	Total number of children discharged during the period (CAC/UNTA/UNTI)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu	400	95%, 713 children (371 girls and 342 boys) AS CECA 20: 192 (100 girls and 92 boys) AS Mongbwalu: 181 (94 girls and 87 boys) AS Pluto: 179 (93 girls and 86 boys) AS Saio: 162 (84 girls and 78 boys), HGR Mongbwalu (49 girls and 46 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Recovery rate (UNTA/UNTI) % (total number of children)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu	85	95% (371 girls and 342 boys) AS CECA 20: 192 (100 girls and 92 boys) AS Mongbwalu: 181 (94 girls and 87 boys) AS Pluto: 179 (93 girls and 86 boys) AS Saio: 162 (84 girls and 78 boys), HGR Mongbwalu (24 girls and 23 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Dropout rate (UNTA/UNTI) % (total number of children)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	15%	5% (19 girls and 18 boys) AS CECA 20: 10 (6 girls and 4 boys) AS Mongbwalu: 9 (5 girls and 4 boys) AS Pluto: 9 (5 girls and 4 boys) AS Saio: 9 (3 girls and 6 boys)	UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Death rate (UNTA/UNTI) % (total number of children)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	5%	0%	UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of healthcare workers (providers) trained/refresher courses on the PCIMA adapted and ANJE	ZS Mongbwalu 0		21 (15 men and 6 women)	Training report UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of community health workers (RECOS)	ZS Mongbwalu 85		60 (46 men and 14 women)	Training report UNTA Monthly Report DHIS2	ZS Mongbwalu

	trained/recycled on the PCIMA adapted and ANJE					
	Number of childcare providers trained/refresher courses on family PB and PFE	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu	600	6249 (350 men and 5899 women)	Training report Monthly report UNTI/UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu
	Number of children under 5-year-olds screened	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	4560	9500 children, including 4560 boys and 4940 girls	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu
	Number of children under 5 years old screened by REC	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	4560	2850 (30% of all children screened), comprising 1368 boys and 1482 girls	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu
	Number of children under 5 years old screened in health facilities	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	600	950 (10% of all children screened), including 456 boys and 494 girls	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu
	Number of children of children under 5 years old detected by childminders out of the total number of children detected	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio		5700 (60% of all children screened), including 2736 boys and 2964 girls	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mongbwalu

	Proportion of new MAS cases detected by RECO, referred and admitted for care (ÿ 15% of MAS)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	30%	30%, 90 (47 girls and 43 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Proportion of new MAM cases detected by RECO, referred and admitted for coverage (ÿ 15% of MAM)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	30%	30%, 135 (70 girls and 65 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Proportion of new SAM cases detected by childminders and admitted to facilities (ÿ 70% of MAS)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	50%	60%, 180 (94 girls and 86 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Proportion of new MAM cases detected by childminders and admitted to facilities (ÿ 70% of MAM)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	50%	60%, 270 (140 girls and 130 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Proportion of new MAS cases detected at the CS and admitted to facilities (ÿ15% of MAS)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	15%	10%, 30 (16 girls and 14 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu

	Proportion of new MAM cases detected at the CS and admitted to facilities (15% of MAM)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	15%	10%, 45 (23 girls and 22 boys)	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	ZS Mongbwalu
	Number of monthly screenings carried out among children < 5 years old in the community	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	1 by half	12 (That is, 1 screening per month for 12 months)	Screening report UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of boxes ATPE planned for the project	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	300 (0.8 cartons per beneficiary, i.e., $0.8 \times 750 = 600$ cartons of ATPE)	UNTA Fact Sheets UNTI Monthly Report / UNTA Stock record and supply plan DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of boxes ATPE books delivered to the area of health	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	300 (0.4 cartons per beneficiary, i.e., $0.4 \times 750 = 300$ cartons of ATPE)	UNTA Fact Sheets UNTI Monthly Report / UNTA Stock record and supply plan DHIS2	ZS Mungwalu
	Proportion of nutritional units with out of stock for less than a week	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mungwalu	5%	0%	UNTA Fact Sheets UNTI Monthly Report / UNTA Stock record and supply plan DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio, HGR Mungwalu

	Median PB at admission for MAS cases	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	ND	110 mm	UNTA Fact Sheets UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	median PB at admission for MAM cases	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	ND	120 mm	UNTA Fact Sheets UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Average number of sachets used per child with cured MAS	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	120	70	UNTA Fact Sheets UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Average number of sachets used per child in a cured acute macular degeneration (AMD)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	120	60	UNTA Fact Sheets UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Average treatment duration for children MAS (CAC/UNTA)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	45 days	42 days	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Average treatment duration for children MAM (CAC/UNTA)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	45 days	40 days	UNTA/UNTI Registers UNTI Monthly Report / UNTA DHIS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio

	Number of functional complaint management committees	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	4 (1 per AS)	Minutes of the meeting	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
Product 2: 9500 People (FEFA, caregivers of malnourished children, men, etc.) benefit from awareness-raising sessions on the concepts of IYCF and good practices food and nutrition practices	Number of childcare providers who received early childhood education and care (ECEC) counseling in emergency situations	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	8500	12960 (1944 men and 11016 women)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of revitalized or created GSANJEs	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	4 (1 functional GSANJE per Health Area)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of functional support groups (having held at least one meeting) per month, 80%)	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	4	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of culinary demonstrations performed	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	10	140 (5 cooking demos per GSA and per CS per month for 7 months, i.e. 140 cooking demos)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio

	Number of radio programs broadcast produced in favor of interventions	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	7 (1 broadcast per month for 7 months)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of structures health having integrated the ANJE-U	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	2	5 (1 UNTI/HGR and 4 UNTA/CS)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
Product 3: The Strengthening of the use and the quality of nutrition services in the structures sanitary facilities and communities (CPS) including other platforms is effective	Number of structures health having integrated the CPSr	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	4	4	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of children aged 0-23 months attending the CPSr	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	8640	11500 (5980 girls and 5520 boys)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of children aged 24-59 months attending the CPSr	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	710	1890 (983 girls and 907 boys)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio

	Number of children aged 6-23 months who received the MNP	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	9500 children (4940 girls and 4560 boys)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
Product 4: the interventions for the stimulation of the early childhood (ECD) are supported	Number of ECD spaces fitted out	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	5 (in 1 UNTI and 4 UNTA)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of stimulated children AS	CECA 20, AS Mungwalu, AS Pluto, AS Saio	ND	750 (390 girls and 360 boys) AS CECA 20: 202 (105 girls and 97 boys) AS Mongbwalu: 190 (98 girls and 92 boys) AS Pluto: 188 (96 girls and 92 boys) AS Saio: 170 (91 girls and 79 boys)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
Product program. Country: 2.1. The DRC strengthens its national commitment to develop, finance, coordinate and evaluate its national multi-sectoral strategic plan nutrition and key sector plans involved in nutrition and to adopt standards	2.1.2 Number of sentinel sites monitoring nutritional functional	ZS Mungwalu 34		2 Supported Sites	UNTI Monthly Report / UNTA DHIS2	ZS Mungwalu

and nutrition regulations						
Product 5: One mechanism of coordination, planning, monitoring, evaluation participatory is in place and operational in health zones	Number of visits programmatic	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	2 (A scheduled visit every 3 months)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of missions monthly supervisions carried out between NGOs and BCZ / one mission per month	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	7 (1 supervision per month for 8 months, i.e., 8)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of missions joint supervision (provincial PRONANUT, NGO and BCZS).	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	2 (1 supervision every 3 months)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of consolidated SitReps, transmitted and shared with the landlord	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	7 (1 sitrep per month, i.e., 8 for 8 months)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of End Users Monitoring performed	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	28 (1 routine EUM per month per AS for 7 months for 4 AS, i.e. 32)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio

	Number of meetings monthly monitoring taking into account the PCIMA and ANJE data made with the BCZS	ZS Mungwalu 0		7 (1 monitoring meeting per month)	Activity Report	ZS Mungwalu
	Number of tracking sheets individual encoded	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	423 (95% of MAM children are discharged) 285 (95% of children with severe acute malnutrition are discharged)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of people formed on the PSEA/VBG	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	190 people, including 63 women and 127 men. Training report.		AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of Banks photos	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	1 photo bank	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of Reports shared statistics	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	7 (1 report per month)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
	Number of reports progress transmitted to lessor	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	0	3 (1 report per quarter)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio

	Number of structures health data monthly are correctly filled in DHS2	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio	5	5 (1 UNTI and 4 UNTA)	Activity Report	AS CECA 20, AS Mungwalu, AS Pluto, AS Saio
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15. Work plan budget

Level of result	Result/activity	Period		Total (CSO + Landlord)	Contribution of the OSC	Contribution of the Landlord
		T1	T2			
Activity 1 xxx of PTR	Result 1: 750 children aged 6 to 59 months are treated for acute malnutrition according to the appropriate approach in the Mungwalu health zone			\$184,284.86	\$1,075.00	\$183,209.86
Sub-Activity 1.1	Training and/or refresher courses for 37 healthcare workers: 8 HGR members, 24 IT/ITA from 12 AS and 5 members of the ECZ of the Mongbwalu health zone on the approach adapted management of acute malnutrition and on ANJE in emergency situations	x		\$10,310.50	\$0.00	\$10,310.50
Sub-Activity 1.2	Training of 144 RECOs in the 12 AS of the health zone from Mongbwalu on screening techniques, visits at home, case referrals and awareness-raising on ANJE and PCIMA adapted	x		\$9,090.00	\$0.00	\$9,090.00

Sub-Activity 1.3	Supplying healthcare facilities with inputs nutritional plans using distribution plans and plans requests and orders for health centers in collaboration with ECZS	xx		\$3,625.34	\$0.00	\$3,625.34
Sub-Activity 1.4	Care (PEC) of 750 children suffering from Acute malnutrition according to the IMAM/adapted approach in outpatient therapeutic nutritional units (UNTA) and CAC for uncomplicated cases medical and therapeutic nutritional units intensive care units (UNTI) for cases with complications medical	xx		\$132,474.02	\$0.00	\$132,474.02
Sub-Activity 1.7 Storage	Storage and securing of nutritional inputs	xx		\$375.00	\$375.00	\$0.00
Sub-Activity 1.8 Support	Support for supervisory missions	xx		\$28,410.00	\$700.00	\$27,710.00
Activity 2	Result 2: 90% of children under 5 years old benefit malnutrition prevention services, research active and referencing of acute malnutrition cases			\$11,410.00	\$0.00	\$11,410.00
Sub-Activity 2.1	Support for the organization of awareness sessions and community active screening	xx		\$4,910.00	\$0.00	\$4,910.00
Sub-Activity 2.2	Strengthening promotion and awareness-raising on Infant and young child nutrition and early childhood stimulation	xx		\$4,565.00	\$0.00	\$4,565.00
Sub-Activity 2.3	Training mothers to identify the early signs of acute malnutrition in their children and to measure them at using a MUAC tape	xx		\$1,935.00	\$0.00	\$1,935.00

Activity 3	Effective and Efficient Program Management - Management, Monitoring, Evaluation, Coordination			\$64,755.00	\$18,960.00	\$45,795.00
A.1	Coordination/facilitation of the implementation of activities	xx		\$38,850.00	\$0.00	\$38,850.00
A.2	Wages of staff who work indirectly on the program (Country Director, M&E, Logistics, etc.) with % pro rata	xx		\$21,400.00	\$18,190.00	\$3,210.00
B	Management Costs/Operational Costs	xx		\$4,505.00	\$770.00	\$3,735.00
Subtotal of expenses program				\$260,449.86	\$20,035.00	\$240,414.86
COST TRANSFER BANK (1% automatic)				\$2,404.15	\$0.00	\$2,404.15
Support expenditures of the headquarters (7% of the component species)				\$16,829.04	\$0.00	\$16,829.04
Total budget of description of program				\$279,683.05	\$20,035.00	\$259,648.05

Activity Calendar – Emergency Nutrition Project							
Mongbwalu Health Zone – March to September 2026 (7 months)							
Main activities	March 2026	April 2026	May 2026	June 2026	July	August 2026	September 2026
START-UP AND PREPARATION PHASE							
Kick-off meeting with BCZS, PRONANUT, local authorities							
Recruitment/briefing of the project team;							
Rapid assessment of the capacities of the UNTA/UNTI/CAC;							
Development/validation of the procurement plan							
CAPACITY BUILDING							
Training/refresher courses for healthcare providers (adapted PCIMA & ANJE-U)							
Training for RECOs (screening, referral, ANJE, VAD)							
Training for childcare providers (PB family, PFE)							
PSEA/GBV training for staff and partners							
NUTRITIONAL CARE							
Supplying facilities with nutritional inputs (ATPE, medicines, equipment)							
Care for children with severe acute malnutrition (SAM)							
Establishment and operation of the CACs							
Monitoring of performance indicators (recovery, abandonment, death)							
PREVENTION, SCREENING AND REFERRALS							
Monthly community screening (<5 years)							
Screening by RECO (door-to-door, community sites)							
Referral and admission of MAS/MAM cases							
ANJE-U, CPSr AND COMMUNICATION							
Implementation / revitalization of GSANJE							
ANJE-U awareness sessions (structures & community)							

Culinary demonstrations (GSA & CS)							
Emissionsradiosnutriti on / IYCF - U							
Distribution and use of MNPs (6-23 months)							
STIMUL AT IONDELAPETITEEN FA NCE (ECD)							
Development of ECD spaces (UN TA / UNTI)							
Stimulation activities for SAM/MAM children							
COORDIN AT ION , MONITORING AND EVALUATION							
Monthly NGO supervisions – BCZS							
Joint supervision (PRONANUT – NGO – BCZS)							
Monthly meetings of my PCIMA / IYCF itorage							
Encoding and validation of DHIS 2 data							
S it R epmonthly shared save the lessor							
Quarterly progress reports							
End User Monitoring (EUM)							
Capitalization , bankofphotosetrappo rtfinal							

SUPPLY PLAN

Description of inputs/Offshore	Unit	Quantity
Therapeutic spread, sachet 92g/CAR-150	Cardboard	730
F-75 Therapeutic milk CAN 400g CAR 24	Cardboard	16
F-100 Therapeutic milk CAN 400g CAR 24	Cardboard	8
Retinol 100,000IU soft gel.caps/PAC-500	Cardboard	4
Retinol 200,000IU soft gel.caps/PAC-500	Pieces	4
ReSoMal, 42g sachet for 1 liter/CAR-100	Cardboard	1
Albendazole 500mg chewable tabs/PAC-100	Pack	7
Amoxicillin 125 mg syrup	Pieces	1500
Weighting trousers (pack/5)	Pack	15
MUAC (pack/50)	Pack	100
25 kg scale (1/CS) of covered CS	Pieces	15
Children's Height Chart CS Covered	Pieces	6
Scale, infant, clinic, beam type, 16kg x 10g	Pieces	1

1. Non-financial contribution from the partner

- Solid expertise at the service of the project

RUPFA has a proven track record in implementing nutritional interventions, both in emergency and development contexts. Thanks to this expertise, the organization will bring significant added value to the project, both technically and in terms of management and operational support.

Building on several Integrated Prevention and Control of Acute Malnutrition (IPCM) projects, RUPFA mobilizes qualified staff who are experts in the entire management cycle of nutrition programs. It also relies on a database of nutritionists trained in various implementation approaches, enabling it to respond effectively to field needs. This accumulated experience will be fully leveraged to guarantee the quality of planned interventions.

As part of the project, RUPFA will provide ongoing technical support to the Provincial Health Division (DPS) and the Central Health Zone Offices (BCZS). This support will focus on training healthcare providers, supervising and monitoring the program's technical aspects, and strengthening local capacities to ensure care is delivered in accordance with national standards. The organization will also ensure optimal management of activities at the programmatic, administrative, and financial levels to guarantee the effective achievement of results.

The experience gained from previous interventions, particularly community-based initiatives in the Kasai and Ituri provinces, is a major asset. A thorough understanding of local realities, community dynamics, and operational constraints will allow for the effective adaptation of intervention strategies.

RUPFA will also rely on the expertise and innovations developed by its technical partners to strengthen the quality of implementation and optimize processes.

- Contribution in kind

In support of the project, RUPFA will provide its infrastructure, including its offices, office equipment, vehicles, and other necessary material resources. While this contribution cannot be quantified as a percentage, it represents essential logistical support to ensure the smooth and efficient implementation of the planned activities.

2. Activation Protocol for Contingency DPS

The response follows the following activation protocols:

- Nutrition cluster guidelines with criteria for classifying priority areas;
- Nutritional crisis/population displacement movements affecting the most vulnerable targets (children under 5 years and FEFA);
- Nutritional alerts according to the SNSAP

3. Additional reports required (special report/humanitarian reports)

The following are the various additional reports expected:

- 2 quarterly progress reports (every 3 months)
- 2 quarterly financial reports (every 3 months)
- 7 compiled sitreps
- 1 training report for healthcare providers
- 1 training report for community stakeholders
- 2 quarterly reports on the management of project inputs
- Monthly statistical reports: submitted to the donor no later than the 15th of the following month, including technical and support activities as well as statistics from 5 supported structures
- Joint mission reports: with development partners, the Nutrition Cluster or humanitarian actors, depending on the missions carried out
- 1 final project report: submitted one month after the end of the project
- 1 interim report: to be presented at the end of the first quarter, no later than the 15th of the following month

4. Scheduled visits

Project management will be carried out in accordance with the principles of High-Level Competitiveness and Action (HACT). This includes capacity building for RUPFA and its partners through joint and programmatic visits aimed at ensuring quality implementation, as well as rigorous management of funds and inputs. The planned monitoring and quality assurance activities are as follows:

a) Programmatic visits: 2 programmatic visits will be carried out.

- VP1: May 2026

- VP2: October 2026

b) Spot check: Two spot check missions will take place during the implementation of the project.

- 1st Spot check: End of the first quarter (May 2026)

- 2nd Spot check: End of the second quarter (August 2026)

Signatures and date

Name of authorized CSO representative:

Signature :

Date:

Name of authorized person (Landlord):

Signature :

Date: