SCALING UP CARE FOR CHILDREN WITH SEVERE ACUTE MALNUTRITION IN SOUTH SUDAN

Lessons learned from expanding quality services
in a complex emergency context

FIELD REPORTS
Lessons from improving
nutrition at scale

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The community-based management of acute malnutrition (CMAM) programme in South Sudan is part of a broader national strategy to prevent and treat malnutrition. During the programme's expansion between 2014 and 2018, the proportion of children with severe acute malnutrition being reached with life-saving treatment increased from 40 per cent to 77 per cent. The number of outpatient treatment sites more than doubled, from 351 to 1145 in 2019, and the number of children admitted for treatment increased from 206,673 in 2018 to 237,123 in 2019. The quality of care also improved: 91 per cent of children successfully recovered in 2019, compared with 88 per cent in 2018. This Field Report illustrates how partnerships and systems-level investments can save lives and improve equity, even in the most challenging humanitarian contexts.

A challenging and complex protracted emergency

Since 2013, South Sudan has faced a complex and protracted crisis. Political struggles and intercommunal conflicts have resulted in sustained poverty, with more than 7 million people requiring humanitarian support and protection. Since 2015, the escalation of hostilities has displaced 4 million people in the country, including 2.4 million children.[1]

In many parts of South Sudan, conflict, displacement and delayed rainfall have halted agricultural production and other economic activities, contributing to food insecurity. Currency devaluation has resulted in hyperinflation, high food prices and diminished household purchasing power. Between 2015 and 2018, the proportion of the population affected by food insecurity increased from 34 percent to around 60 percent.[2]

Even before the upsurge of conflict, the prevalence of global acute malnutrition[3] in 2010 was 23 per cent, requiring an intensification of prevention and treatment of acute malnutrition among affected populations.[4] As the situation deteriorated and the number of children affected continued to escalate, the Government of South Sudan, UNICEF and partners intervened to scale up services for children with severe acute malnutrition (SAM) to protect their future survival and nutritional well-being.[5] This work was initiated in 2013, and became more urgent in February 2014, when a Humanitarian System-Wide Scale-Up Activation (Level 3 emergency) was declared. This national emergency triggered further discussions among government and partners around strengthening and expanding the scope of the nutrition programme to respond effectively to the humanitarian emergency.

Leveraging the potential of community-based care

From the outset, communities were recognized as central to effectively scaling up care for children with SAM in South Sudan. Prior to separation, Sudan had been one of the first countries in the world to use a community-based management approach to detect and treat children with SAM in 2001. The integrated design meant that services for children with SAM extended from inpatient health facilities to outpatient facilities and continued with the provision of community-based services (including early referral), mainly in refugee camps. However, after the separation of South Sudan in 2011, only a few civil society organizations (CSOs) continued to offer outpatient treatment, while many services collapsed or were suboptimal.

With the need to rapidly expand the reach of services for the early detection and treatment of children with SAM, UNICEF led the discussions to design and implement a scale-up plan to strengthen and expand the community-based programme as part of the 2014 emergency response.

A child plays while she waits to be screened for malnutrition at an outpatient treatment site in the Protection of Civilians area in Wau, South Sudan.
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Partnering to deliver results at scale

UNICEF and other international partners had been working closely with the Ministry of Health, CSOs and communities for several years to respond to the protracted nutrition emergency. The health system in South Sudan was – and remains – weak, with limited capacity and infrastructure. Given the shortage of skilled human resources in various locations, prolonged support from UNICEF and CSO partners was required to reach children in need with nutrition services, both through fixed nutrition facilities and mobile outreach sites. However, the upsurge of conflict in 2014 required even closer collaboration with UNICEF, leveraging a network of 40 partner organizations, including international and national CSOs, to implement scale-up.

As Cluster Lead Agency for nutrition, UNICEF upheld its responsibility to strengthen multi-stakeholder coordination and convene partners to jointly plan, implement and monitor activities for the prevention of child undernutrition, together with the scale-up of CMAM services for those in urgent need. Working together, a Nutrition Cluster Response Plan was put in place to deliver basic services during the crisis response.[6,7] In mid-2014, UNICEF and the World Food Programme (WFP) drew up a formal agreement and launched a joint Nutrition Scale-Up Plan to coordinate and leverage the comparative strengths of the agencies to respond to the nutrition crisis. The plan aimed to scale up services and reach more than 235,000 children with SAM through 351 outpatient treatment sites (OTP) in a highly complex and insecure operating environment.[8]

From July to December 2014, UNICEF increased its dedicated nutrition staff from 5 to 30, allowing for expanded field office presence. Staff were brought on board to support nutrition information management, cluster coordination and Rapid Response Mechanism missions (which deliver services directly to vulnerable women and children in hard-to-reach communities). Partnerships with national CSOs were expanded from 36 in 2014 to 40 in 2019 to support capacity building, systems strengthening, and the use of local knowledge and community ties to provide more responsive services, especially in hard-to-reach communities.[9]

In 2015 and 2016, UNICEF and partners focused on improving efficiency and strengthening systems by developing guidelines, protocols, standards, and harmonized training packages. The joint plan concentrated on a community-based prevention approach, promoted continuum of care[10] at nutrition sites, directly delivered nutrition interventions in hard-to-reach areas, developed the capacities of partners and government, strengthened supply chain and pipeline management, and enhanced needs analysis and coordination. The plan included monitoring and evaluation, with annual targets set.[11]

In 2017 and 2018, UNICEF continued to provide support for life-saving treatment services, prevention of acute malnutrition and timely collection of high-quality nutrition data. The strong collaboration between UNICEF, WFP and WHO ensured a continuum of care through seamless referral mechanisms[12] for children across the different treatment programmes depending on the severity of acute malnutrition. This was further enabled by joint monitoring activities. Quarterly and annual progress reports and joint annual review meetings allowed partners to track progress against targets, identify challenges and devise strategies to overcome them, share lessons learned and celebrate achievements. A bottleneck analysis was carried out in July and August 2018 at national and state levels to assess the main determinants of effective coverage of nutrition interventions, identify problems and effectively address them. This exercise improved the delivery of supplies and the overall quality of service. *(see Box 1)*.

Several joint strategies were piloted to improve programme efficiency and accelerate results, such as the adoption of a 'one partner per location' approach for both UNICEF and WFP treatment programmes. The two agencies also tested a digital record system called SCOPE conditional on-demand assistance (CODA) to electronically register, track and manage CMAM participants; and piloted a supportive supervision model for classifying nutrition sites providing CMAM services *(See Box 1)*. With technical assistance from UNICEF, new CMAM guidelines[13] were endorsed by the Government of South Sudan in December 2018. UNICEF, together with WFP and WHO, provided continual support to the government nutrition department under the Ministry of Health at the national and state levels to support the scale-up of nutrition services.

Mobilizing communities for action

Community mobilization and engagement is the backbone of integrated services for the early

BOX 1

Factors supporting quality scale-up

Guidelines and harmonization of treatment protocols

Maternal, infant and young child nutrition guidelines were endorsed by the Government of South Sudan in December 2017, while the CMAM guidelines were endorsed in December 2018, harmonizing messages and protocols. These national guidelines and the roll-out of CMAM trainings in five high burden states in 2018 have been instrumental in scaling up access to treatment.

'One partner per nutrition site' approach

Having a common UNICEF-WFP implementing partner at nutrition sites was critical to improving service efficiency and effectiveness. In 2018, about 81 per cent of counties (64 out of 79) had nutrition sites operated by one partner, and in the following year this figure rose to 91 per cent.

Supportive supervision pilot

The supportive supervision and corrective action project using a star rating model contributed to increasing the coverage and quality of SAM treatment services. Star ratings of CMAM sites in two states provided an opportunity to assess the quality of services on 52 indicators several times a year. The supportive supervision and feedback given to partners encouraged them to take timely corrective action and receive an enhanced star rating in the next round of assessment.

Overcoming supply bottlenecks

Based on the results of the 2018 bottleneck analysis, UNICEF and partners focused on reducing supply-related bottlenecks. For example, dry season pre-positioning of supplies along with an efficient supply pipeline management improved the quality of services by making ready-to-use therapeutic food (RUTF) continuously available.

Simplified approach

While CMAM guidelines recommend the use of RUTF for the treatment of SAM and ready-to-use supplementary food (RUSF) for the treatment of moderate acute malnutrition (MAM), maintaining a continuous supply pipeline of products is extremely challenging in South Sudan. An innovation was piloted to simplify the treatment protocol to a single product. Preliminary findings from a randomized control trial using a combined protocol with a single product, RUTF, for treating both SAM and MAM, show that this approach can achieve comparable/non-inferior recovery rates and be cost-effective when compared with the standard protocol.[14] While more research is needed, when there is a break in the supply chain RUTF can be used for both SAM and MAM.

CMAM digital record pilot

Piloting of the SCOPE-CODA digital beneficiary management system is underway in one state. Preliminary findings suggest that SCOPE-CODA may improve the tracking of individual CMAM programme participants and better track defaulters, capture real-time programme and supply data, improve case management and programme output analysis, and increase programme efficiency.[15]

Caregiver feedback pilot

The caregiver feedback pilot for CMAM programme participants provided valuable insights on site accessibility, quality of interaction with staff, waiting time, and community perceptions of the programme. It also highlighted the importance of integrating feedback mechanisms within the programme to foster accountability among service providers.[16]

Integrating nutrition services in the rapid response mechanism

Integrated Rapid Response Missions are critical to ensuring equity. Since 2017, these missions have been screening children for acute malnutrition in hard-to-reach places and admitting them for treatment, providing age appropriate vitamin A supplements and deworming medication, and counselling caregivers on child feeding. More than 114,600 children were screened for SAM through 66 missions in 2017, and 76,550 were screened in 2018 through 50 missions.

Integrating early childhood development (ECD) interventions in the CMAM programme

Cognitive and physical stimulation is vital to the recovery of severely malnourished children. Several research studies have shown that those who participate in structured play sessions as part of their care make significant improvements in development compared with those who do not. This positive impact has been shown to last beyond the treatment period.[17]

Since 2017, the Government of South Sudan, UNICEF and partners have integrated simple ECD interventions at selected sites offering care for children with SAM: Examples of interventions include the provision of child-friendly spaces, and ECD play and recreational materials (e.g., games, toys and puzzles).

detection and treatment of SAM. In fact, South Sudan's experience of mobilizing and empowering communities has since been taken up by other countries and influenced CMAM programmes globally. In South Sudan, community nutrition volunteers (CNVs) or home health promoters[18] were instrumental in sensitizing community members, creating a demand for CMAM services, and increasing service delivery coverage. Various media were employed, including radio spots and programmes, posters, flyers and word of mouth publicity to reach out to the community through visits to homes, schools, religious centres, water collection points, and during mass campaigns and outreach services. The CNVs, who hailed from the local communities, were trained to identify and refer children with acute malnutrition, while counselling caregivers on the prevention of malnutrition. They were also trained to collect and report nutrition data using the community-based management information system, under the supervision of community health workers.[19]

The CNVs encouraged mothers in the community to form mother-to-mother support groups, and the members of these groups were trained to proactively identify and refer children with acute malnutrition in some locations. For volunteers who had difficulty reading or writing, colour-coded community screening referral slips were provided for referring children to the nearest facility after screening.

Expanding care and improving quality to reach every child

The proportion of children admitted to the CMAM programme for treatment compared with those in need has continued to expand each year, rising from 40 per cent in 2014 to 77 per cent in 2018 *(Figure 1)*. The number of OTP sites also increased from 351 in 2014 to 1,145 in 2019, to expand coverage and accommodate more children in need of life-saving care *(Figure 2)*.

Figure 1. Annual burden, target[25] and admissions data for children with SAM in South Sudan

After being treated for SAM in a UNICEF-supported stabilization center, Awau was referred to an OTP in Tharkueng where she receives weekly rations of RUTF. She is now eating well and recovering.
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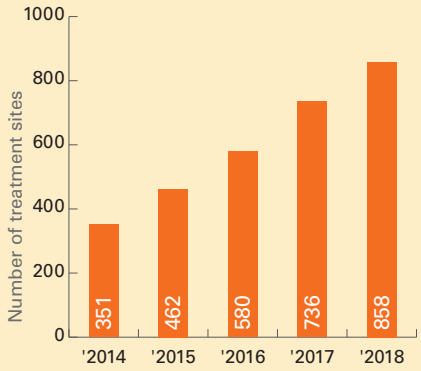

Figure 2. Number of outpatient treatment sites (2014–2018)

The proportion of children who recover successfully from the programme has been consistently high, ranging from 78 per cent in 2014 to 91 per cent in 2019, meeting international programme performance standards. The proportion of children defaulting[20] from treatment also declined steadily, from 17.4 per cent in 2014 to 5.3 per cent in 2019, while the rate of death[21] has remained low at an average of 0.5 per cent.

Expanding CMAM as part of a comprehensive strategy to prevent and treat malnutrition

The scale-up of the CMAM programme took place as part of a broader strategy to improve maternal and child nutrition in South Sudan. This approach was outlined in UNICEF's 'Maternal, infant and young child nutrition programme package and strategy' (2017–2025), which was launched and rolled-out in 2017. Over time, the nutrition programme was strengthened through integration with health, water, sanitation and hygiene (WASH), education, protection and early childhood development (ECD) interventions *(see Box 1).* This included interventions to enhance food security and livelihoods, such as the distribution of seeds together with training on how to plant a variety of vegetables to encourage dietary diversity.

Systems-strengthening efforts focused on the same systems and platforms used to reach mothers and children with preventative services, such as counselling to improve feeding practices and the delivery of essential micronutrients to young children. In this way, preventative services were also included in the scale-up plan.[22]

Access to counselling on infant and young child feeding (IYCF) practices rapidly expanded. In 2014, UNICEF reached about 118,200 caregivers with individual IYCF counselling primarily focusing on the high burden states. Between 2015 and 2016, programme coverage expanded to all ten states in South Sudan, reaching 539,500 caregivers with individual IYCF counselling in 2015, and more than 724,500 caregivers in 2016. The programme was further expanded across the country, reaching about 607,500 caregivers with IYCF messages in 2017 and 1,684,197 in 2019..

With improved access to preventive services, the early initiation of breastfeeding within one hour of birth increased (from 22.7 per cent to 75.9 per cent) and exclusive breastfeeding for first 6 months increased (from 45.1 per cent to 74.1 per cent) between 2010 and 2018. However, complementary

feeding remains a challenge, with only 15 per cent of children eating enough foods from a diverse range of food groups and only 5 per cent of children receiving the minimum acceptable diet.

Monitoring progress, fostering accountability

Since 2014, data have been collected on a monthly basis by partners at state level or county level to monitor progress. In 2015, the Nutrition Cluster launched an information management system based on the OTP/Targeted Supplementary Feeding Programme site structure, which will eventually be integrated into the reformed national health information system. SMART surveys supported by the Nutrition Information Working Group are carried out by designated CSOs each year to generate knowledge on key nutrition indicators and track progress on priority counties.

These data, along with data from the UN-Government collaborative initiative of Food Security and Nutrition Monitoring System (FSNMS), are used for evidence-based programming. Together, they illustrate how investments in systems-strengthening and scale-up have made substantial impacts on rates of malnutrition in the country. National level data from FSNMS reveal that the prevalence of global acute malnutrition declined from 22.7 per cent in 2010 to 13.3 per cent in 2018, while stunting dropped from 31.1 per cent to 17.1 per cent.[23]

Focus group discussions and interviews were conducted with caregivers of children participating in the CMAM programme to solicit feedback.[24] Box 2 presents the voices of caregivers, collected through one-on-one interactions in communities in South Sudan. They provide a small but valuable qualitative validation of the programme, including the importance of attentive play and meaningful interaction with the child.

Challenges to effective scale-up

The scale-up journey in South Sudan was not always smooth; at each stage of the process, UNICEF and partners responded to important challenges:

- As a result of the limited capacity of the health system, CMAM services are implemented by CSOs. This hinders integration into the national health system and compromises the continuum of care and health referral pathways.
- Funding continues to be focused on emergency interventions with one-year financing, which poses a challenge to providing partners with continuous long-term support for sustainable impact. Funding shortfalls for frontline nutrition services lead to delays in disbursement and transfer of funds to implementing partners.
- Poor infrastructure hinders the transport of commodities, and certain areas are inaccessible due to conflict or flooding. Poor road conditions cause delays in movement and limit the number of nutrition sites visited for programme monitoring.
- Occasional looting of nutrition supplies and supply pipeline disruptions result in programme defaulters.
- High staff turnover has made it challenging to ensure adequate training.
- Frequent cancellation or postponement of integrated Rapid Response Missions in hard-to-reach areas due to insecurity prevents essential services from reaching the communities in need.

BOX 2

Voices of children and caregivers

"My child has become healthy again. He now walks, runs and plays. I was taught to make toys for my child and play with him and sing to him."

— Nyajangni, 35, mother of 7 children; one child was recently discharged from the CMAM programme.

"Dokuwa (therapeutic food) has helped my children recover."

— Rose, 25, mother of 4 children, whose twins were cured and discharged from the CMAM programme.

"I see improvements in the children after counselling. This makes me happy."

— Angelina, 37, mother of 5 and lead mother of a mother-to-mother support group.

UNICEF staff member, Cecilia Aldo, is visiting Anna Nyagma who is attending a UNICEF supported mother-to-mother support group meeting. Anna encourages women in her community to exclusively breastfeed their babies, up until the age of 6 months. She mobilizes women by giving them crucial information about children's nutrition and inviting them to attend the mother-to-mother support groups. With improved access to these services, South Sudan's exclusive breastfeeding rate increased from 45 per cent in 2010 to 74 per cent in 2018.

Enablers and lessons learned from five years of scale-up

- Mobilize political support and engagement from the highest levels of government for programme ownership, policymaking, and accountability.
- Leverage global evidence to encourage government endorsement of national guidelines (on CMAM, inpatient management of SAM, and maternal, infant and child nutrition) using clear and easy-to-follow tools and materials.
- Provide technical support, leadership, and coordination to jointly plan, implement, monitor and report on CMAM strategies and activities within a government-UN-NGO partnership, focusing on convergent inter-sectoral community-based action, and Rapid Response Missions.
- Mobilize communities for active programme engagement and create awareness about and demand for CMAM services through the participation of community nutrition volunteers and mother-to-mother support groups.
- Develop the capacities of skilled health workers using harmonized training packages to support programme delivery with expanded coverage and quality; and test innovations to address bottlenecks and improve programme efficiency.
- Facilitate a smooth supply pipeline for therapeutic foods with a tracking system and pre-position supplies to avoid stock-outs, especially during the dry season and in hard-to-reach areas. This also reduces the cost of shipping and transporting supplies.
- Enable evidence based, data-driven decision-making through SMART surveys, FSNMS rounds, and the nutrition information system by integrating child nutrition indicators across sectors and programmes, setting targets and monitoring progress.

Making CMAM fit for the future

UNICEF will continue to support programme scale-up and efforts to improve the coverage and quality of service delivery to children in need in South Sudan. Innovations, such as using a combined protocol for treating both SAM and MAM with RUTF, and using a digital record keeping system for CMAM programme participants, will continue to be tested and evaluated to support continuous programme improvement.

Early childhood development interventions such as psycho-social stimulation, age-appropriate play and responsive feeding will be further integrated into the CMAM programme across the country to reduce recovery time and support cognitive development.

South Sudan's experience shows that it is possible to scale up a resilient CMAM programme based on global guidance during an ongoing humanitarian crisis. At the same time, the future of the programme is in jeopardy without predictable long-term funding and a stronger health system to sustain it. Further investment in capacity development of health workers is needed to support the early detection of acute malnutrition in the community, and the integration of the treatment of childhood illnesses into quality primary care services. This, together with other systems-strengthening efforts that focus on prevention and reducing the burden of acute malnutrition, will ensure that South Sudan's children have a better start in life and a brighter future.

In its support to the Government of South Sudan and state ministries of health, UNICEF served as:

Advocate

Using programme evidence to advocate with the government for continued commitment, ownership and accountability for scale-up.

Policy and programme advisor

Providing technical expertise to harmonize treatment protocols and trainings through national guidelines on CMAM and maternal, infant and young child nutrition.

Bridge builder

Strengthening communication, dialogue and feedback between government, implementing partners and a mobilized and engaged community.

Partner and Convenor

Bringing together government, UN, civil society partners and communities at national and subnational levels to jointly plan, implement and monitor activities for CMAM scale up and the prevention of undernutrition; and strengthening coordination as the Nutrition Cluster Lead Agency to ensure quality implementation and monitoring of key nutrition investments.

Knowledge broker

Gathering and generating primary evidence through annual SMART surveys and FSNMS rounds; leading the Nutrition Information Working Group; and managing data to inform strategic action and programme scale-up.

Trainer and Capacity builder

Developing the capacities of government and partners on CMAM standard treatment protocols and IYCF counselling.

Manager

Bolstering the timely pre-positioning of supplies to eliminate supply chain bottlenecks, and establishing a robust tracking system to avoid stock-outs.

Rapid responder

Undertaking integrated Rapid Response Missions with UN partners to provide nutrition services for children and women in hard-to-reach locations, and guiding implementing partners to re-establish nutrition services disrupted due to conflict.

Innovation champion

Piloting innovations, such as the digital tracking of CMAM programme participants; employing a combined treatment protocol; rating CMAM sites for supportive supervision and corrective action; integrating ECD interventions with CMAM to reduce recovery time; and using caregiver focus groups to improve the quality of care.

Endnotes

1 United Nations Office for the Coordination of Humanitarian Affairs. Humanitarian Needs Overview 2019: South Sudan. November 2018. <https://reliefweb.int/sites/reliefweb.int/files/resources/South_Sudan_2019_Humanitarian_Needs_Overview.pdf.

2 Integrated Food Security Phase Classification (IPC) reports. Accessed from www.ipcinfo.org on 6 November 2019.

3 Global Acute Malnutrition (GAM) is a measure of acute malnutrition, both moderate and severe acute malnutrition, among children aged 6–59 months. At a population level, GAM is used as the indicator to determine the Phase Classification of part of the Integrated Food Security Phase Classification (IPC). GAM levels more than 15% are critical and require significant scale up of services to urgently reduce acute malnutrition levels.

4 Ministry of Health, National Bureau of Statistics (2010), South Sudan Household Health Survey, 2010. https://reliefweb.int/report/south-sudan-republic/republic-south-sudan-sudan-household-health-survey-2010

5 United Nations Office for the Coordination of Humanitarian Affairs. Humanitarian Response Plan, January–December 2019: South Sudan. December 2018. <https://www.humanitarianresponse.info/en/operations/south-sudan/document/south-sudan-2019-humanitarian-response-plan-13-december-2018>

6 UNICEF and WFP. South Sudan: UNICEF and WFP Scale up Nutrition Plan, July 2014.

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8 United Nations Office for the Coordination of Humanitarian Affairs. South Sudan: Crisis Response Plan, 2014. United Nations, 2014. <https://reliefweb.int/sites/reliefweb.int/files/resources/Revision_2014_South_Sudan_CRP_June_2014.pdf>

9 United Nations Children's Fund and World Food Programme. South Sudan: UNICEF and WFP Scale-up Nutrition Plan One Year Report, July 2015.

10 Continuum of care denotes connecting care throughout the crucial time periods in the lifecycle, such as infancy and early childhood, among others. It can be achieved through a combination of well-defined polices and strategies to improve home care practices and health and nutrition care services throughout the lifecycle, building on existing programmes and intervention packages.

11 United Nations Children's Fund and World Food Programme. South Sudan: UNICEF and WFP Joint Nutrition Response Plan, June 2015 to May 2016.

12 Related to referral of children to and from OTPs and Targeted Supplementary Feeding Programmes (TSFPs) as per the referral criteria specified in the action protocols of the CMAM Guidelines (Annex 20 and Annex 34).

13 The Republic of South Sudan. Community management of acute malnutrition: CMAM guidelines, December 2017.

14 Bailey J., et al. Combined Protocol for Acute Malnutrition Study (ComPAS) in rural South Sudan and urban Kenya: study protocol for a randomized controlled trial. Trials, 2018, 19:251.

15 United Nations Children's Fund and World Food Programme. South Sudan SCOPE-CODA Roadmap, 2019–2021.

16 Action Against Hunger. Humanitarian feedback mechanisms: Capturing GBV and nutrition intersections through overall program accountability. Document provided by ACF, South Sudan (year unknown).

17 United Nations Children's Fund. Early childhood development in emergencies: Integrated programme guide. UNICEF, 2014.

18 People living within the community who have been selected and are willing to spend time providing health and nutrition services to their neighbours without formal employment or pay. Compensation is provided in-kind or/and with regular training.

19 Cadres based at the Primary Health Care Units (PHCUs) and Primary Health Care Centres (PHCCs). They support both static and outreach of OTP/TSFP services and are responsible for supervising the activities of home health promoters. Depending on context, community health workers may also support the Blanket Supplementary Feeding Programme services. PHCUs and PHCCs are part of the Ministry of Health's three-tier health care system, along with the County Hospitals (CHs). The PHCCs are the first level referral health facilities, and the CHs are the county-level health facilities with a capacity of managing critically ill children with SAM.

20 Defaulter: A child with acute malnutrition who leaves the programme before being cured from acute malnutrition; the patient misses two consecutive visits to the OTP or TSFP.

21 Death/died: A child with acute malnutrition who dies while registered in the CMAM programme.

22 Bi-annual vitamin A supplementation (VAS) campaigns were a key preventative service implemented between 2014 and 2018 for children aged 6–59 months. Children aged 12–59 months also received deworming medication from 2016 to 2018. Two joint prevention campaigns were undertaken during National Immunization Days, integrating VAS and deworming with measles and polio vaccinations to improve the children's resistance to infections. In 2014, less than half of the counties had carried out a VAS campaign; however, by 2018, this number had increased to 91 per cent, with a corresponding increase in coverage from 1.5 million to 2.3 million children. The deworming programme also increased its reach between 2016 and 2018, from 859,000 to 1.88 million children.

23 Food security and nutrition monitoring system (FSNMS), August 2018. https://fscluster.org/south-sudan-rep/document/food-security-and-nutrition-monitoring-1

24 Action Against Hunger. Humanitarian feedback mechanisms: Capturing GBV and nutrition intersections through overall program accountability. Document provided by ACF, South Sudan (October, 2018)

25 Based on the projected availability of resources and the achievements of the previous year, UNICEF and WFP provide support to a percentage of children in need. This serves as the target for UNICEF, WFP and the Nutrition Cluster, and varies by year.

UNICEF FOCAL POINTS:

Biram Ndiaye, Chief of Nutrition (bndiaye@unicef.org)

Gilbert Dachi, Nutrition Manager (gdachi@unicef.org)

COUNTRY TEAM:

Ismail Kassim, Kiross Abebe, Kibrom Tesfaselassie, Priscilla Bayo, Jesca Wude, Nawal Sadick, Felista Busi, Chandrakala Jaiswal, David Kidega, Ester Mogga, Tesfatsion Shiweredo, Bosco Ojok, Hari Vinathan, Jane Gune, Akol Lonyamoi, Julius Mori, Hellen Martin, Judy Juru, Latifa Dusuman and Lucy Adelino.

PARTNERS:

Ministry of Health, Government of South Sudan

State Ministries of Health, Government of South Sudan

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Implementing partners

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Nutrition Section, Programme Division
United Nations Children's Fund
3 United Nations Plaza
New York, NY 10017 USA
Email: nutrition@unicef.org
www.unicef.org

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