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VIRTUAL CONFERENCE

CASE STUDY 7

SOUTH SUDAN

Scaling Up Management of Wasting in South Sudan: A Case Study

CONCERN worldwide

Irish Aid
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1.

Context

Wasting burden

South Sudan experiences political and climatic shocks which aggravates ongoing issues of access and a lack of basic infrastructure.

These factors contribute to a sustained nutrition emergency. The available data shows that the average GAM rates per year consistently remain above WHO-UNICEF's high or very high thresholds[1], see Figure 1 (1, 2).

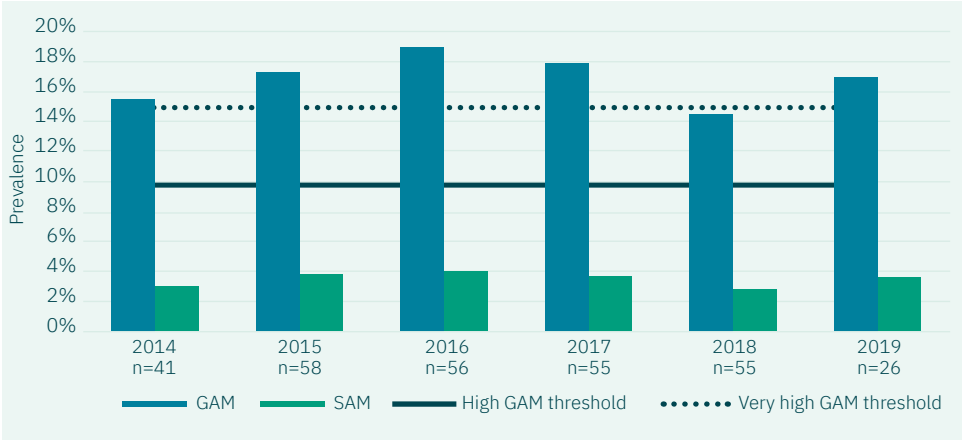

Figure 1. Average GAM and SAM from individual SMART surveys 2014-2019 (2).

Seasonal and geographical variations in the prevalence of moderate and severe wasting often go above the already alarming levels seen above. The states of Jonglei, Unity, Northern Bahr el Ghazal, Upper Nile and Unity are most affected, with over 60% of all SMART surveys in these areas registering a GAM of 15% or over (2).

The maximum GAM value from the individual SMART surveys each year regularly exceeds the critical GAM threshold by over 10 percentage points and in most cases by 15 percentage points. \A total of 53% of counties in South Sudan are experiencing a critical level of acute malnutrition (>10% GAM) (2).

1 Prevalence of Global Acute Malnutrition 10-14.9% is considered high and GAM above 15% is very high and denotes a nutrition emergency

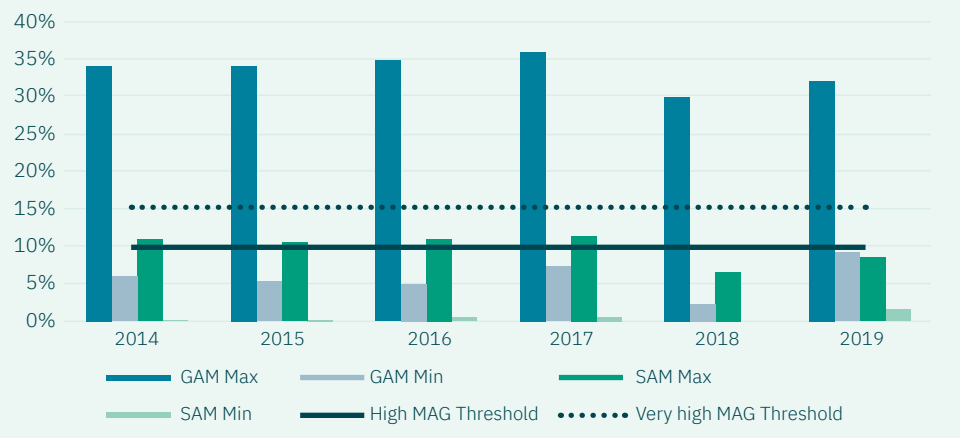

Figure 2. Maximum and minimum prevalence of GAM and SAM from SMART surveys (2014-2019).

Wasting policies and frameworks

In South Sudan, the 2018 CMAM Guideline describes how wasting is to be managed along the continuum of care, and integrates previous guidance which dealt with severe and moderate wasting separately (3). This updated guideline is meant to further support the integration of wasting into the health system. In addition, the National Health Policy (2016-2021) supports strengthening organization and infrastructure for the equitable delivery of the BPHNS (5). However, documents guiding the delivery of wasting services are still not harmonized. For example, the BPHNS has not been updated since 2011 and still includes the necessity for all cases of severe wasting to be treated as inpatients in Therapeutic Feeding Centres. In practice, full integration of wasting services into the health system will require a larger degree of stability in South Sudan. Currently while the Ministry of Health in South Sudan provides normative guidance and oversight, the sector is coordinated by the Nutrition Cluster and funded predominately by UN agencies and donors. NGOs participate in coordination and are the key frontline service providers. Wasting services are still offered in a largely horizontal manner, quasi-parallel to the health system in South Sudan (6).

Service coverage and quality

Access to treatment services, and especially severe wasting services has increased in the last decade. The number of sites for the outpatient management of wasting have increased from 351 in 2014 to 1,191 in 2020[2]. In comparison to the estimated burden, admissions for severe wasting have increased from 40% in 2014 to 74% in 2020[3]. The same dramatic shift was not evident for moderate wasting, in comparison to the total burden of admissions for moderate wasting only increased by 7% form 2014 to 2020[4]. In addition, the quality of services has improved. In 2014 the average rate of recovery for severe wasting was 78% and it rose to 95% in 2020.

2 Informative provided by the Ministry of Health, Republic of South Sudan
3 Information provided by the Ministry of Health, Republic of South Sudan
4 Compared to the total burden admissions for moderate wasting were 40% in 2014 and 47% in 2020. Information provided by the Ministry of Health, Republic of South Sudan.

2.

Key Successes

Although the burden of wasting is still unacceptably high in South Sudan there has been a reduction over the past decade, from a global level of wasting of 23% in 2010 down to less than 17% in 2019 (7,8).

Despite all the complexities of operating in South Sudan, services for wasting have been dramatically scaled up, from less than 400 operational sites in 2014 to over 1000 in 2020[5]. Site locations have also been harmonized, so that 95% of service sites for severe wasting also offer services for moderate wasting (6). This is a reflection of the Joint Nutrition Scale-Up Plan which lays out how UNICEF and WFP are committed to work together and with the MoH and partners to scale up access to wasting services across South Sudan.

The complexities of operating in South Sudan have meant that partners have had to adapt quickly and take advantage of opportunities when they present themselves. The Integrated Rapid Response Mechanism (IRRM) implemented by UNICEF, WFP and FAO, targets hard-to-reach with an integrated package of services[6], including nutritional commodities for the management of wasting[7].

2 In 2020, services for wasting were being provided through 1,102 outpatient sites for severe wasting, 89 Stabilization Centres for the inpatient treatment of severe wasting, and 1,133 sites for the management of moderate wasting.
3 The integrated package includes health, nutrition, WASH, GBV and food security/ livelihood support.
4 For more information on the Integrated Rapid Response Mechanism visit: https://www.unicef.org/southsudan/documents/irrm-briefing-note

3.

Enablers and barriers to the scaling up of wasting treatment

Enablers

South Sudan's decision to harmonized its guidelines and produced one protocol for severe and moderate wasting has improved the continuum of care for wasting in line with global guidance.

The nutrition sector in South Sudan has a strong coordination mechanism among its stakeholders (MoH, Nutrition Cluster team, UN agencies, and implementing partners) at national level. A key action now will be to decentralize and strengthen the coordination systems to a sub-national level. In addition, donor funding in South Sudan has ensured a reliable supply of nutrition commodities, procured through UNICEF and WFP.

Barriers

South Sudan's long history of political instability, insecurity and poor investment in infrastructure means a continued reliance on donor funding and external support for the provision of basic services.

- **Governance and Leadership.** The Ministry of Health in South Sudan provides oversight and normative guidance to wasting services. Nutrition and wasting are integrated into the health sector's strategic frameworks, although in practice service some service providers struggle to implement integrated health and nutrition services and wasting is often a parallel or stand-alone function from health. Coordination is supported by the Nutrition Cluster and its lead agencies. There is a lack of coherence among the various policies and strategic frameworks for health and nutrition in South Sudan which can cause confusion. The National Health Policy (2016-2026) promotes the integration of nutrition and health there is not a multi-sector nutrition strategy which addresses both the causes and management of malnutrition in all its forms.

- **Human Resources.** The organization of roles and responsibilities for nutrition and health staff depends on the service provider (NGO). In some cases the health staff may also be responsible for wasting services but this is not uniform and in some facilities nutrition is offered as a parallel or even a stand-alone function. In-country there is also limited human resource capacity, with years of war having eroded education systems. Difficult working conditions also mean that there is high staff turnover among government and NGO staff.

- **Supplies and infrastructure.** All supplies for the management of both severe and moderate wasting are procured by UNICEF and WFP with distribution facilitated by the NGOs. In some cases the Logistics Cluster is called upon to support product distribution to areas which are particularly inaccessible. The physical infrastructure for service delivery is maintained by NGOs with donor support.

- **Service Delivery.** NGO operate as the services providers in South Sudan. The organization of service delivery is dependent on the service provider's capacities, resources and interest. The delivery of services is complicated by significant access issues as well as insecurity. This complicates supervision, quality assurance and supply systems.

- **Financing.** The financing of interventions to address wasting are financed exclusively by UN agencies and donors. A recent analysis of costing for wasting services in South Sudan has indicated a weighted average unit cost for severe wasting of 358.19$/child, 62.80$/child for moderate wasting and 83.99$/PLW (6). A typical year in South Sudan has over 1.5 million people requiring services for either moderate or severe wasting, making the overall cost of services too high for the government to cover, leading to a high dependence on external financial support from donors and UN agencies.

- **Community.** The Boma Health Initiative (BHI) is a document intended to provide structure to the Community Health System in South Sudan and bridge the gap between health facilities and communities (9). While this document clearly defines the roles, responsibilities and accountability mechanisms for the Community Health Teams, in practice this system is rarely implemented as intended due to time and resource constraints. The BHI limits the roll of CHWs to the detection and referral of moderate and severe wasting, however various organizations have been implementing the detection and treatment of severe wasting into ICCM.

4.

Recent adaptations to wasting services

While some adaptations had started prior to the global Covid-19 crisis, the pandemic did push forward other adaptions as the sector sought to ensure service continuity while reducing or modify patient contact.

The following section reflects the work down by Concern Worldwide South Sudan to reflect on the adaptions made to the management of child wasting in the context of Covid-19 (10).

Modified admission criteria

The CMAM guidelines (3) allow for admission to a nutritional rehabilitation programme based on either biaterial pitting oedema, MUAC, or weight-for-height z-score. In order to reduce physical contact between patient and service provider as well as minimize the time spent on-site, the taking of weight and height was suspended for the pandemic time period. Carers were also trained in how to take their child's MUAC to further reduce contact. While the admissions numbers dropped unexpectedly in May and June 2020 after the modification was made, by July 2020 they were back up to the previous year's baseline. Although this may be due more to a suspension of mass screening events then to a protocol modification. The next step for this adaption is to continue to review outcomes indicators to assess for impact.

Family MUAC

The need for a Family MUAC approach grew out of a need to have continued screening at community level after the suspension of mass screening events following the declaration of the global pandemic. A shortage of MUAC tapes meant that carers of children admitted to wasting services were first prioritized for training so that they could take MUAC measurements at site-visits and for home monitoring. Then to counteract the drop in admissions due to the suspension of mass screenings, other caregivers were trained and provided with a MUAC tape. Although no clear data on this approach is currently available, anecdotal evidence indicates that both caregivers and nutrition staff find it relevant and acceptable for community-based detection.

Modified dosage of therapeutic foods

As weight and height were removed from admission criteria, weight-based dosing of RUTF could no longer. Instead children presenting with severe wasting were advised to have 2 sachets of RUTF/day until cured. This simplified dosing removes the need for ration calculation, simplified stock management at site level and reduced stock-demand due to the reduced dosages. Indicators of programme quality remained acceptable (adhering to SPHERE standards) with the protocol change. Length of stay in both outpatient wasting services (severe and moderate wasting) increased with the reduced dosage protocol. The exact reason for the increase in length of stay is not clear but could be attributable to reduced dosages, reduced contact time with service staff (the number of required visits were scaled back), potential sharing of the ration, and delays in treatment-seeking due to the pandemic.

Integration of treatment for severe wasting into ICCM

The integration of treatment for severe wasting into an ICCM approach was piloted in South Sudan in 2017 by IRC (11). The constraint proposed by the South Sudan context was that most CHWs are low-literate and the tools would have to be adjusted accordingly. Having been successful in providing patient outcomes that meet SPHERE standards, this approach has started to scale up across South Sudan.

It is too early to understand which of these adaptations will remain once the strain of the global pandemic has lessened. However, the experience that the country, guided by the MoH has had with these approaches may help to simply detection and treatment protocols.

5.

Moving forward

In order to continue to take wasting treatment to scale in South Sudan, the MoH will support the roll-out of national guidelines which incorporate wasting treatment with infant and young child nutrition.

In addition, the MoH is further developing the nutrition department within the MoH to ensure there is representation throughout. With donor support the MoH is seeking to develop a multi-sectoral nutrition costed strategy and policy. This process could include the development of a National Nutrition Curriculum, as well as a process for domestic resource mobilization in line with prioritization of a nutrition agenda.

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