



Mothers attending a focus group discussion, Northern Bar el Ghazal, South Sudan, 2018

Michael Mulipeter, Concern Worldwide

Location: South Sudan

What we know: Emergency levels of global acute malnutrition (GAM) continue unabated in Northern Bar el Ghazal State in South Sudan due to ongoing food insecurity and disease.

What this article adds: Focus group discussions with mothers of malnourished children and key informant interviews were undertaken by Concern Worldwide at eight outpatient therapeutic programme (OTP) sites in Northern Bar el Ghazal State to provide insights into factors sustaining childhood malnutrition. Findings showed that mothers are incentivised to keep their children in malnutrition programmes to continue receiving nutritional products and to be admitted into general food distribution (GFD) programmes; household sharing and selling of nutrition products is common; children can become dependent on Plumpy'Nut, leading to readmission; mothers may default from OTPs due to household/childcare pressures; and mothers are concerned about the effectiveness of corn-soy blend (CSB) and the lack of medicines available, even when prescribed. Findings show a need to move away from giving food and nutrition products towards long-term agricultural and food security and livelihoods interventions to prevent malnutrition; targeting for GFD and other programmes must be carefully readdressed to avoid incentivising malnutrition; community-focused nutrition interventions and home visits should be expanded; and agencies must collaborate to prevent mothers attending multiple sites.

Nutrition programming in Northern Bar el Ghazal, South Sudan: A time to reflect

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Background

Concern Worldwide has been operating nutrition treatment programmes in Northern Bar el Ghazal State in South Sudan since 1998. The State, after being ravaged by the war between North and South Sudan until 2005, has largely escaped the direct effects of the ongoing civil war and its population is mainly free to move around the region. Although still impacted by the broader indirect effects of the war (such as the economic crises), Northern Bar el Ghazal is reported to have the highest population of cattle in the country and has some of the most fertile lands. Despite these factors, emergency levels of global acute malnutrition (GAM) remain, as highlighted in a recent analysis on persistent GAM which noted that, “in the nearly ten-year period between September 2005 and November 2014, all but two GAM measurements registered above the emergency threshold of 15%.” (Young and Marchak, 2018). A SMART survey conducted by Concern Worldwide in November 2017 found GAM rates in Aweil West and Aweil North to be 15.2% and 18.5% respectively.

Reasons for the high rates of malnutrition in the country are relatively well known. They are immediately related to food insecurity (below-average harvests and soaring food prices seriously eroding people's ability to feed themselves) and disease (a failing health system and a lack of available medicine to treat basic childhood illnesses). However, a recent series of focus group discussions (FGDs) and key informant interviews (KIIs) in the two counties provide considerable insights into individual and household factors that may be helping sustain childhood malnutrition.

Methods

Eight FGDs were held with groups of seven to ten caregivers and 24 KIIs (with Boma Health Committee members, Health Facility in-charge's,

community nutrition volunteers, Concern Worldwide nutrition staff and village elders) in eight nutrition sites in both counties. Nutrition sites were selected purposefully by the two Nutrition Programme Managers in Aweil West and Aweil North to give a range of perspectives and were paired to allow for comparison between the most contrasting sites (based on accessibility, defaulter rates, relapse rates and quality of farming land). Sampling may have been prone to bias, although it must be noted that the study was only meant to provide insights into programming and was not designed to as a stringent qualitative study. FGDs were held on outpatient therapeutic programme (OTP)/targeted supplementary feeding programme (TSFP) days, when mothers were already available at each site. The OTP supervisor explained the purpose of the FGD to mothers and seven to ten mothers willing to take part were then selected at random.

A predetermined set of eight questions was asked of each group and every key informant. Each FGD and KII was conducted by the Emergency Nutrition Programme Manager, with a Project Officer acting as translator. Having Project Officers well known to the communities acting as translators may have created some bias in the answers provided but, given the tight time schedule of the FGDs, this was unavoidable. As a mechanism to mitigate this, interviews were recorded which enabled future translation checks to be made. Detailed notes were also taken during the interviews. Following interviews, detailed notes and interview recordings were transcribed to allow for analysis. NVivo software was used to identify key themes and commonalities in responses. Analysis was done by the Emergency Nutrition Programme Manager with support from the South Sudan Nutrition Team and broader input from the Senior Nutrition Advisor.



Mothers whose children attending an outpatient therapeutic programme (OTP), Northern Bar al Ghazal, South Sudan, 2018

Results

Mothers wanting their children to be part of the programme

Many informants alluded to the fact that mothers want their children to be part of the nutrition programmes because they are seen as a way of obtaining food for the whole family. Key informants also reported that mothers “don’t need children to get discharged from the programmes” as having a child in the programme takes the stress off having to provide for their families.

Participants added that, when children are discharged from the programme, mothers become stressed because they don’t know how they will feed their children again. They went on to note that, when the child has ready-to-use therapeutic food (RUTF, in this case Plumpy’Nut) or Supercereal (previously known as fortified corn-soya blend flour (CSB)), it gives the mother time to do other things and look for work, rather than having to breastfeed the whole day¹.

Key informants noted that mothers know that if their child recovers, they will no longer be eligible to receive CSB or Plumpy’Nut, so “Sometimes mothers try to control things so that their child doesn’t fully recover”, because then they would be discharged.

This could partially explain why, when analysing registers of children admitted into community-based management of acute malnutrition (CMAM) services during September to December 2017, there was a significant preference for a MUAC of 114mm in many of the sites (a reading of less than 115mm is the criterion for being admitted into severe acute malnutrition (SAM) programmes and thereby receiving therapeutic food). Compared to other populations, this prevalence of MUAC 114mm is high and could reflect the notion of the community ‘wanting’ children to be retained in SAM treatment programmes.

Incentives to be admitted or readmitted: Linkages to other services

Currently, programme registration lists are used as criteria for admission into general food distribution (GFD) programmes. This link was mentioned numerous times in all FGDs. Key informants commented that, because mothers want to get GFD ration cards, they try to be part of SAM treatment programmes. Furthermore, it was reported by informants that they

sometimes register at multiple nutrition sites then, once registered, default from the programme. The phenomenon of attending multiple nutrition sites has been known in the country for several years, with the World Food Programme (WFP) previously supplying ink to nutrition sites and developing protocols for all nutrition-implementing partners to ink children’s fingers once rations have been provided. Informants reported that, while there was previously ink at nutrition sites, now there is none available.

Another concerning aspect mentioned was the control of distributions by village chiefs, particularly in relation to who receives rations and how much of beneficiary’s rations are redistributed to village elders and chiefs.

Incentives to be admitted or readmitted: Sharing and selling of food

The fact that the nutrition products are being used for other purposes was touched upon in almost all FGDs. The maternal feeling that you can’t give the Plumpy’Nut or CSB to only one child came out strongly. Mothers highlighted that it is better to share the food so that their other children don’t get malnourished as well. Mothers emphasised that: “You can’t make special porridge for one child while the others do not get anything.” Another group of mothers said: “Even though you are told at the health facility ‘This is only for the sick child’, you worry about the other children, so it’s better to sell it so you can provide for your whole family.”

It was noted that women use the rations to prepare food for the whole family, particularly when provided with CSB. Key informants said: “If you give the RUTF or CSB to mothers, they might give the children one sachet and then take the rest to the market to sell so that they can feed the rest of the family.”

Other key informants confirmed that sharing and selling of the RUTF is very common as people see it as food and view nutritional commodities “as a valuable asset to be taken to the market.”

Negative longer-term impacts of having children in programmes

Mothers noted that children go from having three sachets of Plumpy’Nut a day when in the programme to just one meal, which makes them more likely to become malnourished again. Mothers asserted that “stress is the cause, because

the child is missing the Plumpy’Nut” and worry that there isn’t enough food at home to feed the child. Other participants confirmed that children get used to the Plumpy’Nut, with one participant commenting: “When it is not there, they miss it.” Mothers elaborated: “The child gets used to the Plumpy’Nut and doesn’t like any other food.” This could potentially create a negative cycle in which children are at risk of returning to nutrition programmes.

Going to the programme prevents other work from being done

Women in the FGDs explained that having to come to the nutrition sites every week prevents them from doing other work, such as collecting firewood, going to the market to sell or groundnut paste, and cultivating their lands to produce food for the family. Many of the women noted that in the past these tasks were done by their husbands but, due to them no longer being there (due to having become soldiers, being sick, having died, being in Sudan, or having many wives), responsibility was left to the women, which meant limited time to care for their children. Such work is vital to improve the household economic situation, increase food security and prevent malnutrition.

Almost all groups mentioned this when discussing why children default from the programmes. Community nutrition volunteers noted that “Mothers would prioritise other tasks over coming to the facility.” This was reiterated by mothers saying, “The sickness won’t finish and it disturbs my business so it is better to go look for food for the rest of the family, rather than just focusing on one child.” Furthermore, mothers felt “You don’t want to risk the other children dying to just get the Plumpy’Nut that is only benefitting one child.” Mothers noted that, because they still want their children to get the nutrition products, they often send an older sibling with the child to the nutrition sites, but that this is not allowed by nutrition staff, who insist on mothers coming to receive nutrition education.

Suspicion around nutrition products

Although most of the products were accepted and even welcomed, there appeared some suspicion in relation to CSB. Some mothers noted that it causes diarrhoea, which is why children don’t get better often don’t respond to the CSB. They felt that this was not the case when children were given RUTF or ready-to-use supplementary food (RUSF). Mothers also argued that when children were given the CSB and it didn’t help them to gain weight, so it must not work.

A lack of medicines and functioning health systems seriously impacts on malnutrition rates

All groups noted that there are no medicines at the health facilities so, even when they take their child to get treated for diseases, there is no treatment available. They said that sometimes the health staff will give them prescriptions to

¹ Worryingly, this could indicate that nutrition programmes may be eroding good breastfeeding practices.

purchase drugs at pharmacies in the markets, but that often the medicines are too expensive. This, they noted, severely impacts on malnutrition rates as: “Even if you take your child to the health facility and want them to be treated early, you can’t, so you wait for the child to become malnourished.”

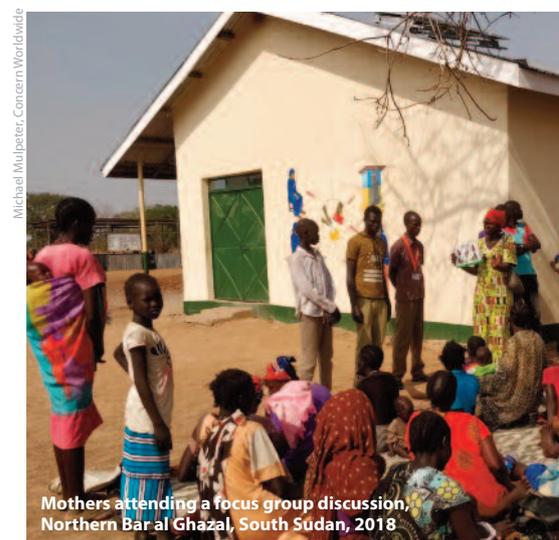
What can be done?

The FGDs reveal issues that the nutrition community has known about for many years but is still grappling to mitigate. In recent years, Concern has shifted emphasis in Northern Bar el Ghazal from emergency programming to a focus on building resilience and delivering sustainable and preventative interventions. This has involved the scaling-up of food security and livelihoods (FSL) interventions and the current piloting of a programme to strengthen preventative actions for nutrition. However, the findings of these FGDs highlight that more still needs to be done in relation to building resilience around nutrition. Not just for Concern, but for all those focussed on treating and preventing acute malnutrition, it is important to think critically about how to implement programmes to avoid any unintended consequences. Some potential options to explore include:

- **Moving programming away from simply giving food and nutrition products:** Programmes should consider how to effectively transition families out of such crises. A comprehensive package of services, involving multiple sectors, is needed. A ‘food-first’ focus continues to dominate thinking and practice in preventing and responding to nutrition emergencies, but these findings, verified by previous analysis of malnutrition in the area², suggest that a lack of food may not be the main driver of malnutrition and thus should not be the main focus of interventions. An additional focus on water, hygiene and sanitation (WASH) interventions as well as on strengthening the health systems in the areas of operation, including ensuring continual access to essential medications, should be given priority. Establishing stronger linkages with integrated community case management should also be considered essential. Furthermore, including hygiene promoters in nutrition

centres and providing mothers with buckets with fitted lids (to prevent contamination) on discharge from the programmes could improve the overall nutrition situation in the community. A truly comprehensive package of services will require additional funding and may take time to reduce the dependency on food-based interventions. However, as these findings show, it is critical to move away from a ‘business-as-usual’ approach in order to really make a difference to the nutrition situation in Northern Bar el Ghazal.

- **Moving to more sustainable, long-term interventions by scaling up agricultural interventions and broadening FSL activities** should also be considered a priority. This should include training farmers on how to create seed banks for communities and developing strategies to encourage people to cultivate their own lands. However, caution is needed in targeting FSL activities through nutritional vulnerability as this can lead to dependency. Instead, targeting should be administered at a community and individual level. Screening for malnutrition can then be integrated into FSL programmes.
- **Better targeting for GFD and other non-nutrition programmes:** It is clear from FGD feedback that the targeting for GFDs and other non-nutrition programmes is problematic and can create dependence on programmes and disincentives for discharge. Better tools for targeting should be developed; simply being part of the nutrition programme should not be the sole criterion. Other factors to be explored in vulnerability assessments could include available food in the household, means of economic engagement and number of children in the household, among others. Targeting could include healthy children in order to incentivise caregivers to keep their children well-nourished, rather than the current situation that seems to incentivise caregivers to have malnourished children. Alternative targeting criteria may be more effective, such as children under two years of age, female or child-headed households and/or number of dependents in the household.
- **Expanding community focused nutrition interventions and increasing home visits:**



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Expanding the preventative aspects of the programme is critical. Concern is currently piloting a five-year, WFP-funded project in several payams³ in Northern Bar el Ghazal to strengthen malnutrition prevention approaches through mother-to-mother support groups and male change agents to catalyse behaviour change. Through these groups mothers are trained and supported to establish vegetable kitchen gardens and educated on the importance of exclusive breastfeeding and handwashing practices, and broadening linkages between nutrition and agricultural interventions. Such programmes do not target beneficiaries according to nutritional status but by vulnerability, usually through a community wealth-ranking exercise, ownership of land and, in some instances, presence of children under two years old. Such programmes should, if possible, be scaled up by Concern and other partners.

- **The need for a collaborative effort between NGO partners:** As noted previously, there are multiple actors working on malnutrition in the region and it is vital that services are mapped out and analysed to ensure that they are in areas of most need and to limit mothers trying to attend multiple nutrition sites for services. All actors must agree on an approach to be used in order not to undermine one another.

For more information, please contact Natalie Sessions at Natalie.sessions@concern.net

² Aweil West and Aweil North. SMART survey report. November 2017; ACF SQUEAC Report in February 2016; Feinstein International Centre Publication on Persistent Global Acute Malnutrition, Case Study: Northern Bar el Ghazal, South Sudan. January 2018.

³ A payam is the second-lowest administrative division, below a county, in South Sudan. A payam is required to have a minimum population of 25,000. They are further sub-divided into bomas. As of 2017, South Sudan had 540 payams and 2,500 bomas.

References

Young H and Marchak A. 2018. Persistent Global Acute Malnutrition: A discussion paper on the scope of the problem, its drivers and recommendations for policy, practice and research. Feinstein International Centre Publication. January 2018.



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