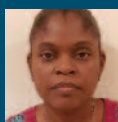


Scaling-up of care for children with acute malnutrition during emergency nutrition response in South Sudan between 2014 and 2018

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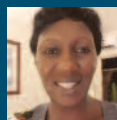
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Location: *South Sudan*

What we know: A division of labour exists between UNICEF and the World Food Programme (WFP) on severe and moderate acute malnutrition treatment respectively. In practice, programmes may be delivered via separate advocacy, caseload planning and partner selection.

What this article adds: In 2014, UNICEF and WFP initiated a unified approach to scale up treatment of children with acute malnutrition in South Sudan to optimise programme delivery and align partners to deliver on the Nutrition Cluster response plan. A joint strategy and an annually updated plan specifies UNICEF and WFP commitments, operating principles, detailed actions and indicators to track deliverables. Collaboration has led to increased coverage and quality of the response. Achievements include a 2.6-fold increase in beneficiary children reached; greater geographic coverage (increased number of sites); and alignment between OTP and targeted supplementary feeding programme (TSFP) services. A simplified 'expanded criteria' approach was introduced for exceptional situations to address treatment continuum gaps. Success factors included a spirit of collaboration between the agencies at management and technical levels; structured and predictable engagement between UNICEF and WFP; collaboration in support of the leadership by the Nutrition Cluster; joint donor engagement; joint shared data management and needs analysis; flexibility in traditional institutional arrangements; and embedding joint actions in agency country plans.

Background

With a national prevalence of 23% global acute malnutrition (GAM) among children aged under five years old in South Sudan, the Nutrition Cluster was first activated in the country in 2010. Between 2010 and 2013 the Nutrition Cluster led and coordinated a limited nutrition response, given the relatively lower needs, restricted resources allocated to nutrition and few implementing partners. Nutrition actors implemented programmes for the management of acute malnutrition, prevention of acute malnutrition, and nutrition surveillance in a few counties in seven former states of South Sudan (Northern Bahr el Ghazal, Warrap, Upper Nile, Unity, Jonglei, Western Bahr el Ghazal, Lakes and Eastern Equatoria). During this time UNICEF and the World Food Programme (WFP) worked largely in parallel, with separate advocacy activities, caseload estimation and partner selection.

In December 2013 a civil war broke out across South Sudan, causing mass displacement, suspension of basic services and deterioration of already-high levels of food insecurity and malnutrition, prompting a large-scale humanitarian response. By August 2014 the integrated food security phase classification (IPC) estimated that 3.9 million people were severely food insecure, with 2.6 million people in the acute phase (Phase 3) and 1.3 million in emergency phase (Phase 4). The same IPC estimated a doubled burden of severe acute malnutrition (SAM)

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF or WFP.



Young boy being measured in a health centre in former Aweil Centre county, South Sudan

Table 1 Set of joint operating principles and commitments from UNICEF and WFP

UNICEF and WFP commit to:	UNICEF and WFP will ensure that:
<ul style="list-style-type: none"> • Agree in partnership to scale up an integrated and comprehensive package of interventions for both the treatment and prevention of acute malnutrition; • Advocate for respective resources for scale-up and to prevent further deterioration; • Maintain a healthy supply chain for nutrition commodities and equipment; • Increase human resources for technical expertise to support quality scale-up and supervision; • Support the Nutrition Cluster, with UNICEF providing the cluster coordinator and WFP providing a cluster co-coordinator; • Streamline respective agencies' administrative procedures for partner contracting and request for supplies; • Provide strategic input and technical support to ensure programme quality; • Provide expertise in nutritional situation analysis, surveillance and assessment. 	<ul style="list-style-type: none"> • All the responses are coordinated under the leadership of the Nutrition Cluster; • Action is based on joint planning between the two agencies; • An agreed deployment consisting of a variety of modalities will be used to maximise the response; • UNICEF and WFP will initiate an 'expanded criteria' approach to treat SAM and MAM when services/supplies for only one are available; • An agreed sensitive approach to programming is used to err on the side of inclusion, ensuring that all needs will be met; • Emergency response actions (whenever possible) include long-term sustainable solutions.

from 2013 to 2014, from just over 100,000 to 235,000 children. The burden of moderate acute malnutrition (MAM) had a 447% increase, from 123,383 to 675,400 children. Faced with this increased burden, wider geographical spread and a continued hazardous environment, it was clear that UNICEF and WFP needed to come together to rapidly scale up the existing response.

The approach

Setting the foundation

In June 2014 the two levels of representations of UNICEF and WFP, technical¹ and management², and the Nutrition Cluster met to kick-start the conceptualisation of the joint UNICEF-WFP emergency nutrition response. Working according to their respective global mandates (WFP as the lead for MAM and UNICEF as the lead for SAM), the agencies marshalled their collective resources and leveraged their comparative advantages to develop a detailed response strategy.

A vital set of overarching commitments and operating principles were agreed that set the tone of the partnership (Box 1). Key foundations for an effective partnership between the agencies were defined as:

1. A joint action plan, regularly revised;
2. Mutually agreed principles and commitments;

3. Close coordination at country and field level;
4. Quarterly and annual progress reports and reviews;
5. Dedicated staff member facilitating and coordinating the partnership; and
6. Scheduled joint UNICEF and WFP management meetings for partnership updates.

The resulting *Joint Nutrition Response Scale Up Plan* included specific actions that each agency needed to take, jointly and separately, to reach their respective targets by the end of 2014, with the overall aim of reaching the nearly 330,000 pregnant and breastfeeding women and one million acutely malnourished children in need of life-saving treatment. The plan was subsequently presented to members of the Nutrition Cluster in July 2014, including non-governmental organisations and the donor community, who readily endorsed it.

A joint nutrition scale-up action plan was also developed, laying out urgent and immediate actions for each agency to contribute to a scaled-up emergency nutrition response and the broader Nutrition Cluster scale-up plan.³ The details of each action were described, as well as timelines, responsibilities, humanitarian scenarios with corresponding implications, risk, and mitigation measures. The plan provided a means to hold

each of the agencies accountable for their agreed actions, on the understanding that targets would not be reached without joint aligned actions

The expanded criteria approach

The ongoing conflict greatly complicated access to certain geographical areas and reduced partner presence on the ground. There was a need to develop a system for the treatment of acute malnutrition when service delivery was compromised. Provision for a simplified approach using expanded criteria was made when treatment for either SAM or MAM was exceptionally unavailable (see Box 2). The expanded criteria approach used in South Sudan has at its base co-location, single product, single partner, rapid delivery, life-saving principle, capacity for inclusion of pregnant and lactating women (PLW) and use of MUAC/WHZ as independent admission criteria. (Box 2)

Coordination

Human resource capacity was increased at all levels to support the scale-up and oversee the response. A dedicated nutritionist was recruited to facilitate, coordinate and oversee progress of the action plan and the overall response between the two agencies. At country-office level, the two agencies' nutrition teams initially met weekly, then biweekly and eventually monthly, to review admissions statistics and actions taken in order to inform decision-making, discuss implementation challenges and decide the way forward. The coordinated nutrition response was integrated into the representatives' regular agenda during bilateral meetings and resourcing and advocacy statements were harmonised to ensure adequate funding was achieved for each agency. This set the tone for a unified partnership from country-office to field-office levels.

At field-office level, as adequate funds were received, UNICEF and WFP increased technical experts. This reinforced the collaboration as nutritionists began consulting regularly on partnership alignment, joint supervision missions and caseload calculations. The Nutrition Cluster structure in South Sudan was such that, while UNICEF is the Nutrition Cluster lead agency and supports a Nutrition Cluster Coordinator and Nutrition Information Specialist, there is also a Co-cluster Co-ordinator position supported by Action Against Hunger. To ensure additional support, a Deputy Nutrition Cluster Coordinator is supported by WFP. This additional appointment was critical in supporting the Nutrition Cluster in responding to the stretched workload emergency needs.

Reporting

Progress reports, jointly produced and published quarterly and annually, allowed UNICEF and WFP to assess progress made and communicate

¹ Regional Advisors for Nutrition, Senior Advisors for Nutrition in Emergencies from HQs, Chiefs of Nutrition from country offices.

² Senior Advisors Nutrition from HQ, Regional Directors and related advisors and county representatives.

³ Experience of the Nutrition Cluster regarding partnership and accountability in South Sudan are detailed in Isack Biseko Manyama (2017). Partnership and accountability in the South Sudan Nutrition Cluster (2015-2017). *Field Exchange* 56, December 2017. p29. www.ennonline.net/fex/56/southsudannutritioncluster

Box 1 'Expanded criteria' approach for acute malnutrition treatment in South Sudan

The expanded criteria approach was developed as an exceptional interim measure to be used when the appropriate product was not available to treat the relevant condition. This could be due to lack of concurrent geographic coverage of programmes to treat children with SAM with ready-to-use therapeutic food (RUTF) and to treat children with MAM with ready-to-use supplementary food (RUSF) or when a respective pipeline break occurred. This is intended as an interim measure until appropriate services to treat children with SAM and MAM with the relevant product is in place.

Possible scenarios for use of the expanded criteria approach were: stock-outs of supplies at site level, breaks in the supply chain, and other logistics/delivery issues or interruptions. The expanded criteria approach could be activated for a distribution period as short as one day to more than one week, depending on the severity of the situation, the number of beneficiaries and how quickly stocks could be replenished at the distribution site. In these circumstances, the agency present could use available commodities (RUTF/RUSF) for treatment of SAM or MAM (without complications) in order to enable treatment and reduce associated mortality. The Nutrition Cluster was responsible for activating the expanded criteria approach after a consultative

meeting with UNICEF, WFP and implementing partners working in the affected location. Under the expanded criteria approach, children with SAM received 14 sachets of RUSF per week (2/day) and children with MAM received seven sachets of RUTF per week (1/day).

UNICEF and WFP had agreed in principle that this approach could be deployed with the condition that use of RUTF/RUSF would not impact availability of the product to treat children with the corresponding acute malnutrition diagnosis.

Since 2015, when the expanded criteria approach was operationalised, it has been used in two circumstances. First, during routine programming when only one product was available (due to product pipeline break, looting/depletion of supplies, or when the nutrition site was immediately inaccessible). The second circumstance was during the rapid response mechanism (RRM) missions when only one agency was present and only one product was used. In 2018, for example, 3,031 children were reached through the expanded criteria in this way, including 180 SAM/MAM children using RUSF and 2,851 SAM/MAM children with RUTF. Data on the use of the expanded criteria approach was not captured in the routine programme prior to 2018.

Achievements

Due to increased investment, collaboration and commitment by both agencies over the past five years, there have been several significant achievements. Data show that, between 2014 and 2017, the number of beneficiary children reached increased each year, even with a rising burden of acute malnutrition (Figure 1 and 2)⁵. This needs to be viewed in the context of the severe conflict, internal displacement, restricted access to certain areas, a nascent health-delivery system and a functioning but severely resource-constrained Nutrition Department of the Ministry of Health (MoH). Coordination, led by the Nutrition Cluster, executed through UNICEF and WFP, and supported by different international and national partners, supported the scope and scale of the response. UNICEF and WFP scaled up coverage from less than 100 operational nutrition sites combined in 2013 to over 900 nutrition sites, covering 76 out of 79 counties, in 2019 (Figure 3), indicating both pre-existing gaps and expanded needs.

Information on how UN agency/Cluster targets are determined is shown in Box 4. This is a yearly exercise that allows for discussion, analysis and forecasting of the expected caseload needs. It uses the programme data from the previous year, as well as the caseload determination calculation, the projected resources and partner capacity for implementation, to derive a target caseload for the year. It is agreed by the agencies and the Cluster and then used for implementation planning.

The spirit of effective collaboration and partnership has successfully fed down from senior management of UNICEF and WFP country offices to field level. Feedback from the teams demonstrates a strong level of collaboration down to field level, particularly in terms of partner alignment, to ensure a continuum of care, joint supervision and monitoring, bilateral and joint meetings with partners, and enhanced sub-cluster coordination systems. Rapid response mechanism (RRM) missions continued to be the best way of reaching women and children in areas made inaccessible by insecurity and limited access. UNICEF, WFP and cluster partners scaled up the use of RRM missions, ranging from annual missions of 37 to 66 over the last five years. Nutrition interventions for the RRM missions have also been harmonised, with dedicated staff from both agencies overseeing the full nutrition-in-emergency package of preventative and treatment interventions.

Co-location of service delivery allowing for a continuum of care is one of the success stories of nutrition treatment in South Sudan. At the start of the conflict in 2014, OTP and TSFP services were co-located in approximately 45% of all sites. This was primarily due to historical

Table 2 Examples of UNICEF and WFP joint activities and indicators

Activities	Indicators
CMAM services in 70% of existing functional health activities	Percentage of functional health facilities that have integrated the community-based management of acute malnutrition (CMAM)
Harmonise field-level agreement (FLA) and programme cooperation agreement (PCA) processes through joint engagement of partners	Number of partnerships established through same cycle of FLA/PCA
Utilise gap analysis of CMAM services to develop PCAs and FLAs	Percentage of facilities with the same partner implementing OTP and TSFP
Align nutrition partner presence at the county level	Number of counties covered entirely by one partner
Continue joint supportive monitoring visits to nutrition partners at the site level	Number of supportive visits conducted by December 2018
Continue joint supportive monitoring visits involving the department of nutrition at the national and state levels	Number of supportive visits involving the Government conducted by December 2018
Integrate infant and young child feeding in emergencies (IYCF-E) into blanket supplementary feeding programme (BSFP) implementation	Number of BSFP sites providing IYCF-E messages

Source: UNICEF and WFP Collaboration Framework, South Sudan, July 2017 to December 2018⁴

externally on the impact and achievements of the strategic partnership. Annual review meetings were held with UNICEF, WFP and the Nutrition Cluster to discuss progress against indicators, impact in terms of targets reached and continued challenges. Subsequently, annual action plans were developed to enable continued collaboration. The initial commitments and operational principles continue to be honoured with each incoming nutrition team and representative, and the stage is set for continued planning, joint funding and advocacy efforts.

In 2015 UNICEF and WFP conducted a review and consultation with key stakeholders on the achievement of targets, implementation of activities and the added value of the partnership between the two UN agencies, as outlined in the joint nutrition scale-up action plan. Feedback

on the challenges and way forward from the consultations and the analysis of the nutrition emergency, at the time shaped the plan for the next 12 months, which was renamed the Joint Nutrition Response Plan. This new plan reflected the focus on maintaining the scale-up gains made through the continued humanitarian response, while improving quality and building systems around delivery of nutrition services.

The Joint Nutrition Response Scale Up Plan continues to be updated annually, with each plan since 2014 building on the previous year's achievements and responding to existing challenges and gaps. Each plan includes specific actions and indicators to enable the measuring of progress and to hold each agency to account. Box 3 provides examples of joint agency actions and corresponding indicators.

⁴ This action plan was developed for one year and a half to align the scale-up calendar (July-June) with the routine programme cycle (Jan-Dec).

⁵ The reduction in admissions observed in 2018 reflects the beginning of an improved trend in the GAM rate as confirmed by the FSNS round 22, which showed a GAM of 13.3%.

Figure 1 Number of children with severe acute malnutrition age 6 to 59 months targeted and reached in South Sudan, 2014-2018

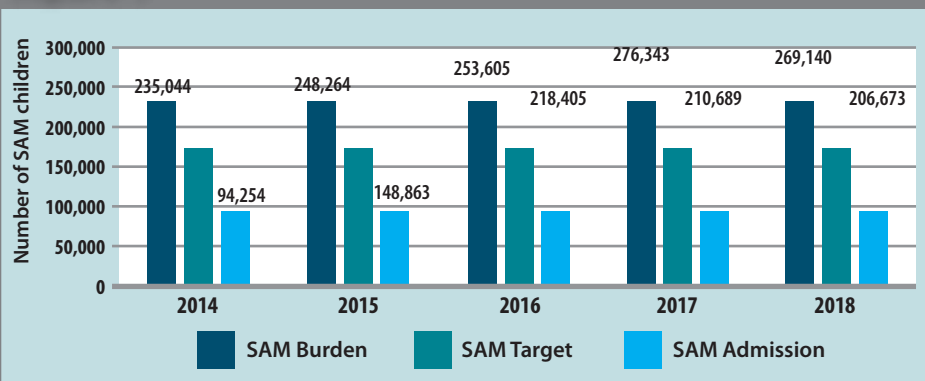


Figure 2 Number of children with moderate acute malnutrition age 6 to 59 months targeted and reached in South Sudan, 2014-2018

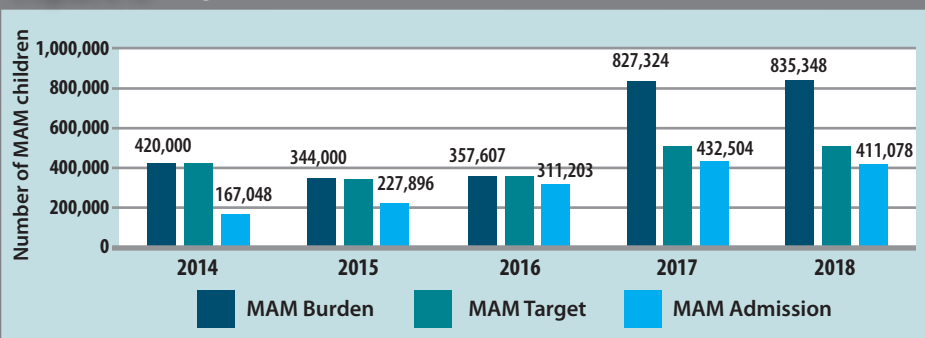
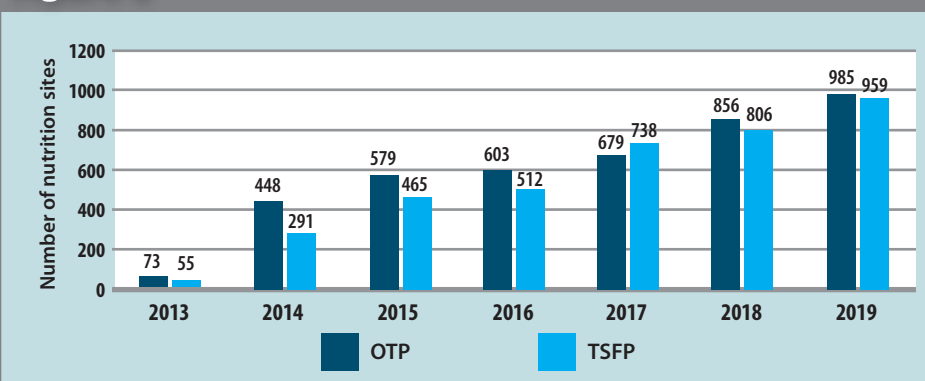


Figure 3 Number of operational nutrition sites in South Sudan, 2014-2019



discordance in partner presence, previous preference of alignment of partners based on agency activities versus sector activities, and limited capacity of partners to implement the full community-based management of acute malnutrition (CMAM) protocol. Over the course of five years, through continued dialogue with partners and with leadership and encouragement from the MoH, Nutrition Cluster and donors, UNICEF and WFP are now implementing joint services in over 91% of nutrition sites.

Co-location enables a more effective flow of beneficiaries between services. (For example, children transferred from OTP to TSFP services to continue treatment once recovered from SAM.) Co-location of services was made possible through cooperation between UNICEF and WFP (with the Nutrition Cluster), specifically when choosing cooperating partners through field-level agreement

(FLA) and programme cooperation agreement processes. Working together on this has helped overcome issues such as different timeframes for contract renewal; cooperating partner preferences (i.e. a cooperating partner may be preferred by one organisation but not the other);

and leveraging different funding modalities, such as the Common Humanitarian Fund (CHF) and organisation-specific funding.

In order to better understand the needs and gaps in the country and help develop a targeted response, in 2014 UNICEF and WFP advocated for the inclusion of nutrition indicators in the Food and Nutrition Security Monitoring System (FSNMS) (conducted biannually to assess food security outcomes) and piloted the Integrated Food Security Phase classification for Acute Malnutrition (IPC-AMN). South Sudan subsequently became one of the few countries to include acute malnutrition within the IPC analysis and projection maps. Furthermore, active participation of nutrition stakeholders was enabled through the Cluster in order to contribute to IPC analysis. UNICEF and WFP continued to improve quality and expand the scope of nutrition data collected within FSNMS beyond anthropometry of children aged 6-59 months, increasing the scope to anthropometry of children aged 0-59 months to capture indicators on stunting and wasting and include information on maternal and women's nutritional status and infant and young child feeding indicators. Further improvement on data quality was done through harmonisation of training through training of trainers, use of mobile phone technology to include controls in measurement, and real-time daily data availability for quality check and feedback to field teams.

In 2015 the Nutrition Cluster launched a new, site-based nutrition information system (NIS) in order to move away from the county/partner-based Excel reporting. The average reporting rate of sites providing treatment of SAM/MAM improved gradually from a pre-crisis rate of below 50% to 98% between 2013 and 2018. The NIS now contains six years of nutrition data and performance indicators and plans are underway to integrate it into the reformed national health information system. These efforts have enabled a much clearer picture of the current and projected nutrition situation in the country. Beside their use in planning and prioritisation of interventions, the assessments contribute to inform the IPC. Three annual IPC exercises were conducted in January, May and September 2018.

Another key success has been the strengthening of the policy environment and capacity of the Department of Nutrition under the MoH.

Box 2 Determining UN agency annual targets for SAM and MAM

The total burden, or people in need (PIN) can be derived from the humanitarian need overview (HNO)/humanitarian response plan (HRP) and is calculated using the total number of individuals with acute malnutrition found using the following caseload determination calculation.

$$\text{Burden} = \text{Population 6-59m} \times [\text{Prevalence} + (\text{Prevalence} \times 1.6)]$$

Or

$$\text{Simplified to: Burden} = \text{Population 6-59m} \times \text{Prevalence} \times 2.6$$

Based on the projected availability of resources and achievement of the previous year, UNICEF and WFP provide support to a percentage of the burden or PIN. This acts as the target for UNICEF, WFP and the Nutrition Cluster and varies from year to year.



A young child having their MUAC measured at a health centre in former Aweil Centre county, South Sudan

WFP and UNICEF contributed to this through the provision of technical staff, development of revised CMAM guidelines and protocol, development of a new maternal infant and young child nutrition strategy and guidelines, and support for cascading capacity-strengthening trainings to state MoH and implementing nutrition partners. UNICEF and WFP also jointly funded and supported the launch of the Scaling Up Nutrition (SUN) Movement in South Sudan.

A strong example of the effectiveness of the partnership was seen in January 2017, when famine was declared by the IPC in Leer county in Southern Unity. The same year, the Greater Equatoria region, previously considered the 'green belt', saw a rising rate of acute malnutrition. Due to the strong collaboration and partnership between UNICEF and WFP and established joint systems for information gathering, commodity delivery and engagement with partners, it was possible to quickly adapt to the growing needs and expand operations in both Unity and Greater Equatoria.

Lessons learnt

Enabling factors

Given the dramatic increase in the estimated number of children affected by acute malnutrition as a result of the civil war, it was clear that, in order to reach their targets, the two leading agencies in nutrition needed to collaborate rather than work in silos. By working together, it was possible to respond to critical levels of acute malnutrition even in the highly complex, insecure environment of South Sudan. In addition, the collaboration created a favourable resourcing environment. This was achieved by donors supporting harmonised planned activities and separate proposals to support the treatment

of acute malnutrition in both programmes. UNICEF, WFP and the Nutrition Cluster all received adequate funding to fulfil their individual and joint commitments in the scale-up plan.

The approach was also helped by the country teams that set the tone for collaboration, with very strong support from both the regional and global teams of both agencies. The regional offices have continued to jointly support each successive joint plan. Through high-level engagement, the joint action plan and strategy provided the notion and practical framework for close collaboration. Joint working is now a given for all existing staff members and there is a clear expectation that the collaboration must be maintained.

Challenges

Despite the achievements, certain challenges persist. Understanding coverage gaps remains an area of confusion. With continued population movement and the limited functional government health system, many nutrition sites still exist outside the health structure, limiting full integration and compromising continuum of care and health referral pathways. And, while partner alignment has greatly improved, due to the fractured environment prior to the joint partnership and pre-existing partner selection, the improvement has taken almost five years; whereas, in 2018, over 90% of nutrition sites could provide OTP and TSFP services by one partner.

Funding continues to be focused on emergency, life-saving interventions with one-year financing. Over this period, four humanitarian response plans have been developed; each including sections and financing specific to the nutrition sector. This funding horizon provides a challenge to achieving sustainable impact, as partners require committed financing to provide longer-term support to enable sustainable change and build community resilience.

Poor infrastructure has also been a challenge for transport of commodities in South Sudan. This requires dry-season prepositioning of essential nutrition supplies for continuity of service delivery. On many occasions, prepositioning is delayed due to lack of timely advance funding to take advantage of the dry-season window.

Discussion and conclusion

The partnership between UNICEF and WFP in South Sudan has allowed for a more complete and integrated response, with each agency providing its comparative advantages: WFP bringing expertise in food security, access, deep field logistics expertise and Cluster experience; and UNICEF contributing health, education, water, sanitation and hygiene expertise.

This successful partnership was impelled by the overwhelming population needs that neither UN agency could meet alone. It required multiple programmatic commitments, including an investment in planned actions and interventions; a dedicated coordinator managing the partnership and holding each agency to account; an acceptance among the nutrition and donor community of

partnership; a harmonised approach to geographic coverage; a joint shared-data management and needs analysis; continued leadership by the Nutrition Cluster; and embedding of the partnership targets and activities in the UNICEF and WFP respective country strategies and plans. Furthermore, the senior management commitment to this initiative, as well as the concerted and joint support from the regional and headquarter levels of both agencies, contributed to the success and continued partnership of the project.

Although the initial stages of the partnership experienced 'growing pains', many lessons were learned that were subsequently reflected in the following years' joint nutrition response plans that allowed both agencies to 'course correct' as needed. While both the Nutrition Cluster and the MoH supported the partnership, the strength and success of the collaboration rested on several factors, including rapport-building, desire to move towards a common goal and the recognition and utilisation of each agency's comparative advantage. Ultimately, strong coordination was critical: where the cluster system is activated, the Nutrition Cluster is best placed to provide the oversight and leadership for this type of co-ordination effort. In the absence of a cluster system, the sector system should be active and the government – in this case the MoH through the Department of Nutrition – should ideally take the lead.

This experience raises questions regarding the *modus operandi* for UN agencies. In South Sudan, alignment had its challenges, given existing institutional approaches and policies. This was an area on which UNICEF and WFP worked hard to reach consensus when selecting a cooperating partner, establishing targets and caseloads, and adding a TSFP or OTP to their programming remit. Alignment had its challenges, given existing institutional approaches and policies, and required goodwill on all sides, as well as a willingness to shift programming norms.

Five years into the emergency in South Sudan and three changes of leadership later, WFP and UNICEF continue to coordinate closely; this year producing their sixth Joint UNICEF/WFP Collaboration Framework. The institutionalisation of this joint initiative has enabled the project to be independent from the leadership changes, both at the technical and management level. This is the result of much hard work by staff in both agencies, motivated by the goal of combating malnutrition in South Sudan.

This case study has been drafted to provide insight into how two UN agencies can work together towards a common objective in an extremely challenging context with a high burden of acute malnutrition. While contexts will be different, the lessons learned here, particularly at the strategic level, can be applied to other contexts, agencies and sectors experiencing similar challenges in the management of overlapping priorities and objectives.

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