Technical Rapid Response Team

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Community Management of Acute Malnutrition in South Sudan

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Esther Busquet
Nutrition / Social and Behavior Change Advisor
Technical Rapid Response Team / International Medical Corps

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Author
Esther Busquet
Nutrition/ social and behavior change advisor
Technical Rapid Response Team / International Medical Corps
1313 L Street NW, Suite 110
Washington, DC 20005 USA
ebusquet@internationalmedicalcorps.org

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Abbreviations

CMAM	community management of acute malnutrition
CUAMM	Collegio universitario aspiranti medici missionari (known as Doctors with Africa CUAMM)
IMC	International Medical Corps
IPC	integrated phase classification
IYCF	infant and young child feeding
MAM	moderate acute malnutrition
MoH	Ministry of Health
NGO	non-governmental organization
OFDA	Office of US Foreign Disaster Assistance
OPD	outpatient department
OTP	outpatient therapeutic program component
PHCC	primary health care center
PHCU	primary health care unit
PI	Plan International
QAAP	quality and accountability to affected populations
SAM	severe acute malnutrition
SC	stabilization center
SCI	Save the Children International
SMART	Standardized Monitoring and Assessment of Relief and Transitions
Tech RRT	technical rapid response team
ToR	terms of reference
TSFP	targeted supplementary feeding program component
TWG	technical working group
USAID	United States' Agency for International Development
WFP	World Food Program
WVI	World Vision International

1. Introduction/background

In South Sudan, the 2013 civil war has resulted in widespread insecurity and instability. Conflict and insecurity across South Sudan has resulted in a breakdown in community structures, food insecurity, poverty, poor health and nutrition status. According to the Integrated Food Security Phase Classification, a famine was declared in Unity State from February till June 2017. Although the famine has been denounced, in January 2018, 5.3 million people (48% of the population) were estimated to be facing Crisis and Emergency (IPC Phases 3 and 4) acute food insecurity, out of which 1 million people are facing Emergency (IPC Phase 4) acute food insecurity. Compared with the same time last year, this reflects a 40% increase in the population facing severe food insecurity in the post-harvest season[1]. Acute malnutrition remains a major public health emergency in several parts of South Sudan. Over 1.1 million children are estimated to be acutely malnourished. A total of 57 SMART surveys were conducted in 2017 by numerous organizations; 37 of the surveys showed a global acute malnutrition prevalence above the emergency threshold of 15%[2].

2. Objectives

To ensure the quality of nutrition activities is high, all nutrition partners are expected to monitor and supervise their programs and report their findings bi-annually to the nutrition cluster. Efforts to improve the quality of nutrition programs should be made throughout the year by all partners to ensure all nutrition programs in South Sudan meet or exceed the minimum standards. However, it can be challenging for NGOs to objectively monitor their nutrition activities.

The main objective is to support the nutrition cluster to conduct a review of routine nutrition activities and provide recommendations and corrective actions to strengthen the nutrition activities, and especially CMAM and IYCF activities implemented by all partners (both international and national organizations).

This will be achieved by focusing on the following:

1. Review of existing program documents, including the South Sudan CMAM Guideline, monitoring and supervision tools, 5Ws and other relevant information at national level
2. Conduct in-person monitoring visits of selected nutrition projects in four Counties as per request/recommendations of the Ministry of Health Nutrition Department and the QAAP technical working group taking into consideration the State representation in South Sudan for the sampling. All the selected nutrition projects will be assessed. This includes coordinating with partners for transport, logistics and conducting any trainings necessary to carry out the agreed upon methodology.
3. Conduct on the job trainings and coaching of nutrition staff during the field monitoring for gaps that cannot wait for training to be organized or for action whose continuation of the status quo may lead to more harm to the beneficiaries.

[1] Key messages from the South Sudan TWG: http://www.ipcinfo.org/ipcinfo-detail-forms/ipcinfo-map-detail/en/c/1103832/
[2] South Sudan nutrition cluster SMART Survey Database (version of 28 February 2018)

4. Maintain regular communication with the nutrition cluster coordination team while in the field.
5. Compile and analyze the data collected during the in-person monitoring visits and making any necessary recommendations for corrective actions in the final report
6. Present the results for discussion to all nutrition partners at district and national level ensuring that all partners understand the results and are able to carry out the corrective action. The nutrition cluster will monitor the implementation of the corrective actions[3].

3. Methodology

3.1 Selection of counties for field visits

Meetings and discussions with the cluster coordination team, the Director of Nutrition of the Ministry of Health and with the Quality and Accountability for Affected People (QAAP) technical working group provided a list of counties in various states that would be preferred/most suitable for a visit to see the programs there, mainly because these counties have not been visited in the (recent) past, so it is unclear what is exactly happening in these counties.

Unity and Northern Bhar El Ghazal States were excluded from field visits as UNICEF is in the process of starting a 'supportive supervision and corrective action' project funded by OFDA, which has among others, the objective to ensure proper monitoring of CMAM programs.

Commentaire [EB1]: Please check if this is correctly phrased, or suggest how to correct it..

There was clear preference for five states to be visited (in order of preference): Jonglei, Warrap, Eastern Equatoria, Upper Nile, and Lakes. For each state, two or three preference counties were identified, and then discussed with the IMC Security Coordinator for clearance to travel. The selected states, counties as well as security clearance per county are shown in Annex I. The only county selected for which no clearance was given, due to security issues was Renk County, in Upper Nile.

Based on the WFP/UNHAS flight schedule and time available for field trips, it was not possible to visit four different counties, as indicated in the Terms of Reference (ToR); only three different counties in three different states could be visited. Two of the identified counties could not be visited: Fangak county (or the neighboring counties that were selected as alternative) due to logistical issues, and Kapoeta due to a security incident, so alternative counties were selected (Rumbek Center and Juba Town).

In the end the following counties were visited:
Rumbek Center (Lakes State), Juba (Central Equatoria State) and Twic (Warrap State).

[3] As agreed in the Terms of Reference between the South Sudan nutrition cluster and the Technical Advisor

3.2 Field visits

During each field trip, two to four different sites were visited, and where possible these visits were done together with several partners involved in providing CMAM services in the county:

Rumbek Center, Lakes State

- Sites visited: Rumbek State Hospital, Malual Bab PHCC, Mathangai PHCC
- Partners met: CUAMM (hosting), Plan International, UNICEF, Director General of the State Ministry of Health, County Health Department's nutrition focal point

Juba, Central Equatoria State

- Sites visited: Gumbo PHCC, PoC3 in Juba
- Partners met: Concern Worldwide, International Medical Corps

Twic, Warrap State

- Sites visited: Wunrok PHCC, Aweng PHCC, Pagai PHCU, Pandit PHCU
- Partners met: World Vision (Hosting), World Food Program

In all sites the following topics were checked, observed or asked about:

- Staff
- Protocol
- Equipment
- Measurements/anthropometry
- Register books, beneficiary cards
- Nutrition education
- Storage
- Reporting
- Referrals
- Any other topics/observations

These topics are the topics mentioned in the monthly supportive supervision checklist for OTP/TSFP in annex 45 of the new CMAM Guideline. The same topics, as well as some broader topics (such as presence of WASH activities in the facility, staffing rosters, reporting) are included in the quarterly supportive supervision checklist in annex 46 of the new CMAM Guideline, which are here reported under 'any other topics/observations' if relevant. As staff in all sites visited were proud and motivated to show their program and show their knowledge of running the OTP/TSFP, it was difficult to use the checklists, as the staff continued discussing the program while the advisor was searching in the list where to tick the correct boxes, or write observations; it worked better to listen carefully and after the 'tour' of the program check if all topics were being discussed, make additional notes and bring up the topics not yet discussed. However, the tool is very useful for making sure all aspects of a program are being checked and discussed with the team. The checklist is shown in Annex XX.

Not all topics were possible to check for each visit; non-checked topics were left out of the text. For example, in one site all children were treated before the Advisor arrived at the site, and mothers and children already left the location, so no measurements were observed at this site, and the heading 'measurements/anthropometry' is not mentioned in the results as there was nothing to comment about.

All visits were done together with one or more of the supporting/implementing partner, as a minimum with the partner that was hosting the Tech RRT Advisor during her field trips. It would be useful to do unannounced visits from time to time as well, but this was not feasible during this exercise, due to the way things were organized; the Tech RRT Advisor was hosted by one of the international agencies working in a county; this agency also provided transportation to and from sites, and thus the program manager was accompanying the Advisor when visiting sites – which was very useful to get a better picture of the overall program. For most visits to the sites one or more of the other partners involved in providing the CMAM services joined as well.

4. Results and Discussion

4.1 Findings and observations of all visited sites

4.1.1 Rumbek Center County, Lakes State

Rumbek State Hospital
OTP and SC supported by CUAMM

OTP

- General notes:
  - OTP had more than 100 beneficiaries in charge
  - Good flow: first seeing clinical officer and then referred for screening/measurements and if needed admission into the OTP
- Staff
  - Staff motivated; eager to show the Nutrition Advisor around and tell how they work
  - Team of 3 people; follow up 2 days per week; 2 days for outreach, 1 day for follow up in morning and visit to orphanage in afternoon ('outreach')
- Protocol
  - Copy of new guideline available
  - Team knows the guideline, can explain that "cured" from OTP is improvement from SAM to MAM but not real recovery
- Equipment

- Equipment OK
- Using hanging scale with pants (not basin)

- Measurements/anthropometry
  - MUAC measurements done correctly (only MUAC observed);
- Register books, beneficiary cards
  - Register book and cards look good; no empty spaces, everything filled; clearly indicated when child was cured/discharged – however, exact number of children still in charge could not be provided (115 children entered in register book, but quite a few were already discharged, so fewer still under admission – hence the indication above that there were "more than 100" beneficiaries in charge, without providing an exact number)
- Nutrition education
  - Nutrition education provided, using UNICEF IYCF counseling cards. People appreciate the nutrition education and were asking questions; two mothers were asked to repeat the 3 messages provided in their own words, to cross-check they had correctly understood the messages; other messages (than IYCF) were also introduced such as WASH (mainly hygiene) messages and the importance of a varied diet. People in the area are not used to consume vegetables but do vegetable gardening when advised to do so. When discussing, staff expressed the need to give several messages per week ('as there are so many things that people have to change/improve')
- Reporting
  - Sometimes high defaulter rates, especially between August and December due to moving to grazing grounds for the cattle (far away – too far for most people; some mothers do walk full day to come to OTP, and full day back; I mentioned possibility to consider bi-weekly treatment visits, but staff preferred weekly – but something to look into) other reason: too busy harvesting (various crops one after another)
- Referrals
  - No referrals were being observed while visiting the hospital
- Any other topics/observations
  - The team of 3 people is doing outreach on Friday morning. However, the area covered by the hospital included 76 villages which require regular visits for screening, which is impossible with such a small team and so many villages. We discussed the possibility to identify women – for example mothers of children who have been in the program in the past – who could be trained in measuring MUAC of their own child and the children of neighbors regularly. The comment from the nutrition coordinator is that there is no funding for paying so many people incentives; but this should not be based on an incentive scheme as is common in South Sudan but 'true' volunteering, and not doing the screening of one or more entire villages, but only their own child(ren) and those of their nearest neighbors, which would only cost them maximum one hour per week or even per month. Staff seemed not very confident this would work; they seemed convinced all these mothers would expect and demand an incentive for this 'work'. However, in order to make it feasible to have all children screened at least once per month, a system not based on incentives is required, especially on the long-term.

SC

- General notes:
  - 12 beneficiaries in charge (2 patients of 3 weeks old of which mother died; 3 patients >5 years old); main complication: severe malaria plus anemia
  - Sometimes severe oedema (but rare in SS), one child with zinc deficiency (diagnosed and treated correctly!! Very impressive!!), one hydrocephalus case (going to Uganda for treatment)
- Staff
  One nurse in charge, several nutrition assistants to support
- Protocol
  - Staff trained in the new Guideline and using it; copy of protocol in the SC
  - One of the 3-week old babies was fed by bottle; the SC nurse herself was cleaning the bottle and teaching the grandmother how to clean it correctly as they indicated the baby was too small to be fed by cup or spoon
- Equipment
  - All equipment seen was in good order
- Register books, beneficiary cards
  - Correctly and clearly filled; no missing information
- Referrals
  - No referrals observed during the visit
- Any other topics/observations
  - Observation/remark Gloria (SC nurse): they have no blankets for treating hypothermia (and building is semi-open and windy, which is not good for hypothermia)

<u>Malual Bab PHCC</u>
OTP supported by CUAMM, and TSFP supported by Plan International

- Staff
  - OTP: staff know the guidelines, explain things properly, books and cards filled correctly
- Protocol
  - Staff has been trained in the new CMAM Guideline and is using it
- Measurements/anthropometry
  - OTP: Weight measurement: still done with hanging scale and pants – better to replace pants by basin; instructions provided on how to put the pants on in easier way
  - TSFP: suggestion to replace height board as part of the measuring tape was not glued to the board (it seems to have a 'loop' and is not fitting exactly so correct measurement is difficult/impossible); Plan promised to request a new height board from UNICEF
  - TSFP: height measurement done by 3 people plus several people watching, so scary for the child as the child could no longer see its mother (the people watching came for the Advisor's visit, but 3 staff to do measurement is too many)

- In general: MUAC measured while child is sitting on mothers arm. Not always tried to have the child standing ('because it is crying if I ask it to stand alone') and not really tried to let arm hang loose and relaxed while reading. Midpoint calculated and dot marked on child's arm
- Register books, beneficiary cards
  - Correctly filled
- Nutrition education
  - Plan gives beneficiaries a bucket with lid, jerrycan and soap (and will soon distribute a towel as well – to be used for the child)
- Reporting
  - TSFP: From time to time relatively high defaulter rate (10%) due to insecurity; many come from far away areas where there is no TSFP available (long distance combined with insecurity)
- Referrals
  - Screening: jointly by PI and CUAMM
  - Growth monitoring recommended by MoH; but not requested by UNICEF so often not done

<u>Mathangai PHCC</u>
OTP supported by CUAMM and TSFP supported by Plan International

- General notes
  - OTP: in charge 15 children (since 6 Dec)
  - OTP done outside under trees; benches available for the caregivers and children and staff
  - TSFP in charge: 86 children/PLW
- Protocol
  - All staff in OTP and TSFP has been trained in the new CMAM Guideline and are using it; copy of protocol present at the site
- Equipment
  - Height board in TSFP: the measuring tape is not properly fixed to the board (same as yesterday), making precise measurements is not possible. Advisor reported this to UNICEF so they can check all spare height boards in stock; and PI will try to get the boards changed for proper ones, but they probably will have to check all height boards as they are all made the same way…
  - Scale used is a hanging scale with pants not basin
- Measurements/anthropometry
  - Done correctly (observed measuring weight)
- Register books, beneficiary cards
  - OTP: not many children/low caseload. In old register book (till 4 Dec 2017), it was noted that not for all children it was indicated that they were already discharged. The OTP nutrition volunteer did know this for each child in the register book, but had not filled this in the book (it was noted on the beneficiary cards). With the new MoH register books it is easier than in the old ledger book, so from now on discharges will be recorded for all children
- Nutrition education
  - Using UNICEF counseling cards

- Storage
  - Noted: storage space is issue; they emptied the ante-natal care room to store supplies for TSFP/OTP as there was no storage space available; not clear where ANC is now taking place (sharing space with one of the other wards now)
- Referrals
  - In the OPD registration MUAC columns were not filled, as there seems to be no communication between MoH and NGO staffs (as literally said by the in charge of the facility: "they don't speak with me"); they both do their own thing although working in the same building. Recommended to start filling the MUAC in the register book as well as it is a way of cross-checking and making sure all children in the PHCC are being screened. In-charge not trained in new CMAM Guideline yet (roll-out plan is being worked on) and it was the first time for him to see the book with CMAM monthly reporting forms (one form for both OTP and TSFP); Jane briefly explained to him what should be filled and which columns could be cross-checked by checking both CMAM register books as well as the OPD book (which records MUAC in cm, as well as those with yellow or red MUAC (3 different columns), so yellows and reds can be cross checked as they should show up in the register books of OTP and TSFP as well. In charge promised to work together with the people from CUAMM and PI on the monthly reports so he is aware as well.

4.1.2 Juba County, Central Equatoria State

Gumbo PHCU

Supported by Concern (OTP/TSFP)

- General notes
  - OTP: in charge
  - In charge: 473 cases of which about 60 with SAM
  - Separate building for the CMAM program, with space for mothers to sit and wait on mats on the floor, with toys for the children. Mothers receive nutrition education here
- Staff
  - One staff was systematically giving explanations on how to use the RUSF to all mothers when giving out the ration for the next two weeks (really good!)
- Protocol
  - Concern staff trained in new Guideline; Staff know the new Guideline and use it; they have laminated sheets with admission and discharge criteria; nutrition education topics, WFH tables, amount of RUSF and CSB++ to give etc…
  - We had some discussion about some of the medical check-ups for children with MAM: is it really necessary to check with every child if it has fever, diarrhea or any other issues? As Gumbo is a very large center as to number of patients in charge (470 in total of which 60 in OTP) it just takes too much time to check temperature for all children and for many you know they are not having any fever, so staff requested if it is OK to only measure for temperature if the child feels hot, or mother is indicating that the child is/was not well since the last visit. I basically agree with this in TSFP, but it is not protocol (but simply more realistic/feasible for large sites)

- Equipment in order
- Measurements/anthropometry
  - Measurements done correctly, but not always correctly noted on the patient card or in register book; for several cases the information was present on the beneficiary card, but team had not had time to copy the required info into the register book
- Register books, beneficiary cards
  - Not all information was copied from the beneficiary cards into the register books, mainly due to the high caseload at the site (however, this makes it complicated to correctly tally all info required for the weekly reporting)
- Nutrition education
  - Tools used: UNICEF counseling cards, but also providing information about the treatment that the children receive, hygiene and other important messages
- Any other topics/observations
  - Although catchment area is one part of Juba only (Gumbo), some people have to come from relatively far away as the PHCU is not placed centrally in the area, but at one side (next to the main road to Uganda)

<u>PoC3 – Juba</u>

Stabilization Center run by International Medical Corps; OTP run by Concern (OTP not visited; at the day of the visit all OTP staff was out in the PoC for screening/outreach)

- General notes
  - SC: At time of visit 7 children in charge
  - Complications: severe malaria/anemia and pneumonia
- Protocol
  - Using new guideline
  - Protocol knowledge: good, protocol available in SC
- Measurements/anthropometry
  - Equipment in order; no measurement taking seen
- Register books, beneficiary cards
  - Correctly filled; no gaps
- Nutrition education
  - Using UNICEF counseling cards as well as specific information about the treatment of acute malnutrition
- Storage
  - Storage space: sufficient space available, therapeutic foods and medication for treatment in the SC are kept separately from the rest of the pharmaceuticals used in the clinic
- Referrals
  - Good collaboration with Concern for referring to and from OTP

4.1.3 Twic County, Warrap State

Wunrok PHCC

SC and OTP, supported by World Vision; WFP supports the TSFP and joined during the visits

- General notes
  - SC: 7 beneficiaries in charge. Main complications: severe malaria/anemia, and pneumonia. Few months ago child with zinc deficiency: correctly identified and treated; now also: one child with heart complications, and one with pneumonia
  - OTP: 54 children in charge
- Staff
  - Staff knows the protocol and is very motivated
- Protocol
  - Staff trained in and using the new CMAM Guideline
- Measurements/anthropometry
  - Scale was hanging too high (not eye height but about 5 cm higher)
- Register books, beneficiary cards
  - Books and cards correctly filled
- Nutrition education
  - Nutrition education: UNICEF counseling cards
- Storage
  - Storage room is OK (large, airy, using pallets or alternative

Aweng PHCC

OTP and TSFP, supported by World Vision; WFP supports WVI for the TSFP and joined the visit

- General notes
  - On 14 Feb: in TSFP 177 children aged 6-59 months and 270 PLW admitted; in OTP 45 children aged 6-59 months admitted
- Staff
  - Staff requested to have SC in Aweng, and is confident they can do this if they get trained in the new protocol/guideline. Children come from very far and refuse to go to Wunrok which is the nearest SC, but considered too far to go; other SCs even further away so not an option
- Protocol
  - Present in site; staff trained in and using the new CMAM Guideline
- Equipment
  - Equipment OK
- Measurements/anthropometry
  Not observed; mothers and children already left upon arrival
- Register books, beneficiary cards
  - Register books and cards are correctly filled
- Reporting

- Weekly report: percentages of discharges were not being calculated so we discussed this and they will start doing this from now on; we discussed how these performance indicators can help them monitor their program and indicate if there are any issues

Pagai PHCU

OTP and TSFP supported by World Vision

- Staff: motivated, knowing protocols
- Protocol: staff trained in new Guideline
- Equipment: OK
- Measurements/anthropometry: not observed; mothers went home before arrival at the PHCU
- Register books, beneficiary cards
  - Still using old register book
- Nutrition education: UNICEF counseling cards
- Storage
  - OTP; no supplies for TSFP at the moment (short period!) – will arrive any moment (NOTE: supplies arrived the day after the visit)
- Reporting
  - Not calculating the discharge percentages
- Referrals
- Any other topics/observations

Pandit PHCU

- Staff : good knowledge of protocols and treatment
- Protocol
  - Children were discharged when improved to MAM level, despite the fact that there was no TSFP running at the time of the visit. Shown the team the alternative protocol for when there is no functioning TSFP (on page 91 of the draft Guideline), and sent email to Nutrition Manager in Twic (Elijah); however, the lack of supplies was very short and supplies arrived the day after visiting the center
- Equipment
  - Equipment OK
- Measurements/anthropometry: not observed
- Register books, beneficiary cards
  - Register book and beneficiaries cards correctly filled; Protocol knowledge OK, for standard protocol, but did not know the alternative protocol for when there is no TSFP. Using old register book; we delivered the new one during the visit
  - WVI did not receive any forms or register books from MoH so printed their own (but did receive the new register books now?)
- Nutrition education: using UNICEF counseling cards
- Storage

- OTP only (TSFP will start as soon as they get supplies)

4.2 Results per topic

Protocol

In all facilities, a hard copy of the protocol (new CMAM Guideline) was present so staff could check if needed. All NGO staff have been trained in the new CMAM Guideline, but MoH staff not yet; planning of the roll-out per county is on-going, and the training of MoH staff has started.

Trained staff know the protocol and apply it as well as possible. In Rumbek the alternative protocol for treatment of SAM in situations where there is no TSFP present is followed; in Twic staff needed to get an explanation of this protocol, although new TSFP supplies arrived the day after the Advisor's visit, so TSFP was only suspended for a few days.

The new CMAM Guideline is in the very last stages of being finalized and officially launched. However, all implementing partners were introduced to the new guideline at the end of 2016 (?) and have been using the Guideline since this introduction workshop. In all sites the NGO staff running the CMAM program were trained in the new Guideline, but MoH staff in charge of the health facility have not been trained yet. The first training of MoH staff started in February 2018 in Juba.

Equipment

All sites had working equipment, although not all sites had the same equipment. In several sites the height boards from UNICEF had an issue making correct height measurements impossible: the metal measuring tape was not correctly fixed to the boards, causing a loop (the tape was not glued all over, but only at the ends).

Scales were either hanging scales with pants, or an electric mother-baby scale. Only Concern uses basins with the hanging scale, the other agencies used the (uncomfortable) pants that UNICEF provides with the scales.

Measurements/anthropometry

Measurements observed were taken correctly, although in several occasions the scale was not hanging at eye height of the measurer, which can cause over- or underestimation of the weight. It was immediately suggested to correct the height of the scale; in one occasion an alternative needs to be found as it was not possible to hang the scale any lower.

Height measurements observed were taken correctly, but no one had raised the issue of the measuring tapes being attached incorrectly to the boards, so this requires correction. UNICEF in Rumbek was informed about the issue so they could check the height boards in UNICEF storage, to see if more boards have the same problem and to replace the boards identified with a problem.

Register books, beneficiary cards

Most sites are using the new register books – which are preferred over the old books (as most staff indicated), as more information can be entered, and it is all clearer than in the smaller, old register books. Few sites were still using the old register books, but they received the new books and the request to copy the few remaining beneficiaries into the new register and start using this register book.

In general, register books were filled correctly, although from time to time not all discharges were indicated in the register book, but only on the patient cards. The staff knew exactly which children were still admitted in the program, but this was not (yet) recorded in the books. This was corrected, and from now on all information will be filled in the register books, even if the information is correctly available on the beneficiary cards already. This will make reporting at the end of the week and end of the month easier.
No rounding off of measurements was observed in any of the register books checked.

Reporting (including data collection and analysis)

The new weekly and monthly reporting forms are appreciated; they are clear to fill for the staff, and the fact that the reports are done in threefold for easy sharing is considered positive. It was noted that most staff did not calculate the percentages per type of discharge (cured rate, defaulter rate, death rate, non-responder rate); when this was observed, a discussion was held with the staff to make them understand why it was important to calculate these rates, and how this can help them monitor their own program and know when to investigate or take action.

Nutrition education

All sites use the UNICEF counseling cards for nutrition education.
In Gumbo (Juba) one staff was assigned to give all mothers/caretakers the weekly ration for the child, and to give one-on-one explanation to each mother about how to use the product, how much to give each time, etc.

Storage

Storage spaces seen were adequate, in all facilities the cartons with RUTF or RUSF were placed on pallets or alternatives (elevated from the floor). Not all spaces were large enough to have space around the pallets at all sides; in some cases the cartons were resting against the wall. In one site, the room originally meant for ante-natal care was being used as storage space. This room was well organized and provided sufficient space for proper store keeping, but it was unclear where antenatal care visits were taking place now.

Referrals

Referral of beneficiaries between the different components of a CMAM program was done correctly according to the staff at the sites, even if the different components were run by different agencies. Referral for a medical check-up or form the health center/unit to the nutrition program was also correctly done, although communication between the MoH staff and NGOs can improve – there was less

communication between MoH staff and NGO staff than between staff of various NGOs. However, it seems that nutrition coordinators and other nutrition partners (such as WHO) were not entirely agreeing with this, and during the presentation of the key findings of all field visits, several people indicated they are concerned about correct referrals between the various CMAM components and CMAM and health programs. Since several people stated their concerns this is something to follow up on, as a good referral system is critical for successful implementation of any CMAM program.

Integration

All sites visited were in hospitals, PHCCs, and PHCUs, so 'integrated' into the health system, although often the CMAM component was in a separate room, or even a separate building/construction done by the implementing partner, so it was not true integration as activities were kept separate (Although people were referred from health to nutrition and vice versa, staff did not check if people were indeed also visiting the other program. On-site screening is done in the health program in order to refer all acutely malnourished children and pregnant and lactating women. In turn, patients in the nutrition program are being medically checked by the medical in-charge, or referred to the medical staff in case further medical checks are deemed necessary. Communication between different agencies running OTP and TSFP in the same site is going well, and referrals in both directions are happening as stated by the staff in the sites visited. However not in all sites OTP and TSFP were happening on the same day, so referral from one CMAM component to the other would mean that the caretaker would have to come back for a second visit to the other component.

However, communication with the in-charge and/or medical staff in the health facility was not always as good as between the different nutrition partners. One in-charge literally said "the NGO staff are not talking with me"; but he did not do any effort to discuss with the NGO staff either. This in-charge was not trained in the treatment of malnutrition, so he had no clear idea of what the nutrition teams were doing in OTP and TSFP. In his OPD book, the MUAC was not filled although he did measure the MUAC of all children; but he referred if needed and did not fill the column in the OPD register book. He also had not seen the weekly/monthly reporting forms yet (which is logical as he was not trained), so the report was explained to him and all agreed to work together in filling the reporting forms, so he would learn from the nutrition staff how to report correctly and what it all means. The in-charge is looking forward to receive the training about the Guideline so he can better lead his facility.

Integration with other sectors is not really happening at field level (where checked/asked); in two sites we had a discussion about preventing malnutrition and the importance to support people with prevention for example to include mothers of a child in the OTP/TSFP could be referred to the food security program of another agency.

Staff

In all sites visited, the staff was motivated and proud to show their program to the Advisor. Staff told about things they would like to change/improve, such as more sites so mothers don't have to travel far to reach OTP/TSFP, an ambulance service to transport children and caretakers referred to SC as the SC is even much further away. Staff in one site asked if they could open their own SC at their site as they were

convinced they could do it after getting training on the SC Guidelines, as they observed that mothers refused to go to the nearest SC, as it is considered too far away.

The minimum requirement of staff per site is 5 people for OTP and/or TSFP; some of these staff are partly funded by WFP or UNICEF. Both UNICEF and WFP allow for two staffs for OTP and/or TSFP to be funded through the PCA, which would give four staff in a site to run OTP and TSFP. For many sites this seems sufficient staff, but especially for sites with a high caseload, this is not enough staff to guarantee good quality care for all beneficiaries.

Any other topics/observations (including surveys/assessments done/not done)

It seems most organizations were familiar with conducting SMART surveys and doing them as part of the ongoing monitoring of the nutrition situation in the country. However, it also seems that there are agencies (such as CUAMM and Plan International with whom this topic was discussed) have no experience of SQUEAC assessments, and are thus not conducting any, while SQUEAC assessments should be part of the routine monitoring of a CMAM program as it provides lots of useful insight and information to improve both quality and coverage of a CMAM program.

Main gaps/problems identified/mentioned by staff from OTP/TSFP and/or health facility:

- Insecurity
- Distance to health facility
- Limited number of staff per site (UNICEF and WFP each allow salary for two staffs per site – but in some areas even the 4 staff together is insufficient to run a good quality program, due to the large number of beneficiaries – this is an issue for agencies where UNICEF and/or WFP are the main donors)
- Funding. Donors are not always willing to support the number of sites proposed for a county (so distance to reach facility is still an issue), or only willing to fund OTP and not TSFP. Emergency donors not wanting to fund prevention activities either (lack of funds available for South Sudan)

5. Recommendations

General recommendations

- In Rumbek: More TSFP sites needed (now more OTP than TSFP sites); for each child with SAM there are up to 10 children with MAM (plus the PLW) (plan working with WFP to increase number of TSFP in 11 sites in Rumbek Center and possibly 13 in Rumbek East – Rumbek East needs assessment first, then can be added to list of WFP)
- In general there seem to be more OTPs than TSFPs while there are many more children with MAM than with SAM. It seems cost-ineffective to wait till children deteriorate from MAM to SAM and then enter them in a program for treatment; while treatment is quicker, and cheaper when the child is 'only' MAM and not yet SAM…
- Only when properly measuring coverage and performance indicators you can say something about the impact and effect of a program in an area…

Protocol

- Develop roll-out plan for introducing the new CMAM Guideline, including all referral and reporting tools provided in the Guideline, and start the trainings (note: trainings started in Juba in February)

Equipment

- Small issues in equipment: UNICEF heightboards (measuring tapes not properly attached)
- Hanging scales should use a basin and no longer the pants provided with the scales as these are too uncomfortable for the child, and the child can easily fall out of the pants

Register books/ beneficiary cards

- Make sure all agencies are using the new register books; these are better and much appreciated by staff using these new register books already (majority of sites visited already use the new register books, but some are still using the old ones)

Reporting

- In the trainings on the new CMAM Guideline, enough time should be planned for training on correct reporting, so people understand which data to collect and why, and are able to do some data analysis for their own program/program component and understand how to interpret the findings, so they can immediately investigate and take action in case something goes wrong (for example observing that Sphere minimum standards are not being met – investigate the problem and come up with solution so program quality improves). Just collecting data to send to a supervisor without having any idea why this information is collected does not motivate staff to collect good quality data, and understanding the data at site level will mean that any action can be taken much quicker than when data is send to another location where it is compiled with data from other facilities and might not be noticed.

Nutrition education

- All agencies visited are using the UNICEF counseling cards for their nutrition education component. However, the counseling cards are focusing mainly on IYCF practices, while there are other critical nutritional practices that require improvement as well, such as maternal nutrition, hygiene, specific nutritional needs of adolescents and especially adolescent girls, nutrition of a sick child, etc. One package that could be considered is the Facts for Life package (see: https://www.unicef.org/publications/files/Facts_for_Life_EN_010810.pdf and http://www.factsforlifeglobal.org/)

Referrals

- Increase community outreach: increase number of community screeners – now the TSFP/OTP staff is doing outreach on Fridays in some areas (Rumbek), and in other areas a few community volunteers have to cover quite a few villages. It should be investigated if it is possible to have 'real' volunteers who only screen (and possibly educate) their neighbors, so it will cost them only an hour per week max, and not 3 days per week (For which an 'incentive' is paid instead of salary while it is a part-time job!)
- Correct referral between CMAM components and between CMAM and health seem to go well according to local staff at sites, but it is a major concern among nutrition partners at Juba level, so it is important to look into this and if needed to develop an action plan to improve the referral system, as this is one of the most critical facets of a CMAM program. This would be something for the CMAM technical working group to look into, and to come up with a way to check this nationwide. Increasing the number of community screeners would also help to improve referral from community to the CMAM program.

Integration

- Continue/improve communications and collaboration between the different parties (MoH, NGOs) to improve services, as well as data collection and analysis and reporting
- Referral between CMAM components and CMAM with other programs/sectors could be a problem; it is possible that this is partly due to the fact that different CMAM components are done by different agencies, and relatively separate from the health services provided, which indicated integration is not fully happening yet. Training of MoH health staff in the HFs will give them a better understanding of treatment of acute malnutrition which will help in easier/better communication with NGOs and partners.

Staff

- Staff was motivated and overall doing a good job, but in some HFs with a large caseload the number of staff was insufficient, and this seems to be at least for a (large) part due to donor/funding constraints. It is known for a long time that treatment of acute malnutrition is relative intensive treatment (as it is not just giving out pills such as for malaria treatment), which requires a high number of well-trained staff. Due to the current funding climate for South Sudan the number of staff being allowed in proposals is reduced considerably, which might hamper the quality of the

services provided, especially in nutrition facilities serving a high number of people. It is critical that there is dialogue between the organizations implementing CMAM services and donors on ensuring the quality of services provided; if staff needs to be further reduced or cannot be increased because of donors demands, agencies will have to consider serving a smaller population in order to maintain good quality services; but this will mean other people/areas might not get any services at all. The nutrition cluster could possible a good 'platform' to have this dialogue with donors, and otherwise the CMAM technical working group can for example look into the minimum number of staff required to serve a population of xxx people with good quality CMAM programs.

- In community-based programming, the people from the community play a critical role in the success of the program. It was noted that in some areas there are insufficient screeners to reach all villages in the area, which means (many) cases of acute malnutrition might go undetected, so an increase in the number of people available for and able to screen will need to be increased. One successful approach can be to involve mothers in MUAC screening, which has been proven successful in various countries. Evidence from Niger has shown that caregivers are able successfully to measure MUAC and are not inferior to community health workers (CHW), with children being admitted to care earlier and requiring fewer hospitalisations. Additionally, this approach has been shown to cost less to implement than the traditional CHW-led approach. See https://www.alima-ngo.org/empowering-mothers-prevent-malnutrition and https://archpublichealth.biomedcentral.com/track/pdf/10.1186/s13690-016-0149-5

Any other issues

- IYCF: support groups have been set up (CUAMM), but they are set up for mothers of children in OTP/TSFP, so not having a preventative objective, but more as a way to monitor the CMAM patients, and try to prevent future malnutrition in the child or its siblings.
- SQUEAC is not part of routine monitoring of CMAM programs; agencies are still running CMAM programs without ever doing a SQUEAC, while this is currently not anymore the international recommendation

Annexes

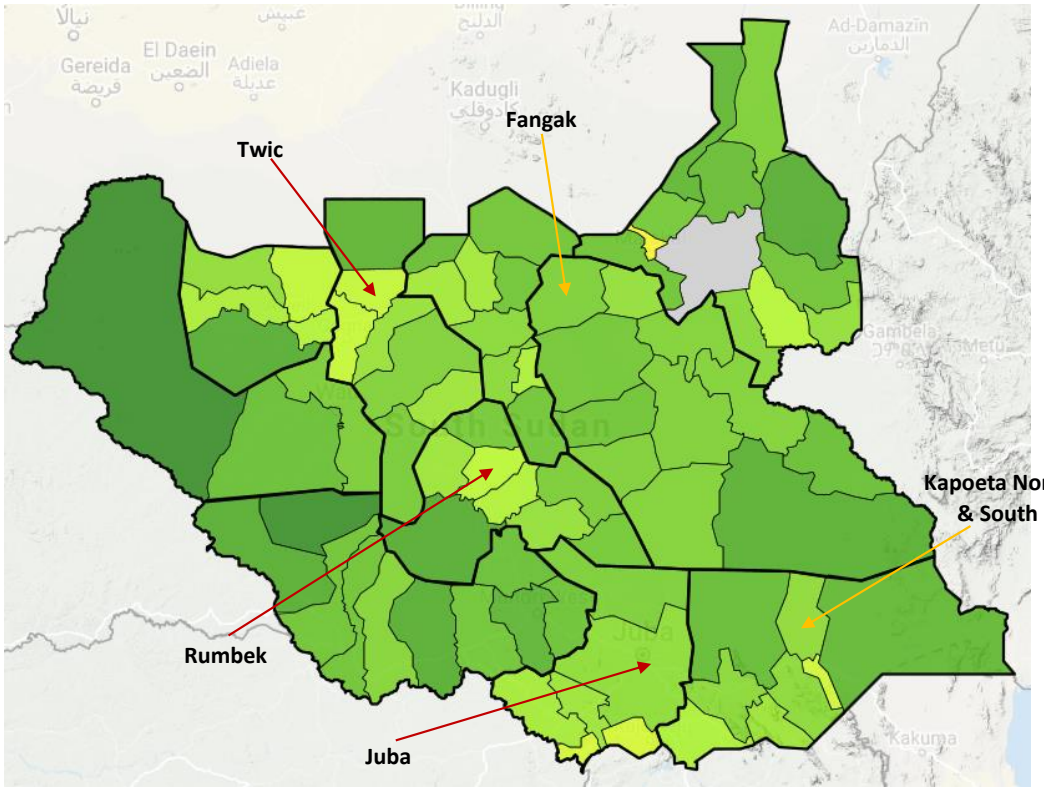
I. Selection schedule for field visits
II. Map of South Sudan, with counties visited
III. Monitoring forms / checklists used during field visits
IV. ToR Tech RRT Advisor
V. List of QAAP TWG members?
VI. Contact details of people met
VII. Timeline of deployment

Annex I – Schedule of counties to visit in order of preference

State	County	Nutrition partners	Security clearance to travel
Jonglei	Fangak	AAH CMA HCO NileHope World Relief	Yes
	Nyirol	CMA SCI	Yes
	Ayod	CRS RMF	Yes
Warrap	Twic	WVI CCM	Yes
	Gogrial West	AAH WVI DAI	Yes
	Gogrial East	WVI	Yes
Eastern Equatoria	Kapoeta East	SCI PI AFSS	Yes
	Kapoeta South	SCI CREDO MaCDA	Yes
Upper Nile	Renk	MedAir	No
	Malakal	IMC	Yes
Lakes	Rumbek (town & surroundings)	CUAMM PI	Yes
	Awerial	CUAMM PI	Yes

NB: states and counties are presented in order of preference for a visit

Annex II – Counties selected and visited



Source: https://www.citypopulation.de/php/southsudan-admin.php

= selected and visited
= selected but unable to visit

NB: Presidential decrees of 2015 and 2017 replace the ten states by 32 new states.