South Sudan
UNICEF and WFP Scale-Up Nutrition Plan
One Year Report
Foreword

Since the initiation of the Joint Nutrition Scale-Up Plan in July 2014, the World Food Programme (WFP) and the United Nations Children’s Fund (UNICEF) have demonstrated that by working together, in collaboration with Nutrition Cluster and government partners, it is possible to respond to critical levels of malnutrition, even in the highly complex, insecure environment of South Sudan. In early 2014, due to conflict, the already fragile basic social service infrastructure of the country had collapsed and many humanitarian services were halted in highly volatile areas. As a result, traditionally high levels of malnutrition were driven to alarming rates with 900,000 children in urgent need of treatment.

In response, over the past year, UNICEF and WFP invested in building technical expertise, partnerships, securing supplies and strengthening evidence base required to expand the coverage of lifesaving nutrition services. Innovations such as the rapid response mechanism and social mobilization were used to identify and treat children who would otherwise not be reached. As a result, we have treated far more children for acute malnutrition in the first half of 2015 than the whole of 2014. Both agencies are on track to reach or exceed the targeted caseload by the end of the year, despite the disruption of services in conflict-affected states.

Going into the second year of the WFP-UNICEF partnership, conflict, food insecurity and a worsening economic crisis continue to devastate the lives of children and their families in South Sudan. In remote areas cut off from assistance, the threat of famine is very real. Systems put in place over the past year will allow our agencies to better respond and re-establish services in the worst-affected areas, while continuing to expand the reach and quality of services, including in areas of the country that have historically suffered high levels of acute malnutrition.

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Acronyms

BSFP  Blanket Supplementary Feeding Programme
CES   Central Equatorial State
CMAM  community management of acute malnutrition
CNV   community nutrition volunteers
CO    country office
CSB   corn-soya blend
EES   Eastern Equatoria State
FLA   field level agreement
FO    field office
FSNMS Food Security and Nutrition Monitoring System
GAM   global acute malnutrition
HQ    headquarters
IDP   internally displaced person
IPC   Integrated Food Security Phase Classification
IYCF  infant and young child feeding
L3    Level 3
MAM   moderate acute malnutrition
MOH   Ministry of Health
NBeG  Northern Bahr el Ghazal
NGO   non-government organizations
OTP   outpatient treatment programme
PCA   partnership cooperation agreement
PLW   pregnant and lactating women
RB    regional bureau
RRM   rapid response mechanism
RUSF  ready-to-use supplementary food
RUTF  ready-to-use therapeutic food
SAM   severe acute malnutrition
SC    stabilization centres
SMOH  State Ministry of Health
SO    sub-office
SOP   standard operating procedures
SRP   Strategic Response Plan
TSFP  targeted supplementary feeding programme
TWG   technical working group
UN    United Nations
UNHAS United Nations Humanitarian Air Service
UNICEF United Nations Children’s Fund
USD   United States Dollars
WBeG  Western Bahr el Ghazal
WFP   World Food Programme
Map 1: May – August 2014 Food Security Projections

The information shown on this map does not imply official recognition or endorsement of any physical, political boundaries or feature names by the United Nations or other collaborative organizations. UN OCHA and affiliated organizations are not liable for damages of any kind related to the use of this data.

* Final boundary between the Republic of Sudan and the Republic of South Sudan not yet determined.
** Final status of Abyei area not yet determined.
Background: The Rapidly Deteriorating Situation in 2014

The conflict in South Sudan which broke out in Juba in December 2013 and spread quickly to Greater Upper Nile (Jonglei, Upper Nile and Unity states) had forced 1.4 million people from their homes by May 2014. Basic services – already weak before the crisis – collapsed. Fifty-seven percent of health facilities and 40 percent of WASH facilities were destroyed or non-functional. Livelihoods and markets were devastated. The NGOs who provided the vast majority of services were forced to evacuate or drastically scale back. Trained national health and nutrition professionals fled with their families to escape the violence. Combined, these factors rapidly increased traditionally high rates of malnutrition to alarming levels. Due to the active conflict provision of nutrition services was rapidly decreasing, only 183 of 336 outpatient therapeutic programme (OTP) centres were operational and many targeted supplementary feeding programmes (TSFP) sites were also halting services. The threat of famine loomed, with displaced and host community families unable to fill the hunger gap.

The May 2014 Integrated Phase Classification (IPC) forecast estimated that the number of children suffering from severe acute malnutrition (SAM) had more than doubled from a pre-crisis estimate of 100,000 to a revised estimate of 235,000\(^1\). The burden of moderate acute malnutrition (MAM) increasing by over 400 percent from 123,383\(^2\) to 675,400\(^3\), over 900,000 children were estimated to be acutely malnourished and in urgent need of treatment. The worst-affected areas were Jonglei, Upper Nile and Unity States, along with the traditional high-burden states of Northern Bahr el Ghazal and Warrap, which also showed a corresponding increase in acute malnutrition. Counties including Leer, Panyijiar and Akobo East registered global acute malnutrition (GAM) rates above 30 percent, double the WHO standard nutrition emergency threshold of 15 percent. The May IPC forecast was equally dire in terms of food security. With 4 million people (34 percent of total estimated population of 11.6 million) expected to experience acute and emergency levels of food insecurity between June and August 2014; meaning that 840,000 children under 5 and 328,000 pregnant and lactating women were facing unacceptably high levels of food insecurity.

In the extremely complex and insecure operating environment in South Sudan in May 2014, it was not possible to rely on a traditional nutrition response. Access to the conflict-affected states was severely constrained by insecurity as well as the March through November rainy season. Humanitarians faced growing levels of risk. National staff were particularly vulnerable, being targeted based on their ethnicities. In the first half of the year, 394 violent incidents against aid workers were reported, with 5 humanitarians killed and 150 vehicles lost.

Nutrition services continued where possible, including in the more stable but high-burden states of Northern Bahr el Ghazal and Warrap. As of June 2014, UNICEF had treated 40,622 children with SAM (well above the original 2014 target of 29,276) and WFP was well on track to meet their original target of 61,692 children under five (58 percent) suffering from MAM. Based on the increased burden of acute malnutrition, in June 2014, the Nutrition Cluster underwent a mid-year target revision. The targets for SAM more than doubled from 60,000 to 176,000 and the MAM target experienced a four-fold increase from 120,000 to 420,000.

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1 Based on the unstable context, UNICEF is using elevated incidence rate of 3 based on global standard of 2.6.
2 Derived by the nutrition cluster through application of a MAM rate ranging from 8% for the ‘stressed’ category to 11% in the ‘IDP’ category, to the estimated under-five populations in each of these categories
3 WFP is using standard incidence rate of 1.5. The total burden comprises of MAM and SAM cases to be transferred for supplementary
To reach these revised targets, increased resources along with innovative solutions were required. UNICEF and WFP identified coverage gaps and bottlenecks and developed a detailed plan outlining urgent and immediate actions and inputs needed to reach more children and avert a famine. This plan was improved through a series of consultations with the Nutrition Cluster, NGOs and donors and finalized as the WFP/UNICEF Joint Scale-Up Nutrition Plan for South Sudan.

The Scale-Up Plan was aligned to the August 2014 Nutrition Cluster Response Plan and based on the following objectives:

1. To deliver quality, life-saving management of acute malnutrition for at least 75 percent of SAM cases and at least 60 percent of MAM cases in all children under five;
2. Provide access to programmes preventing malnutrition (including blanket supplementary feeding programmes (BSFP), vitamin A supplementation, deworming and infant and young child feeding (IYCF) for at least 80 percent of vulnerable people; and
3. Ensure enhanced needs analysis of the nutrition situation and enhanced coordination and monitoring of the response.

To reach the three objectives, a number of operational priorities needed to be addressed to enhance the nutrition response and support an effective scale-up of nutrition activities:

**Strategy 1:**
Optimize nutrition services with existing partners

**Strategy 2:**
Expand operational partnerships

**Strategy 3:**
Improve community outreach and screening/referrals

**Strategy 4:**
Direct implementation through Rapid Response Mechanism

**Strategy 5:**
Provision of technical support to enhance service quality

**Strategy 6:**
Strengthen existing supply chain pipeline management

**Strategy 7:**
Enhanced needs analysis and coordination
The Scale-Up

Immediately, both agencies began to bring on board the technical capacity required to lead the Scale-Up. From July to December 2014, UNICEF increased from 5 to 30 dedicated nutrition staff, including increased field office presence and separating the Nutrition Section within the UNICEF programme. Staff were brought on board to support nutrition information, Cluster coordination and the Rapid Response Mechanism (RRM).

At the same time, WFP increased their nutrition team from 3 to 14 qualified nutritionists to support the additional activities and responsibilities of the scale up. Additional staff were added to help build the capacity of the sub-offices, deploy on RRM missions, integrate nutrition into food security analysis, and support the Nutrition Cluster coordination team.

Increasing partnerships

To rapidly increase service delivery, WFP and UNICEF focused on strengthening the coverage and quality of programmes implemented by existing partners and expanding operational partnerships with new NGOs, with an emphasis on national NGOs. Along with the Nutrition Cluster, UNICEF and WFP conducted an analysis of the current treatment programmes and met with new and existing partners to advocate for them to move into remote and underserved counties. UNICEF advocated with BRAC, a Bangladeshi NGO with a strong background in nutrition, to establish services in South Sudan, including supporting social mobilization activities that had proved effective in other country contexts. OTP and TSFP sites increased by 152 percent and 50 percent respectively. As of June 2015, operational partnerships cover 95 percent of 2015 targeted beneficiaries for SAM and 78 percent of 2015 for MAM.

Figure 1: Increase in Number of OTP and TSFP Sites from 2014 to 2015
Ensuring the Availability of Supplies

UNICEF and WFP, as core pipeline managers, provide over 99 percent of the supplies for the treatment and prevention of acute malnutrition in South Sudan. To support expanded sites and the increased caseload, each agency identified supply requirements and advocated for additional funding to ensure there would be no breakage in the supply chain. From July to December 2014, UNICEF procured 104,492 cartons of ready-to-use therapeutic food (RUTF) to secure the pipeline through July 2015. WFP procured over 2,551 metric tons (MT) of ready-to-use supplementary food (RUSF), securing the pipeline through December 2014. Given the limited access to certain locations during the peak of the rainy season (May-September), WFP and UNICEF used the dry season to preposition supplies in key locations or provide a three-month supply directly to partners. This drastically reduced the costs required to airlift supplies during the rainy season.

The pipeline for RUTF is secured through January 2016 with a 35,000 carton buffer while RUSF is fully secured until mid-2016. Super Cereal, the product used for the treatment of acute malnutrition for pregnant and lactating women, is secured through January 2016. Pipeline breaks for the product used in the BSFP programme, Super Cereal Plus, will begin to appear in September 2015.
Technical Assistance and Capacity Building

Along with ensuring that partners had the supplies to reach the expanded caseload, it was equally necessary to ensure that the staff operating nutrition centres – often new staff due to the mass displacement and high turnover – had the technical skills to deliver nutrition services. UNICEF conducted a training needs assessment in early 2014 and rolled out trainings based on partner needs: 1,161 participants were trained on infant and young child feeding (IYCF), 119 on inpatient therapeutic care, and 306 on outpatient therapeutic programmes. So far in 2015, 1,703 people have been trained.

WFP conducted partner meetings and trainings on quality nutrition programming and commodity management in December 2014 and in March 2015. WFP also met with partners nationally and in the field for on-site supportive supervision and on-site training.

Innovation: Reaching children cut off by conflict

In order to reach children displaced by the conflict in Unity, Upper Nile and Jonglei, the Rapid Response Mechanism developed by WFP and UNICEF in March 2014, was given a “nutrition lens”. Nutrition criteria, such as GAM prevalence, morbidity and dietary indicators are used to select RRM intervention sites, along with food security analysis and population movement and displacement.

From March 2014 to June 2015, 124,924 children have been screened for malnutrition in 50 joint WFP/UNICEF RRM missions in 40 locations. Through direct implementation, UNICEF reached 3,200 children newly identified as suffering from SAM with therapeutic treatment and WFP reached 9,100 children suffering from MAM with targeted supplementary feeding. Additionally, 89,420 children were provided Vitamin A supplementation and 75,081 deworming treatment.

If a nutrition partner was present and active in the RRM location, the RRM resupplied and strengthened partner capacity. Where a nutrition partner was not already present, the RRM missions assisted in establishing or re-establishing presence in these communities. The RRM missions contributed to introducing or re-introducing nutrition partners in 72 percent of missions.

Innovation: Treating children where nutrition service coverage is low

Where only OTP or TSFP services are available, UNICEF, WFP, MoH and the Nutrition Cluster defined an expanded protocol for the management of acute malnutrition. Under the expanded criteria both MAM and non-complicated SAM are treated using the same product, either RUTF or RUSF, where only one is available. However, children with severe oedema and/ or other medical complications are referred for treatment in stabilization centres. In practice, UNICEF/WFP used this modality mainly through the Rapid Response Mechanism when the RUSF or RUTF was not available, which occurred in fourteen of the 50 joint nutrition missions.

Innovation: Treating children in high-burden, non-conflict areas

To reach children in the high-burden, non-conflict affected states, state Ministry of Health (sMoH) social mobilizers, regularly engaged to increase polio vaccination coverage, were trained on active case finding and referrals as well as deliver IYCF and WASH best practice messages to caregivers. The initiative
was piloted in Juba, where 39,756 households were reached and 81,999 children screened. The proxy MAM and SAM rates were very low at 1.4 and 0.3 percent respectively, which is expected in Juba, a non-conflict and low burden county.

Based on the lessons learned in Juba County, in October 2014, the programme was rolled out in Northern Bahr el Ghazal, reaching 149,784 households and screening 197,878 children under 5. A total of 7,303 (3.7 percent) and 16,261 (8.2 percent) of children between 6 and 59 months were found to be severely and moderately malnourished respectively, giving a proxy GAM of 11.9 percent. About 62 percent of country-wide SAM admissions in the first three months of 2015 were children referred through the social mobilization initiative. The initiative is underway in Warrap based on lessons learned from the first two states.

WFP supports 60,000 Community Nutrition Volunteers (CNVs) to conduct outreach activities. CNVS are responsible for identifying children under five and pregnant and lactating women (PLWs) with acute malnutrition by conducting nutrition screenings throughout the community. Once identified, the CNVs refer newly identified SAM and MAM cases to the respective nutrition services, provide home visits for beneficiaries not responding to treatment and follow up on those who defaulted on treatment. CNVs provide a key link between the community and other services, such as health centres and mobilization for food distributions. Going into the second year of implementation, both agencies are looking into harmonizing and strengthening the two initiatives for a more complementary community outreach approach.

Figure 2: Prevalence of GAM and SAM from February 2014 - November 2014
Improving information for a more targeted response

In mid-2014, at the outset of the Scale Up Plan, there was a lack of adequate nutrition and mortality data to support targeted nutrition interventions by WFP, UNICEF and partners. The Nutrition Information Working Group (NIWG), led by UNICEF and comprising WFP and other NGO partners, began increasing the quantity and quality of available data. Additional SMART surveys were conducted in high burden counties and small-scale SMART surveys were introduced where it was not possible to undertake full scale surveys. For the first time in South Sudan, nutrition data was integrated into the WFP-FAO Food Security and Nutrition Monitoring System (FSNMS) which provided state-level malnutrition rates to complement county-level SMART surveys.

Additionally, as part of the IPC process, analysis of nutrition indicators and corresponding nutrition situation map was produced alongside the traditional food security map.

A total of 38 validated SMART and Rapid SMART surveys as well as two rounds of FSNMS contributed to the two IPC analyses in September and December 2014. The 12 SMART assessments, conducted in December and early 2015, and the March round of FSNMS contributed to the IPC analysis in April 2015. In addition, data from the RRM screenings bolstered these analyses.

Figure 3: Prevalence of GAM and SAM from December 2014 - May 2015
This increased availability of reliable information has improved targeting of areas of greatest need. In terms of SAM, the improved evidence base showed that the majority of children with SAM/MAM live in rural areas, where coverage is naturally lower due to the dispersed population and limited infrastructure. In the December IPC and the 2015 Strategic Response Plan, the proportion of children targeted for SAM treatment was therefore lowered to 60 percent, based on international Sphere Standards for rural areas, however MAM treatment remains focused at targeting 60 percent. Improved targeting, together with increased nutrition treatment sites, improved quality of care through technical assistance, and new response modalities including the RRM and social mobilization, meant that WFP and UNICEF were prepared by 2015 to respond at scale to the nutrition crisis that continued in the country.
Results of the Scale-Up

The first six months of the scale up focused heavily on ensuring that the building blocks of the system – technical expertise, supplies, funding and partnerships were in place. Six months after the launch of the Scale-Up, the end of 2014, UNICEF had treated 53 percent of children targeted for SAM and WFP had treated 40 percent of targeted children with MAM. Even with the increased caseload and challenging operating environment, SAM treatment increased 17 percent and MAM treatment increased 8 percent from 2013 to 2014.

Increased Treatment of Malnutrition

The new systems developed in 2014 allowed each agency to reach a much higher number of children in 2015, despite the on-going difficulties in the operating environment, including the renewed violence in Unity and Upper Nile beginning in April 2015.

In May 2015, the Nutrition Cluster revised the caseload of children with acute malnutrition based on the May IPC food security and nutrition situation findings and the resurgence of conflict, particularly in Unity and Greater Upper Nile states. Although the overall caseload for acute malnutrition decreased by 100,000 from 900,000 to 812,812 (a 10 percent decrease), the number of children with SAM increased by 11,075.

As of 30 June 2015, UNICEF and WFP identified and treated 50 percent and 45 percent of targeted SAM and MAM cases, respectively. See table 1 on next page for details. This is a 58 percent increase of treated SAM cases as compared to the first half of 2014 and a 283 percent increase of treated MAM cases.
For the treatment of SAM and MAM, 87.7 and 87.4 (respectively) percent of children have been discharged as cured in 2015, with fewer than 1 percent of these children dying. The scale up in nutrition services is believed to have contributed to a reduction in malnutrition-related mortality in children under 5. Together with food assistance, provision of nutrition services, including preventative services detailed below, contributed to an improved nutrition situation, helping to avert a famine.

### Increased Prevention of Malnutrition

**Blanket Supplementary Feeding:** WFP oversees and implements the blanket supplementary feeding programme (BSFP), which provides a specialized food product to children regardless of their nutritional status to prevent them from deteriorating into acute malnutrition. In the conflict affected states, BSFP is year round targeting children from 6 to 59 months. However, due to the seasonality of acute malnutrition in South Sudan, BSFP was implemented during the lean season to children between 6-23 months, who are at the highest risk of malnutrition and mortality in high burden States of Warrap and Northern Bahr el Ghazal.

As of December 2014, 415,000 children 6-59 months were reached with BSFP, 109 percent of the target. In the new 2015 Nutrition Cluster targets, the BSFP target was increased from 23 to 30 percent of all children 6-59 months in the country, and as of 30 June, 357,224 children have been reached, 97 percent of the target. See table 2 on next page for details.

**Infant and Young Child Feeding:** Limited awareness and strong social norms and beliefs have affected optimum IYCF practices and greatly impacted the nutritional status of children resulting in poor growth and development even before the crisis. This was demonstrated by pre-crisis GAM rates as high as 36 percent in Gogrial East County in Warrap and stunting rates of 31 percent (SSDS 2010). IYCF counselling, including the importance of exclusive breastfeeding for children under six months, is a key strategy for long-term and sustainable improvements in levels of malnutrition. In emergencies, IYCF programming is crucial to preventing increased morbidity and mortality.

In 2014, 98 percent of the targeted pregnant and lactating women and caregivers with children under 2 received IYCF interventions. Many of these women were reached through individual and small group counselling sessions undertaken during RRM missions, in PoCs or during National Immunization Days. From January - June 2015, 155,821 women have been reached with IYCF counselling, which is 54 percent coverage of the 2015 target.

### Table 1: Scale-Up Plan Objective 1 Achievements in 2015 (Jan-June)

<table>
<thead>
<tr>
<th>Total Beneficiaries Reached (as of June 2015)</th>
<th>2015 Nutrition Cluster Target</th>
<th>% reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 6-59 months with SAM</td>
<td>74,748</td>
<td>148,958</td>
</tr>
<tr>
<td>Children 6-59 months with MAM</td>
<td>153,335</td>
<td>344,226</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>227,869</strong></td>
<td><strong>520,509</strong></td>
</tr>
</tbody>
</table>
Micronutrients: Micronutrients are essential for survival, improving immunity, physical strength, productivity, and promoting healthy cognitive ability. Populations affected by crisis and with inherently high malnutrition rates are particularly vulnerable to micronutrient deficiencies. Through vaccination campaigns and RRM, 1,933,604 children received at least one round of Vitamin A supplementation in 2014, an estimated 97.7 percent of all children under 5, above the planned target of 90 percent. However, only 13 percent of targeted children received deworming tablets as this was not adequately integrated into nationwide vaccination campaigns. In 2015, deworming tablets continue to be provided through RRM and will be systematically distributed along with Vitamin A during immunization campaigns which will be undertaken in November and December 2015.

Table 2: Prevention of Acute Malnutrition Achievements 2014 (January to December) & 2015 (January to June)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number of Beneficiaries Reached in 2014</th>
<th>May 2014 Target</th>
<th>% achieved</th>
<th>Number of Beneficiaries reached in 2015</th>
<th>May 2015 Target</th>
<th>% achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSFP</td>
<td>415,089</td>
<td>380,000</td>
<td>109%</td>
<td>129,974</td>
<td>366,687</td>
<td>35%</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>1,933,604</td>
<td>1,980,069</td>
<td>98%</td>
<td>121,162</td>
<td>1,712,944</td>
<td>7%*</td>
</tr>
<tr>
<td>Deworming</td>
<td>246,635</td>
<td>1,771,640</td>
<td>14%</td>
<td>100,088</td>
<td>1,226,107</td>
<td>8%*</td>
</tr>
<tr>
<td>IYCF</td>
<td>230,698</td>
<td>1,111,617</td>
<td>21%</td>
<td>176,599</td>
<td>288,496</td>
<td>61%</td>
</tr>
</tbody>
</table>

* Nationwide expansion planned for November 2015

Value-added of the Partnership between WFP and UNICEF

UNICEF and WFP used their respective comparative advantage for the effective implementation of the scale-up plan. Some of the achievements recognized due to the partnership include: training and capacity building of NGOs, strengthening the pipeline and supply chain, strengthening the management, coordination and logistics of supplies, providing a continuum of CMAM services and improving analysis of the nutrition situation through the integration of nutrition indicators in both the FSNMS and developing a nutrition situation map in the IPC.

The Scale-Up offered a powerful platform for joint advocacy, drawing global attention to the appalling situation facing the children of South Sudan. This included joint press releases, alignment of social media campaigns, capitalizing on high-level and Goodwill Ambassador visits, and leveraging national and international political advocacy opportunities to make a joint call for the resources and access required to stop the loss of a generation. Having a united voice elevated the profile of the nutrition situation in South Sudan.
The Scale-Up has taken place within the context of a humanitarian crisis which has increased in scope, scale and urgency. In the year since the Scale-Up Plan was introduced, the situation in South Sudan consistently deteriorated in terms of violence, human rights violations, displacement, destruction of basic services and resultant increases in levels of food insecurity and disease. Renewed fighting since April 2015 has forced hundreds of thousands to flee into the bush or swamps for protection, where they are cut off from humanitarian assistance and suffering high levels of mortality. Over 200,000 civilians are now sheltering in PoC sites, which increased by a third in July and August 2015. The overstretched sites diluted the provision of nutrition, health and WASH services posing a risk to children’s nutrition and health status. In June 2015, malnutrition rates were steadily increasing in Bentiu PoC. Led by the Nutrition Cluster, UNICEF, WFP and partners responded by implementing a multi-sectoral approach to mitigating the increasing SAM/MAM rates, including provision of BSFP to newly arrived children and pregnant and lactating women; increasing the number of nutrition service sites; strengthening IYCF support and scaling up technical and nutrition support to implementing partners.

Families have not been able to plant crops and the markets used to bridge the hunger gap remain disrupted. Nearly 70 percent of the country’s population – 7.9 million out of 11.6 million people – are expected to face food insecurity this rainy season. Across the country, accelerated economic decline is now compounding the humanitarian crisis, drastically increasing the price of basic food staples and putting the urban poor at risk as well. The situation is especially severe in areas cut-off from assistance, where households are likely to face Catastrophic Levels (IPC Phase 5) of food insecurity. The situation remains equally as dire for access to basic services.

Basic services re-established over the past year in Unity, including hospitals, nutrition treatment sites and in some cases entire towns, have been destroyed while food stocks and humanitarian supplies were looted or burnt. In terms of nutrition services, 65 percent of OTPs in Unity were disrupted – suspended or destroyed – along with 25 percent in Upper Nile and 20 percent in Jonglei. For TSFP sites, 40 percent were disrupted in Unity, 15 percent in Upper Nile and 14 percent in Jonglei. In the most affected counties of Koch, Guit, Mayendit, Leer and Panyijar 73-100 percent of services were disrupted. Many of these areas had registered high rates of malnutrition in recent SMART surveys.

The impact on children with acute malnutrition cannot be underestimated. A total of 5,624 children that were admitted to the SAM programme defaulted, or were lost to follow up, during this period while an estimated 5,849 children that were supposed to be reached during this period of violence could not be reached. The majority (81 percent) of these children are in Unity state. Without treatment, these children are at a far higher risk of death. In May, only a third of the expected number of children were admitted to treatment programmes. Guit, Koch and Mayendit Counties reported zero admissions while Pariang, Abeinmhom, Leer and Panyijar reported 50 children or less.

WFP and UNICEF are working in cooperation to respond to this increasingly dire situation. Both agencies, together with the humanitarian community, have intensified advocacy with all parties to allow safe access to affected areas. Every opportunity is being used to re-establish services or restart RRM’s. Unfortunately, in late July, the first RRM to visit Southern Unity since the upsurge in violence was cut short by insecurity. Malnutrition screening of children during the mission showed that children were in terrible condition, with over 30 percent GAM rates. The extensive network of partnership established under the Scale-Up means that partners who had presence in these areas before the most recent fighting are now working to establish services wherever the displaced have moved. The RRM is more important than ever now, with the renewed violence and loss of access.

Outlook and Way Forward

The Scale-Up has taken place within the context of a humanitarian crisis which has increased in scope, scale and urgency. In the year since the Scale-Up Plan was introduced, the situation in South Sudan consistently deteriorated in terms of violence, human rights violations, displacement, destruction of basic services and resultant increases in levels of food insecurity and disease. Renewed fighting since April 2015 has forced hundreds of thousands to flee into the bush or swamps for protection, where they are cut off from humanitarian assistance and suffering high levels of mortality. Over 200,000 civilians are now sheltering in PoC sites, which increased by a third in July and August 2015. The overstretched sites diluted the provision of nutrition, health and WASH services posing a risk to children’s nutrition and health status. In June 2015, malnutrition rates were steadily increasing in Bentiu PoC. Led by the Nutrition Cluster, UNICEF, WFP and partners responded by implementing a multi-sectoral approach to mitigating the increasing SAM/MAM rates, including provision of BSFP to newly arrived children and pregnant and lactating women; increasing the number of nutrition service sites; strengthening IYCF support and scaling up technical and nutrition support to implementing partners.

Families have not been able to plant crops and the markets used to bridge the hunger gap remain disrupted. Nearly 70 percent of the country’s population – 7.9 million out of 11.6 million people – are expected to face food insecurity this rainy season. Across the country, accelerated economic decline is now compounding the humanitarian crisis, drastically increasing the price of basic food staples and putting the urban poor at risk as well. The situation is especially severe in areas cut-off from assistance, where households are likely to face Catastrophic Levels (IPC Phase 5) of food insecurity. The situation remains equally as dire for access to basic services.
 Scaling Up Year Two: the development of the Joint Nutrition Response Plan

The first year of the nutrition response focused on responding to the emergency by investing in and re-building a previously weak foundation to deliver nutrition services at scale, however, this was only made possible with huge financial support. The next phase is to capitalize on the benefits from investments made last year and to strengthen the systems established, both externally and internally. WFP and UNICEF will use the second year to ensure all beneficiaries are receiving high quality nutrition services to prevent and treat acute malnutrition.

The objectives of the UNICEF/WFP Joint Nutrition Response Plan is to:

1. Deliver quality, life-saving management of severe and moderate acute malnutrition for in children (6-59 months) and pregnant and lactating women.
2. Provide access to programmes in preventing malnutrition including: BSFP, vitamin A supplementation, deworming and IYCF.
3. Ensure enhanced needs analysis of nutrition situation and enhanced coordination and monitoring of response.
4. Strengthen alignment and coordination between UNICEF & WFP.

To meet these objectives, the Plan outlines 7 strategies that guide the second phase of the nutrition response:

**Strategy 1:**
Strengthen community based prevention approach

**Strategy 2:**
Promoting continuum of care at site level

**Strategy 3:**
Direct delivery of nutrition programmes in hard to reach areas

**Strategy 4:**
Capacity development (partners and government) and standards setting

**Strategy 5:**
Strengthening and developing nutrition capacity and systems within the Ministry of Health

**Strategy 6:**
Strengthening existing supply chain and pipeline management

**Strategy 7:**
Enhanced needs analysis and coordination