World Health Organization
South Sudan

Knowledge Management Series for Health

# From Crisis Response to System Reform: Reframing Nutrition Action in South Sudan

Malnutrition in South Sudan remains a persistent public health concern, with rates of acute malnutrition continuing to exceed the WHO emergency thresholds. In 2025, worsening food insecurity, conflict, and systemic health service disruptions have intensified the nutrition crisis, particularly among children under five and pregnant or breastfeeding women.

Undernutrition is a condition that affects individuals across all age groups. In children, it leads to wasting, stunting, and micronutrient deficiencies—resulting in increased morbidity, mortality, and impaired development. Among adolescents, it hampers physical growth and cognitive potential. In adults, particularly women of reproductive age, it contributes to adverse pregnancy outcomes and reduced labor productivity. Among the elderly, undernutrition increases susceptibility to infection, impairs recovery from illness, and accelerates loss of functional capacity.

Undernutrition is therefore a crosscutting issue, with impacts that extend beyond health to education, livelihoods, and national development outcomes. This factsheet provides an overview of the current nutrition situation in South Sudan, highlights the key drivers of malnutrition, and outlines priority actions for an effective nutrition response.

## Key statistics

- Global Acute Malnutrition (GAM) among children under five: **17.4%**
- Severe Acute Malnutrition (SAM) among children under five: **3.8%**
- Children under five in need of treatment: **2.3 million which corresponds to 9.5 percent** increase in number of acute malnutrition cases countrywide from 2.1 million children.
  - ◊ Of this, 714,000 children are at risk of SAM and 1.6 million at risk of MAM. (10% increase in SAM from 650,000 and 14% increase in MAM from 1.4 million) (IPC analysis, 2024)
  - ◊ Between 10–20% of children with SAM develop complications requiring inpatient care.

- Pregnant and breastfeeding women in need of treatment: **1.2 million**

- Adolescent girls (10–19 years) underweight: **22.8%**

- Women of reproductive age (15–49 years) underweight: **15.7%**

- Adults aged 50 years and above with Mid-Upper Arm Circumference (MUAC) < 21 cm: **16.3%**

- Stabilization centers functional for SAM with complications: **89 facilities**



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### Facility-Level Case Outcomes (2024)

National treatment outcomes for children with SAM admitted to stabilization centers (NIS 2024):

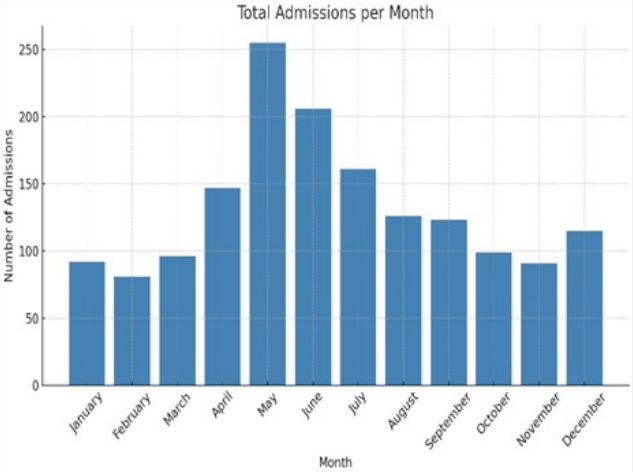
- Cured: **92%**
- Defaulter: **3%**
- Died: **4.6%**

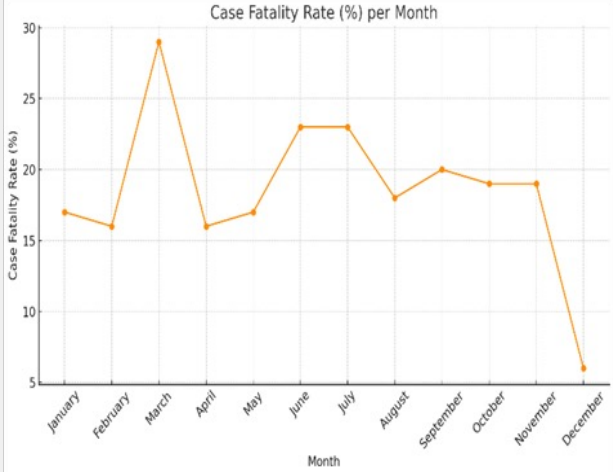
However, facility-level outcomes vary considerably:

- In Greater Equatoria, the CFR at Al-Sabah Hospital (Juba) reached **19%.**
- In Upper Nile, **over 6,000 children** were discharged with favorable recovery outcomes.

Audit data from Al-Sabah Hospital show additional seasonal pressures:

- Admissions peaked in March, June, and July.
- Case fatality rate peaked at **29% in March**, falling to **6% by Decembe**r.




## Main Drivers of Malnutrition

### Food Insecurity and Poor Diet Quality

According to the Food Security and Nutrition Monitoring System (FSNMS) 2024 survey, 63% of households reported experiencing food shortages in the week preceding the survey, and 42% had reduced the number of meals consumed daily as a coping strategy.

Only 27% percent of households met the threshold for an acceptable Food Consumption Score (FCS). Diets remained heavily reliant on cereals and oils, with minimal intake of nutrient-dense foods such as pulses, animal-source proteins, and vegetables.

Among children aged 6–23 months, only 16% received the Minimum Acceptable Diet (MAD), with particularly poor Minimum Dietary Diversity (MDD) reported in Jonglei, Unity, and Upper Nile states.

Based on the Integrated Food Security Phase Classification – Acute Food Insecurity (IPC-AFI) analysis, 2.11 million out of 2.3 million children under five at risk of acute malnutrition (92%) are living in areas classified as IPC-AFI Phase 3 or higher.

Additionally, 63of 80 counties fall within either IPC-AFI Phase 3+ or IPC – Acute Malnutrition (IPC-AMN) Phase 3 and above, reflecting widespread constraints in food availability, access, and utilization.

Nutritional stress may also be aggravated by unequal intra-household food allocation, which could disproportionately affect adolescent girls, women of reproductive age, and older persons.

### Child Morbidity

- According to the FSNMS (October 2024), approximately 50% of children are estimated to be sick at any given time.
- Common childhood illnesses contribute to:
  - ◊ 54% of the increase in SAM cases with complications
  - ◊ 15% of the rise in SAM cases without complications

  (Nutrition Cluster Analysis, Jan–Sept 2024)

# Analysis

## Access

Geographic and physical access to care: Despite the presence of 89 stabilization centers across the country, access to therapeutic care remains misaligned with population needs and constrained by environmental and infrastructural barriers.

- Counties such as Jonglei and Northern Bahr el Ghazal face persistent service gaps due to conflict, flooding, and poor road networks. Some centers have closed due to funding shortages, even in areas reporting high levels of acute malnutrition.
- Stabilization centers primarily provide curative services and lack preventive outreach, limiting early identification and timely care.
- Environmental shocks such as seasonal flooding and drought reduce community mobility and disrupt market access, further hindering the ability of households in remote areas to reach care or obtain diverse food.

**Financial barriers:** 63.2% of households reported food shortages in the week preceding the FSNMS survey, with 42% reducing meal frequency as a coping mechanism. The inability to afford sufficient or nutritious food reflects both poverty and limited livelihood options.

**Sociocultural constraints:** The FSNMS found that only 16% of children aged 6 to 23 months received a minimum acceptable diet. Feeding practices remain suboptimal due to limited nutrition knowledge and cultural norms that restrict dietary diversity, particularly in regions where households rely heavily on cereals and oil with minimal intake of vegetables, pulses, or animal protein.

## Quality

While national data report a 93.3% cure rate for severe acute malnutrition (SAM), outcomes vary considerably across facilities, reflecting inconsistencies in care quality. The 19% case fatality rate (CFR) at Al-Sabah Hospital in Juba underscores systemic gaps in the management of complicated cases, including weak adherence to clinical protocols and inadequate decision-making.

Upper Nile State showed a better cured rate although such performance is not widespread. In many facilities, discharge practices lack adequate referral or follow-up, weakening continuity of care.

**Quality is further compromised by:**

- Limited staff trained in addressing medical complications of malnutrition
- Lack of adherance to the national protocol for inpatient management of severe acute ma
- Inconsistent availability of therapeutic products and essential medicines.
- Overburdened health workers in high-caseload areas.

Moreover, weak linkage between community-based nutrition services and facility-based care undermines the sustainability of recovery. Children discharged from stabilization centers frequently return to the same food-insecure households with limited access to continued support or preventive services, thereby increasing their risk of relapse.

## Demand

Despite the scale-up of stabilization services, demand for nutrition care remains uneven and often delayed. A default rate of 3% and seasonal peaks in SAM-related mortality point to possible hesitancy or barriers in timely care-seeking. Families frequently present children at advanced stages of malnutrition, especially during the lean season, when food scarcity and illness are at their worst. This reduces the effectiveness of treatment and increases the risk of fatal outcomes.

Community-level demand is influenced by multiple behavioral and systemic factors. These include limited awareness of early malnutrition signs, mistrust or poor perception of facility services, and physical challenges in accessing care. The FSNMS 2024 shows that only 63.8% of sick children were taken to a health facility, with worse access among flood-affected and insecure regions, indicating gaps in health-seeking behavior across vulnerable populations.

Moreover, nutrition programming has largely focused on children under five and pregnant or breastfeeding women, with insufficient visibility and support for other high-risk groups. Men in food-insecure households often remain excluded from nutrition support, despite their central role in household food decision-making and income generation. Elderly persons, who comprise 16.3% of adults with MUAC <21 cm, are similarly overlooked, yet their nutritional decline can go unnoticed due to limited screening and weak integration in community-based care systems.

## Resilience

The nutrition service delivery system in South Sudan is vulnerable to both seasonal and systemic shocks. Mortality peaks during March, June, and July, corresponding with the lean season and increased disease transmission. This points to a lack of surge readiness and limited contingency planning as well as challenges in maintaining quality and continuity of care in high-risk periods.

In the broader population, chronic undernutrition leaves many individuals in a borderline nutritional state. This precarious baseline means that even minor stressors, such as displacement, food price shocks, or seasonal illness, can rapidly push large segments of the population into acute malnutrition. Without investment in anticipatory and preventive systems, nutrition service resilience will remain limited.

## Call to Action

To reduce the burden of acute malnutrition in South Sudan, a coordinated response is required that moves beyond treatment to address underlying determinants and prevent progression from undernutrition to severe outcomes. Key actions include:

- **Adopt a whole-of-household nutrition strategy:** Design interventions that target not only children under five and pregnant or breastfeeding women, but also adolescents, men, and older persons. This includes tailored messaging and support for nutritionally vulnerable family members often overlooked in traditional programming.

- **Strengthen nutrition-sensitive livelihoods:** Partner with FAO and other actors to promote diversified food production and consumption through climate-adaptive agriculture. Introduce non-monetary incentives to encourage adoption of culturally appropriate and nutritionally diverse cropping and feeding practices.

- **Expand prevention-focused services:** Shift programming emphasis upstream by addressing undernutrition before it progresses to acute malnutrition. This includes improving access to dietary supplements, promoting early identification, and integrating growth monitoring at community level.

- **Enhance multisectoral collaboration:** Strengthen collaboration across health, education, agriculture, and social protection sectors to ensure coherent action on the social and structural determinants of undernutrition.

- **Expansion school-based nutrition initiatives:** Promote meal programs in primary and secondary schools to improve dietary intake for school-age children and adolescents. These platforms can also serve for health and nutrition education.

- **Build Surge and Resilience Capacity:** Nutrition services must be prepared for seasonal and shock-related demand increases. Prepositioning supplies and developing localized surge plans can reduce response delays. Establishing mobile rapid response teams will ensure continuity of care during emergencies.

- **Support elderly-inclusive programming:** Establish a program to address undernutrition for the elderly, who are often nutritionally deprived and invisible in routine programming.



*June 2025 | The development of these knowledge series is coordinated by Anabay Mamo, Strategic Health Information, WHO, South Sudan*

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