Khulisa Management Services (Pty) Ltd
Reg No.: 99 09520/07

# EASTERN CAPE CASE STUDY

## Diagnostic/Implementation Evaluation of Nutrition Interventions for Children from Conception to Age 5

South Africa Department of Performance Monitoring and Evaluation (DPME)

Nutrition SLA 12/0287

**Written by:** Bongani Manzini with Mary Pat Selvaggio and Edna Berhane

November 2013

**Submitted by:**
Mary Pat Selvaggio
Director
Khulisa Management Services (Pty) Ltd
26 7th Avenue, Parktown North
Johannesburg, 2193, South Africa
Tel: +27 11 447 6464, Ext 3215
Fax: +27 11 447 6468
Email: mpselvaggio@khulisa.com
www.khulisa.com

**Submitted to:**
Ian Goldman
DDG: Evaluation and Research
The Presidency
Dept of Performance Monitoring and Evaluation
Private Bag X944
Pretoria, 0001, South Africa
Tel: +27 12 308 1918
Fax: +27 86 686 4455
Email: ian@po.gov.za

This report has been independently prepared by Khulisa Management Services (Pty) Ltd. The Evaluation Steering Committee comprises the Presidency, Department of Performance Monitoring and Evaluation in the Presidency, The Department of Health, the Department of Social Development, the Department of Agriculture, Forestry, and Fisheries, and UNICEF. The Steering Committee oversaw the operation of the evaluation, commented and approved the reports.

# TABLE OF CONTENTS

# LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Ante Natal Care |
| APP | Annual Performance Plan |
| ART | Antiretroviral Treatment |
| BANC | Basic Antenatal Care |
| BFHI | Baby Friendly Hospital Initiative |
| BMI | Body Mass Index |
| CBO | Community Based Organisation |
| CCG | Community Care Giver |
| CHC | Community Health Centre |
| CHW | Community Health Worker |
| DAFF | Department of Agriculture, Forestry, and Fisheries |
| DDG | Deputy Director General |
| DHIS | District Health Information System |
| DLGTA | Department of Local Government and Traditional Affairs |
| DOH | Department of Health |
| DPME | Department of Performance Monitoring and Evaluation |
| DRDAR | Department of Rural Development and Agrarian Reform |
| DRPW | Department of Roads and Public Works |
| DSD | Department of Social Development |
| EBF | Exclusive Breastfeeding |
| EC | Eastern Cape |
| ECD | Early Childhood Development |
| FGD | Focus Group Discussion |
| HCBC | Home and Community based Care |
| HIV | Human Immunodeficiency Virus |
| HOD | Head Of Department |
| IDP | Integrated Development Plan |
| IEC | Information Education, and Communication |
| IMCI | Integrated Management of Childhood Illnesses |
| INP | Integrated Nutrition Programme |
| IT | Information Technology |
| IYCF | Infant and Young Child Feeding |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MCWH | Maternal, Child, and Women's Health |
| MEC | Member of the Executive Committee |
| NDA | National Development Agency |
| NGO | Non-Governmental Organisation |
| OPD | Out-Patient Department |
| ORS | Oral Rehydration Salts |
| PEPFAR | President's Emergency Plan for AIDS Relief |

| | |
|---|---|
| PHC | Primary Health Care |
| PIAPS | Provincial Integrated Anti-Poverty Strategy |
| PMTCT | Prevention of Mother to Child Transmission |
| SANHANES | South African National Health and Nutrition Examination Survey |
| SASSA | South African Social Security Agency |
| SAW | Social Auxiliary Worker |
| SETA | Sector Education and Training Authority |
| SOP | Standard Operating Procedure |
| SP | Special Programmes |
| TB | Tuberculosis |
| TSF | Targeted Supplementary Feeding |
| U5 | Under 5 (years of age) |
| UN | United Nations |
| WHO | World Health Organization |

# GLOSSARY

| | |
|---|---|
| **Ante-natal** | Before birth; during or relating to pregnancy |
| **Basic Antenatal Care (BANC)** | The regular preventive care recommended for women during pregnancy that benefits both mother and child. Essential interventions include identifying and managing obstetric complications and infections, promoting healthy behaviours such as breastfeeding, giving medical information around biological changes, and giving nutritional counseling and vitamins to prevent maternal anaemia and malnutrition and to enhance a healthy pregnancy outcome. In South Africa, the recommended schedule for BANC is 4 visits during pregnancy starting in the first trimester. Routine BANC plays a part in reducing maternal death rates, miscarriages, birth defects, low birth weight, and other preventable health problems. |
| **Beneficiaries** | Beneficiaries in this evaluation included pregnant women and/or caretakers of children 0-5 years of age who were present at health facilities during fieldwork. Beneficiary focus groups were carried out as part of this evaluation. |
| **Breast milk substitute** | Any food being marketed or otherwise represented as a partial or total replacement for breast milk whether or not it is suitable for that purpose. |
| **Breastfeeding Protection, Promotion and Support.** | In South Africa, Breastfeeding Protection, Promotion and Support consists of 4 main activities: (i) enforcement of the International Code on Marketing of Breast milk substitutes (e.g. responsible advertising about breast-milk substitutes and effective legislation to define and monitor unacceptable marketing), (ii) behavioural change from mothers to exclusively breastfeed (no other liquids or solid foods) for the first six months of life and after introducing solids at 6 months of age, continued breastfeeding for up to 2 years, (iii) promotion of breastfeeding during delivery, and (iv) workplace opportunities to breastfeed. Combined, these actions have been shown to promote more optimal breastfeeding behaviours which in turn reduces diarrhoea, acute respiratory infections, and malnutrition in infancy. |
| **Complementary Feeding** | The feeding of solid foods that are readily consumed and digested by the young child and that provide additional nutrition to meet all the growing child's needs. The recommended age range for beginning complementary feeding is from 6 months of age. |
| **ECD food support** | Provision of food at Early Childhood Development (ECD) centres is one element contributing to South Africa's Food Security Strategies. DSD subsidises registered ECD centres based on the number of children enrolled. The DSD signs 1-year Service Level Agreements under which the ECD Centre receives ZAR15 per child per day and a portion of this is to be spent on food. The DoH provides guidance on meal plans for ECD centres, and these are meant to guide the centres and DSD in assuring nutritious meals for children. |
| **Exclusive Breastfeeding** | Defined as "an infant's consumption of human milk with no supplementation of any type (no water, no juice, no nonhuman milk, and no foods) except for vitamins, minerals, and medications."[1] National and international guidelines recommend that all infants be breastfed exclusively for the first six months of life. Breastfeeding may continue with the addition of appropriate foods for two years or more.<br>Exclusive breastfeeding has dramatically reduced infant deaths by reducing diarrhoea and infectious diseases. It has also been shown to reduce HIV transmission from mother to child, compared to mixed infant feeding. |

[1] WHO. Accessed in January 2014. http://www.who.int/elena/titles/exclusive_breastfeeding/en/.

| | |
|---|---|
| **Food Access** | Food Access, or "Access to food" is fundamental to South Africa's social safety net, as it provides supplemental food through various means including soup kitchens or food parcels for at-risk groups. Food Access is a key element that contributes to South Africa's Food Security Strategies. |
| **Food Fortification** | The process of adding vitamins and minerals to food. The main reasons for adding nutrients to food is to restore losses due to processing, storage and handling of foods; to improve overall nutritional quality of the food supply; and as a public health measure to correct recognised dietary deficiency(ies). Fortifying everyday staples means people become healthier, live longer, and lead more productive lives. Infant mortality is less likely to occur and children show higher levels of physical and mental development, resulting in improved performance in school. In South Africa, the following vitamins and minerals are added to maize and wheat flour: Vitamin A, Vitamin B1, Vitamin B2, Vitamin B6, Niacin, Folic Acid, iron and zinc, and iodine is added to salt. |
| **Food prices/zero-VAT rating** | Since 1984, South Africa has removed VAT (i.e. zero-VAT rated) from certain basic foodstuffs as a means to make basic foods more accessible to the poor. Currently the following foods are zero-rated: brown bread, maize meal, samp, mealie rice, dried mealies, dried beans, lentils, tinned pilchards/sardines, milk powder, dairy powder blend, rice, vegetables, fruit, vegetable oil, milk, cultured milk, brown wheaten meal, eggs, edible legumes and pulses of leguminous plants. This is a mechanism to enhance access to food and contain food prices |
| **Food Security (output 2 of Outcome 7)** | The South African Government's Output 2 of Outcome 7 is "improved access to affordable and diverse food". Food Security in South Africa consists of four main strategies implemented through the combined efforts of the Department of Agriculture, Forestry and Fisheries (DAFF), DoH, and DSD: (i) ensuring access to food (through various DSD interventions), (ii) improved nutrition security (through various DoH health and nutrition interventions), (iii) improved food production capacity of households and poor resourced farmers (DAFF), and (iv) development of market channels for food (DAFF). |
| **Growth Monitoring and Promotion (GMP)** | Growth Monitoring (GM) is the process of periodic, frequent measurements of the growth of a child in comparison to a standard. GMP is a prevention activity comprising of GM linked with promotion (usually counseling) to increase awareness about child growth; improve caring practices; and serve as the core activity in an integrated child health and nutrition programme. As an intervention, GMP is designed to affect family-level decisions and individual child nutritional outcomes. |
| **Household Food Production and Preservation** | Household food production / food preservation is one component of South Africa's Food Security Strategy. DAFF has promoted and supported home gardening as well as school, community, and clinic gardens to complement and supplement the food parcels programme carried out by the Department of Social Development (DSD) as part of its Food Security strategy. DSD now promotes home gardening as part of its Sustainable Livelihoods programme. |
| **IMCI (Integrated Management of Childhood Illnesses)** | IMCI is an integrated approach to child health that focuses on the well-being of the whole child and that aims to reduce death, illness and disability and to promote improved growth and development among children under five years of age. IMCI includes both preventive and curative elements that are implemented by families and communities as well as by health facilities. WHO notes that if implemented well, IMCI can reduce under-five mortality and improve nutritional status. In South Africa, IMCI is delivered through health facilities by IMCI-trained nurses as part of the primary health care package of services. |

| | |
|---|---|
| **Improved Hygiene Practice** | Improved water quality, improved disposal of human excreta, and interventions that promote hand washing have been shown to reduce diarrhoea. Repeated diarrhoea incidence in the first two years of life significantly increases the risks of being stunted by age two years, and some water, sanitation and hygiene interventions may improve height growth in children under five years of age. In South Africa, most hygiene education, improved water quality, and sanitation is delivered through local government/municipalities, although the DoH is also responsible for hygiene education as part of the primary health care package of services. |
| **Indicator** | A monitoring and evaluation term for an objectively verifiable measurement which reflects the activity; assumption, or effect being measured. |
| **International Code of Marketing of Breast Milk Substitutes** | An international health policy framework for breastfeeding promotion adopted by the World Health Assembly (WHA) of the World Health Organisation (WHO) in 1981. The Code was developed as a global public health strategy and recommends restrictions on the marketing of breast milk substitutes, such as infant formula, to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed. The Code also covers ethical considerations and regulations for the marketing of feeding bottles and teats. |
| **Intra-partum** | During childbirth or during delivery. |
| **Lactation** | The secretion or production of milk by mammary glands in female mammals after giving birth |
| **Mainstreaming Interventions** | Mainstreaming an intervention involves planned action, including legislation, policies or programmes, in any area and at all levels[2]. It is the process of bringing together common functions within and between organizations to solve common problems, developing a commitment to a shared vision and goals, and using common technologies and resources to achieve these goals[3]. It is a strategy for making concerns and experiences an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres[2]. |
| **Malnutrition** | A broad term describing the condition that develops when the body does not get the correct amount of kilojoules, vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function. Commonly used as a broad term to refer to under nutrition and over nutrition. |
| **Management of Moderate Malnutrition** | See Targeted Supplementary Feeding. |
| **Management of Severe Malnutrition** | A medical and a social disorder, whereby malnutrition is the end result of chronic deprivation by carers who because of poor understanding, poverty, or family problems are unable to provide the child with the nutrition and care that is needed. Successful management of severely malnutrition requires both medical and social interventions. If the illness is viewed as only a medical disorder, the child is likely to relapse when returning home. In South Africa, management of severe malnutrition is mainly delivered through district and other tertiary hospitals, although health workers at all levels are responsible for identifying cases. |
| **Micronutrient deficiency** | Occurs when the body does not have sufficient amounts of essential vitamins or minerals required by the body. Deficiency occurs when there is insufficient dietary intake and/or insufficient absorption and/or suboptimal utilisation of the vitamin or mineral. |

[2] Anon. International Labour Organization (ILO). 2013. http://www.ilo.org/public/english/bureau/gender/newsite2002/about/defin.htm

[3] http://www.afro.who.int/en/clusters-a-programmes/iss/immunization-systems-support/integrated-child-survival-interventions.html

| | |
|---|---|
| **Micronutrient supplementation** | Enhancing or boosting the nutritional content of one's diet with vitamins or minerals. Young children are highly vulnerable to micronutrient deficiencies as they have low body stores of these nutrients, and can have low intake due to improper feeding practices, and losses due to infections. Micronutrient supplementation in pregnancy and during early childhood is associated with proper growth and decreased complications of infections. In South Africa, the most common micronutrients given to pregnant women are Iron and Folic Acid, along with general multi-vitamins. Children in South Africa are supposed to be given routine Vitamin A supplementation. |
| **Mixed Feeding** | Feeding breast milk along with infant formula, baby food and even water. |
| **Moderate malnutrition** | A growth measure between minus two (-2) and minus three (-3) standard deviations from the median of the standard reference population. |
| **Morbidity** | Refers to the state of being diseased or unhealthy within a population. |
| **Mortality** | Refers to the number of deaths in a population. |
| **Nutrition** | The process of providing or obtaining the food necessary for health and growth. The intake of food, considered in relation to the body's dietary needs. Good nutrition – an adequate, well balanced diet combined with regular physical activity – is a cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity. |
| **Nutrition Education and Counseling** | Enhancing the quality of the diet, by educating about foods and what quantities are needed in order to achieve optimal dietary intake. This can also include counseling on micronutrient supplements. There is some evidence that nutrition training of health workers improves energy intake, feeding frequency, and dietary diversity of children between six months and two years of age. In South Africa, health facilities have the prime responsibility for delivery nutrition education and counseling, but with PHC re-engineering it is expected that community based nutrition education and counseling will be strengthened. |
| **Obesogenic** | Causing and leading to obesity. |
| **ORS (Oral Rehydration Salts)** | A dry mixture of salt and sugar/glucose (sodium chloride) which is mixed with water to prepare a solution of used for treating dehydration due to diarrhoea or other causes. UNICEF In South Africa, both ORS and Zinc are given to children during diarrhoeal episodes. |
| **Over nutrition** | A form of malnutrition which occurs if a person consumes too many kilojoules. |
| **Overweight** | A form of over nutrition. Scientifically defined as weight for height above two standard deviations from the median weight for height of the standard reference population. |
| **PHC Re-engineering** | A restructuring of the South African health system to better implement Primary Health Care to take comprehensive services to communities with an emphasis on disease prevention, health promotion and community participation. PHC Re-engineering is focused on strengthening the district health system (DHS) through three cohesive and co-coordinated streams: (a) the deployment of ward based PHC outreach teams; (b) strengthening of school health services; and (c) deployment of district clinical specialist teams aimed at improving maternal and child health in particular. |
| **Post-partum** | After childbirth. |
| **Prioritised Nutrition Interventions** | Prioritised nutrition interventions are services which have policies, guidelines, protocols, budgetary allocation and are actually delivered on the ground to all or most eligible patients/clients as evidenced by coverage rates or other measures. |
| **Regulations** | Refers to rules issued by Parliament governing the implementation of relevant South African legislation. Examples of regulations issued under the Foodstuffs, Cosmetics, and Disinfectants Act (Act 54 of 1972) in South Africa, include R. 991 relating to foodstuffs for infants and young children, and R146 relating to the labelling, marketing, educational information, and responsibilities of health authorities related to general foodstuffs. |

| | |
|---|---|
| **Sanitation** | Refers to facilities that ensure hygienic separation of human excreta from human contact, including flush or pour flush toilet/latrine to piped sewer system, septic tank or pit latrine; ventilated improved pit (VIP) latrine; pit latrine with slab; and composting toilet. |
| **Severe acute malnutrition** | Defined as below minus three (-3) standard deviations from the median of the standard reference population, mid-upper arm circumference (MUAC) less than 115 mm, visible severe thinness, or the presence of nutritional oedema[4]. |
| **Stunting** | Too short for one's age. Scientifically defined as height for age below minus two standard deviations from the median height for age of the standard reference population. |
| **Supplementary feeding** | Additional foods provided to vulnerable groups, including moderately malnourished children. |
| **Targeted Supplementary Feeding (TSF)** | An intervention to treat moderate malnutrition in South Africa. TSF is mainly delivered through health facilities and is intended as a short-term intervention with specific entry and exit criteria. The intervention includes the provision of food supplements according to age-specific needs and disease-specific conditions. |
| **Under nutrition** | A form of malnutrition that occurs if the diet does not provide adequate kilojoules and protein for growth and maintenance, or if the person is unable to fully utilize the food eaten due to illness; the outcome of insufficient food intake, inadequate care and infectious diseases. It includes being too thin for one's age (underweight), too short for one's age (stunting), dangerously thin for one's height (wasting) and deficient in vitamins and minerals (micronutrient deficiencies). |
| **Underweight** | Under nutrition that is scientifically defined as weight for age below minus two standard deviations from the median weight for age of the standard reference population. |
| **Wasting** | Underweight for one's height. Scientifically defined as weight for height below minus two standard deviations from the median weight for height of the standard reference population. A child can be moderately wasted (between minus two and minus three standard deviations from the median weight for height) or severely wasted (below minus three standard deviations from the median weight for height). |
| **Zinc** | An essential mineral with a wide variety of functions within the human body. Zinc is needed to repair wounds, maintain fertility in adults and growth in children, synthesize protein, help cells reproduce, preserve vision, boost immunity, and protect against free radicals, among other functions. |

[4] World Health Organization. Supplement – SCN Nutrition Policy Paper 21. Food and Nutrition Bulletin, 27 (3). 2006. http://www.who.int/nutrition/topics/malnutrition/en/

# 1 INTRODUCTION

Malnutrition in infants and young children typically develops during the period between 6 and 18 months of age and is often associated with intake of low nutrient or energy dense diets, consisting predominantly of starch-rich staples, and frequent infections. Linear growth (i.e. height) and brain development are especially rapid during the pregnancy first 2 years of life and young children are particularly susceptible to growth failure and developmental delays if they are not breastfed and are fed complementary foods with low nutrient/energy density and poor bioavailability of vitamins and minerals. Furthermore, conditions of poor hygiene and sanitation can lead to frequent infections, which further impairs children's nutritional status. Infant and child malnutrition contributes to increased morbidity and mortality, impaired intellectual development, suboptimal adult work capacity and even increased risk of disease in adulthood.

## 1.1. Background to the Nutrition Evaluation

Although nutrition programmes have been in place in South Africa since the 1960's, they were not very effective in reducing malnutrition because they focused primarily on providing food to the needy and not the underlying causes of malnutrition (i.e. illness, poor household access to food, inadequate maternal and child care, poor access to health services, and an unhealthy environment with limited access to clean water and sanitation).

In the mid-1990's the Government introduced the Integrated Nutrition Programme (INP) which aimed to improve nutrition through emphasizing collaboration between Government departments (inter-sectoral collaboration of line departments) to promote joint action for addressing nutrition problems. Inter-sectoral collaboration was envisioned mainly between the Departments of Health (DOH), Social Development (DSD), Agriculture, Forestry, and Fisheries (DAFF), and Rural Development and Land Reform (DRDLR)as these departments each deliver food and nutrition interventions specific to their sector. The expected outcome of this approach was to improve nutritional status of South Africa's vulnerable populations, namely pregnant women and children under the age of five.

To date, however, malnutrition persists as an underlying cause and contributor to child mortality and morbidity in South Africa. Indeed, South Africa is one of only 15 countries where little to no progress has yet been made in reducing under-five mortality by two-thirds[5] (Millennium Development Goal 4), and although this situation is partly due to South Africa's heavy burden of HIV, it is also due to a variety of underlying factors, including poor infant and child nutrition as evidenced by the recent 2012 South African National Health and Examination Survey (SANHANES)[6] which found that 21.6% of children age 0-5 are stunted, and 5.5% are underweight.

> In South Africa, a large percentage of young children age 0-5 show signs of malnutrition: 21.6 % are stunted, and 5.5 % are underweight for their age (2012).

[5] UNICEF. *Levels & Trends in Child Mortality. Report 2011*. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf.

[6] HSRC. South African National Health and Nutrition Examination Survey. 2012. http://www.hsrc.ac.za/en/research-outputs/view/6493 and http://www.hsrc.ac.za/en/research-areas/Research_Areas_PHHSI/sanhanes-health-and-nutrition

Given this, the Department of Performance Monitoring and Evaluation (DPME) in the Presidency commissioned the "Diagnostic/Implementation Evaluation of Nutrition Interventions for Children from Conception to age 5" to examine critical systemic and implementation issues that inhibit or enable access to nutrition interventions for pregnant women and children under the age of 5.

The findings from this evaluation are meant to assist the Government in improving implementation of existing nutrition interventions by identifying inhibiting or enabling factors that affect access to nutrition services (particularly among children) and to support the scale-up of interventions as required.

## 1.2. Objectives/Terms of Reference (TOR) for this Evaluation

This qualitative evaluation aims to identify the factors contributing to effective or non-effective implementation of 18 nutrition interventions being delivered by Government, with an emphasis on the first 4 interventions as listed in Table 1 below. The full terms of reference for this evaluation can be found in Appendix A.

### Table 1: 18 Nutrition Interventions Explored in this Evaluation

| **Nutrition Intervention**<br>*(NB: the first four interventions (bolded) are the main focus of the evaluation)* | **Responsible Department** |
|---|---|
| **1. Breastfeeding support*** | Health |
| **2. Management of moderate malnutrition including Targeted Supplementary Feeding*** | Health |
| **3. Household food production and preservation (home gardening)** | DAFF |
| **4. Food access (e.g. food parcels, soup kitchens)** | DSD |
| 5. Early Childhood Development (ECD) (food in ECD centres) | DSD |
| 6. Complementary feeding* | Health |
| 7. Food fortification (Vitamin A, Iron and Iodine)* | Health |
| 8. Micronutrient including Vitamin A supplementation* | Health |
| 9. Oral Rehydration Salts (ORS) and Zinc* | Health |
| 10. Management of severe malnutrition* | Health |
| 11. Deworming | Health |
| 12. Growth monitoring and promotion including the use of Mid-Upper Arm Circumference (MUAC) measurements | Health |
| 13. Nutrition education and counselling (part of all of these) | Health |
| 14. Improving hygiene practice (including in relation to water and sanitation) | Health |
| 15. BANC (Basic ante-natal care) – education and supplements, timing | Health |
| 16. IMCI (Integrated management of childhood illnesses) | Health |
| 17. Access to (nutritious) food, food prices | DAFF |
| 18. Food security (output 2 of outcome 7 in the National Priority Outcomes) | DRDLR/DAFF |

* High impact interventions

## 1.3. Approach

Khulisa's approach to the evaluation examined the following six moderating factors that have been identified as influencing the policy implementation:

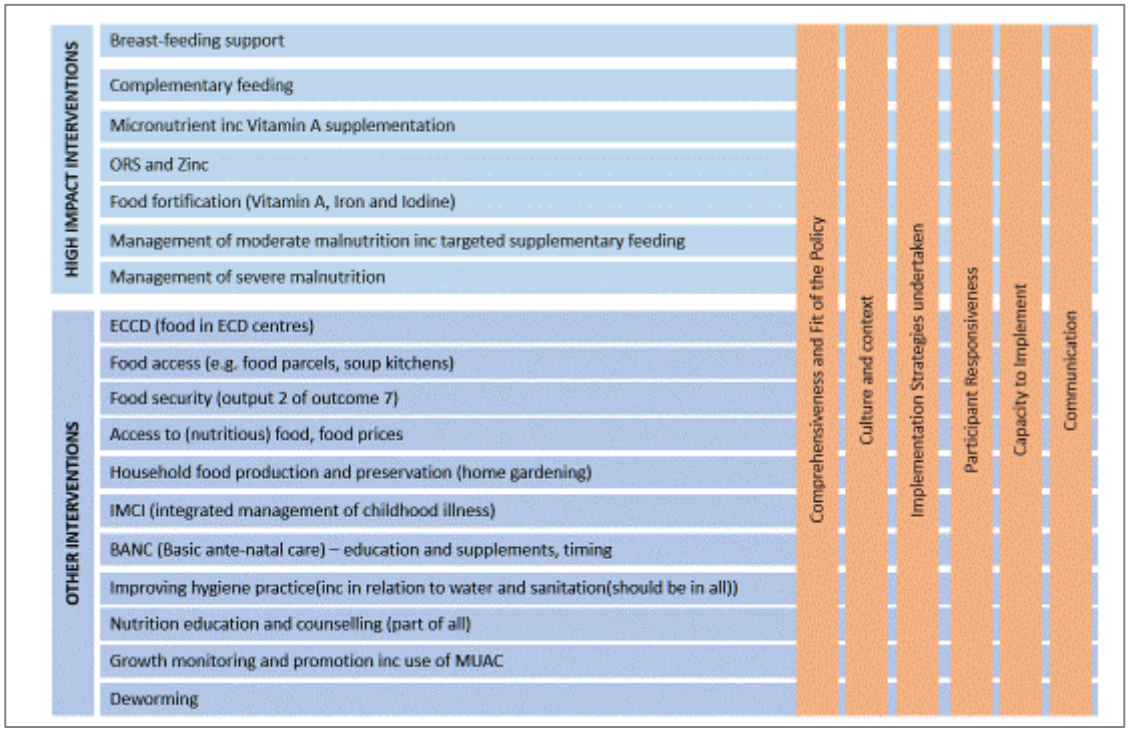
1) the policy's content and fit for the local environment,
2) the institutional context and culture, including readiness to change and the extent of commitment at all levels through which the policy passes,
3) the various implementation strategies (i.e. models) devised for carrying out the policy,
4) the institutional capacity to implement the policy,

5) participant responsiveness, and

6) communication to the general public and within government itself.

These moderating factors comprised the "lens" through which Khulisa examined the implementation of the INP and its 18 nutrition interventions, and for answering the 17 evaluation questions put forth in the TOR. Figure 1 below depicts this conceptual approach in graphical form.

**Figure 1: Conceptual Framework for the Evaluation**




## 1.1 Methodology

### 1.1.1 Literature Review

The starting point for this evaluation was a literature review that provided the context for this implementation evaluation. The literature review examined the following relevant topics:

1. Current health and nutrition status of children under 5 and pregnant women in South Africa;
2. South Africa's policy framework on maternal and child nutrition;
3. A review of nutrition policies and interventions from 5 countries that have successfully improved their nutrition performance (Brazil, Colombia, Malawi, Mozambique, and Malaysia). These countries were selected by the Evaluation Steering Committee as comparisons to South Africa based on one of the following two reasons:
   - the country has similar economic or infrastructure characteristics to South Africa but much better nutrition performance at a national level (i.e. Brazil, Colombia, and Malaysia), or
   - the country is geographically proximate to South Africa and thus has similar environmental and cultural characteristics, but again better nutrition performance (i.e. Malawi and Mozambique);

4. An analysis of implementation issues present in the literature.

### 1.1.2 FIELDWORK

#### Sampling

Before we began fieldwork, the Evaluation Steering Committee identified the geographic areas where fieldwork was to be carried out and the important subgroups or categories of people to be sampled. These are further described below.

##### (1) STAGE 1: SELECTION OF PROVINCES

Aside from data collection at national level, the Evaluation Steering Committee identified 4 provinces (purposefully-selected) for the reasons indicated below:

**Table 2: Justification for the provinces sampled**

| Province | Justification |
|---|---|
| **KwaZulu- Natal** | Its emphasis on community nutrition |
| **Western Cape** | The general perception that nutrition and health programmes are well implemented in the Western Cape |
| **Free State** | The general perception that nutrition and health programmes are well implemented in the Free State |
| **Eastern Cape** | Its unique development profile and its challenges in implementing government programmes |

##### (2) STAGE 2: SELECTION OF DISTRICTS

In each province, 2 districts were purposefully selected based on their levels of performance (i.e. high performing and low performing). We obtained recommendations from provincial nutrition focal persons regarding the names of high-performing districts in their province. Selection of the poor-performing districts were identified with the Evaluation Steering Committee using the following criteria:

- NDOH score for district's performance in child health indicators
- NDOH pilot districts for implementing the NHI (these tend to be districts with vulnerable population and have a high burden of disease, and have demonstrated poor performance in 27 socio-economic, health service and financial and resource management indicators).
- Rural Development scores for district performance
- Agriculture scores for district performance
- DSD district performance scores

Two of the poor-performing districts chosen with the Evaluation Steering Committee (in FS and WC) were revised, with the final sample of districts being presented in Table 3.

**Table 3: Districts included in the sample**

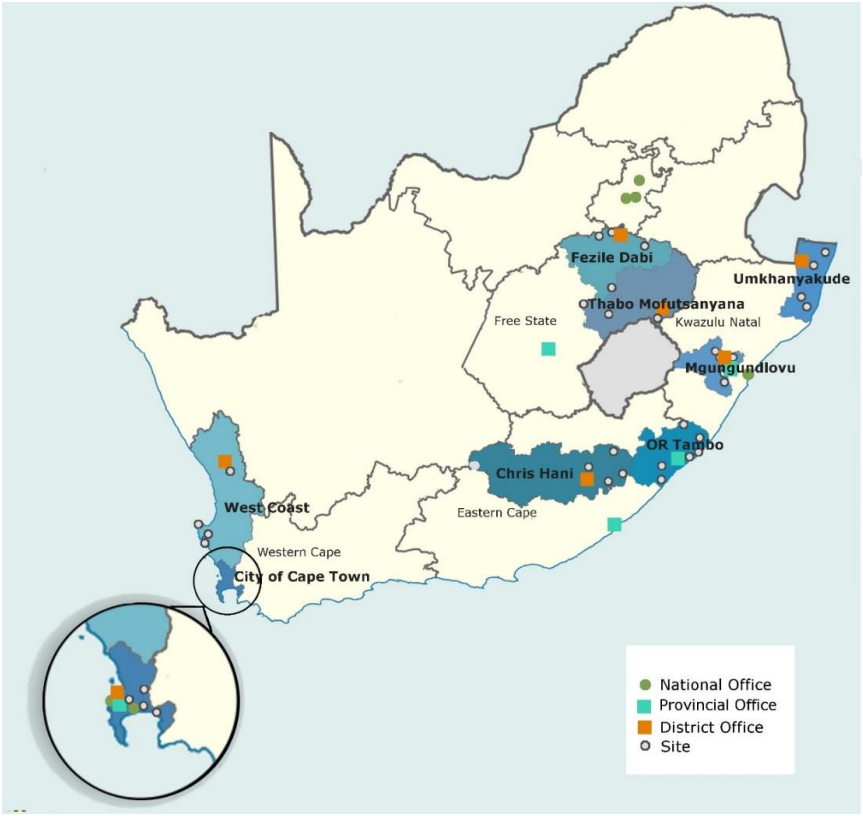
| PROVINCE | HIGH PERFORMING DISTRICTS | | POOR PERFORMING DISTRICTS | |
|---|---|---|---|---|
| | District Name | Justification | District Name | Justification |
| **Eastern Cape** | Chris Hani | Recommendation from the EC nutrition focal person. | OR Tambo (Umtata) | NHI pilot site<br>Poor Child Health indicator score |

| PROVINCE | HIGH PERFORMING DISTRICTS | | POOR PERFORMING DISTRICTS | |
|---|---|---|---|---|
| | District Name | Justification | District Name | Justification |
| | | | | Poor Rural Development indicator Score |
| **KZN** | uMgungundlovu | Recommendation from the KZN nutrition focal person. | uMkhanyakude (Mkuze / Jozini) | Poor Child Health indicator score<br>Poor Rural Development indicator Score<br>High poverty levels based on DSD indicators |
| **Free State** | Thabo Mofutsanyane | Recommendation from FS nutrition focal person | Fezile Dabi | Recommendation from Nutrition Manager in FS province |
| **Western Cape** | West Coast | Recommendation from WC nutrition focal person. | City of Cape Town | Recommendation from Nutrition Manager in WC province |

## (3) STAGE 3: SELECTION OF FACILITIES/ORGANISATIONS

In each district, Khulisa randomly selected 4 health facilities according to their geographic status (urban/rural), and purposefully selected 4 NGOs that work in food/nutrition. This resulted in a total sample of 32 health facilities and 16 NGOs as across the 4 provinces.

### Figure 2: Fieldwork Locations



### (4) STAGE 4: SELECTION OF INDIVIDUAL RESPONDENTS

Key informant respondents were purposefully sampled based on a list of stakeholders provided by the Evaluation Steering Committee. The sampling strategy for beneficiaries was based on a convenience sample obtained during site visits to health facilities and NGOs. The method for data collection in each group in the sample is indicated in brackets in Table 4.

**Table 4: Proposed Respondents *(and method of data collection)***

1) **National Level Respondents** *(in-depth interviews)*
   - National DOH nutrition managers
   - National DSD managers
   - National Rural Development food/nutrition managers
   - National Agriculture food security managers
   - National ECD managers
   - Bilateral Donors: USAID, CDC
   - Multi-lateral Donors: UNICEF, WHO
   - Relevant local and international health/development organizations:
   - Relevant food industries
2) **Provincial Level Respondents in WC, EC, FS, and KZN** *(in-depth interviews)*
   - Provincial DOH nutrition managers
   - Provincial DSD nutrition managers
   - Provincial Rural Development food/nutrition managers
   - Provincial Agriculture food security managers
3) **District Level Respondents** *(in-depth interviews or focus group discussions)*
   - District DOH nutrition managers
   - District DSD nutrition managers
   - District Rural Development food/nutrition managers
   - District Agriculture food security managers
4) **Health Facility Respondents** *(in-depth interviews or focus group discussions)*
   - MCH nurse or nursing assistant
   - Counsellors for pregnant women and/or mothers of young children
   - Community health workers attached to health facilities
5) **NGO Respondents** *(in-depth interviews or focus group discussions)*
   - Programme or Site Manager
   - Community workers
6) **Beneficiary Respondents** *(focus group discussions)*
   - Pregnant women and mothers of children under 5 years present at health facilities
   - Beneficiary participants in NGO programmes

## Data Collection Methods

Data collection methods used in the evaluation are as follows:

1. Semi-structured Key Informant Interviews
2. Focus Groups with beneficiaries
3. Rapid Performance Assessments of health facilities

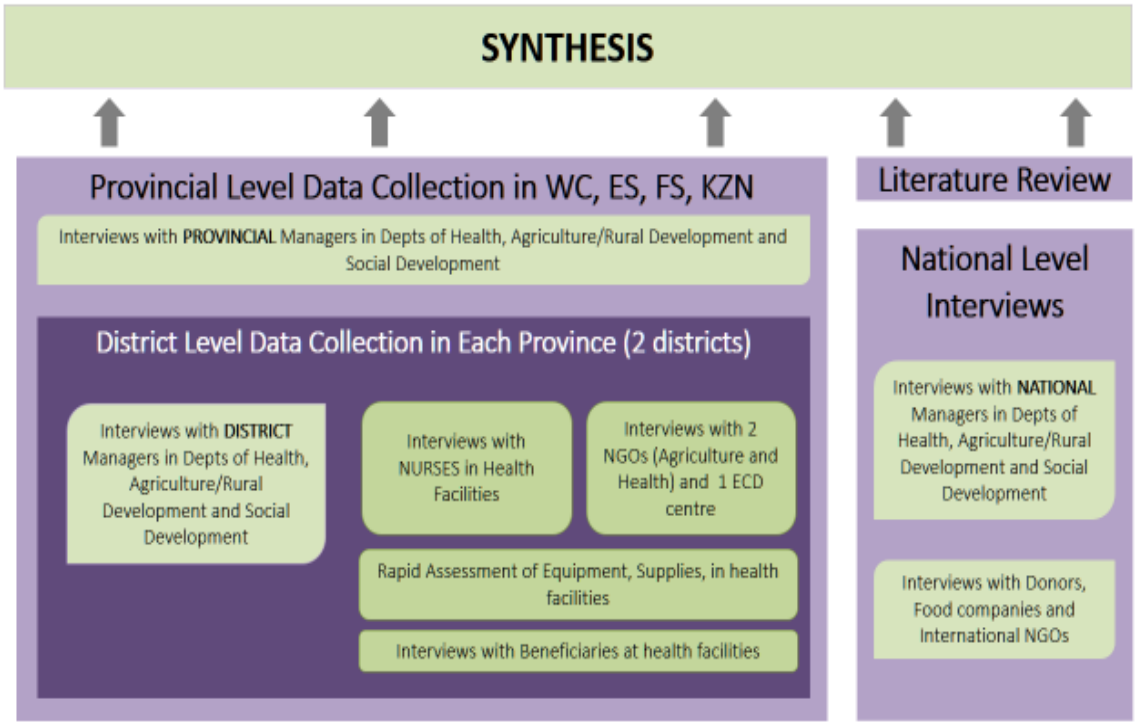
4. Assessment of Health Worker Knowledge around nutrition

Table 5 below presents the data collection methods used, the target respondents for each method, as well as the content explored. Figure 3 summarises the data collection components of the evaluation.

### Table 5: Data Collection Methods and Target Respondents by Content

| Method | Target Respondents | Content explored |
|---|---|---|
| **Key informant interviews** | Relevant Government managers at national, provincial, and district levels | • Perceptions on current needs and practice around nutrition<br>• Moderating factors (i.e. policy content and fit, organisational context and culture, commitment, capacity, facilitation processes that affect participant responsiveness, and communication)<br>• Institutional arrangements<br>• M&E for food/nutrition<br>• Funding levels |
| | Food industry representatives | |
| | Bilateral and multilateral donors and international health/development NGOs | |
| | Health facility staff or managers | |
| | Representatives from CBOS/NGOS involved in food/nutrition programmes | |
| | Programme managers at district level, groups of health staff at facility level | |
| | Representatives from community-based projects and services (ECD, agriculture, health) | |
| **Focus Group Discussions** | Beneficiaries | • Experiences with food and nutrition programmes and services<br>• Satisfaction with services<br>• Need for food/nutrition support |
| **Rapid Performance Assessment** | Health Facilities | Review of relevant infrastructure, equipment, and supplies for delivering nutrition interventions |
| **Assessment of Health worker Knowledge** | Nurses, counsellors, or others providing nutrition services | Knowledge of diagnostic steps and counselling around breastfeeding difficulties, growth faltering, and knowledge of the benefits of micronutrient supplementation |

**Figure 3: Summary of Data Collection Components of the Evaluation**




## 1.4. Eastern Cape Sample

In the Eastern Cape Province, data was collected at 22 sites as presented in **Error! Reference source not found.**. At each site, various key informants (**Error! Reference source not found.**) were interviewed about the nutrition needs in their area, the types and quality of nutrition interventions that are implemented, the resources (financial and human) available for nutrition interventions, and enabling and constraining factors related to implementation of various nutrition interventions. The vast majority of the sites and respondents were from the health sector, and this was purposeful as described in the methodology in Appendix B of this report.

**Table 6: Actual Data Collection points in the Eastern Cape**

| **Provincial Offices Interviewed** | | |
|---|---|---|
| Provincial Department of Health – Bisho<br>Provincial Department of Social Development – King Williams Town<br>Provincial Department of Rural Development and Agrarian Reform (DRDAR) – East London | | |
| **District Offices Interviewed** | | |
| Chris Hani District | District Department of Health – Queenstown<br>District DRDAR – Queenstown<br>District Department of Social Development – Queenstown | |
| OR Tambo district | District Department of Health – Mtata<br>District DRDAR – Mtata<br>District Department of Social Development – Mtata | |
| **Health Facilities Interviewed** | **Urban / Peri-urban** | **Rural** |
| Chris Hani District | Philani Clinic – Queenstown<br>Middelburg Clinic – Middelburg | Tsitsikamma Clinic - Whittlesea<br>Mahlubini Clinic – Cofimvaba |
| OR Tambo district | Lusikisiki Village Clinic – Lusikisiki<br>Port St. Johns CHC – Port St. Johns | Mzintlava Clinic - Mzintlava<br>Nkanunu Clinic – Nkanunu Village, Lebode |

| NGOs Interviewed |
|---|
| ECD site: Sivumile Pre-school Caeguba Administrative area– Caeguba Village, Port St Johns<br>Agriculture/home gardening: Wild Coast Farm and Forest/Mzimvubu nurseries - Port St Johns<br>PEPFAR-funded health project: Nomonde Clinic - Moltino<br>Non-PEPFAR funded health project: Philani, Zithulele Mentor Mothers – Zithulele Village, Coffee Bay |

**Table 7: No. Interviews/FGDs and Respondents in Eastern Cape Province**

| | No. Interviews/FGDs | No. respondents |
|---|---|---|
| Provincial and District DOH managers | 3 | 7 |
| Provincial and District DSD managers | 4 | 8 |
| Provincial and District DRDAR managers | 4 | 6 |
| NGO staff | 4 | 4 |
| Health facility staff | 9 | 21 |
| Beneficiaries | 12 | 90 |
| **TOTAL** | **36** | **136** |

NB: *No. Resp* = Number of respondents across the interviews and focus group discussions. Because interviews were often with more than one person, the number of respondents can be greater than the number of interviews or FDGs held.

### 1.1.3 Data Recording and Capturing

During each interview or assessment, the researcher took extensive notes on the instruments specific to the interview. An interview guide provided researchers with further guidance on when to probe for answers and when not to. The notes were then captured in Excel for data analysis and then coded according to themes.

### 1.1.4 Data Analysis

Quantitative data collected in the KIIs, FGDs, Health Facilities Rapid Assessments, and Health Worker's Assessment of Nutrition Knowledge were analysed using descriptive statistics.

Qualitative data collected under the KIIs and FGDs were analysed using content analysis, from the notes that had been transcribed into Excel. The following criteria were utilised to determine the 'reliability and validity' of the data.

1. Truth value/Credibility: Truth value describes the level of confidence the researcher has with the truth of the findings based on: research design, informants and context.
2. Consistency/Dependability: Due to the non-experimental and complex nature of qualitative research, variability is expected and consistency is explained as dependability. Dependability requires that variability is tracked and explained and informant's range of experience from typical to atypical experience explained.
3. Neutrality: Neutrality in qualitative research involves neutrality in relation to data rather than the investigator.

Once the qualitative notes were checked for reliability and validity, these were coded for themes. These themes were tabulated and reported on according to the KII and FGD questions.

### 1.1.5 Reports Produced

Case Study reports were prepared for each of the four provinces where fieldwork took place, as well

as for each of the four priority interventions. In all, 12 reports were prepared for this evaluation as listed below:

1. Literature Review
2. Fieldwork Report
3. Breastfeeding Case Study
4. Targeted Supplementary Feeding Case Study
5. Home Gardens Case Study
6. Food Access Case Study
7. KwaZulu-Natal Provincial Case Study
8. Eastern Cape Provincial Case Study
9. Free State Provincial Case Study
10. Western Cape Provincial Case Study
11. Final Evaluation Report
12. Summary of Final Evaluation Report (1-5-25)

## 1.2 Limitations of the Evaluation

By their nature, qualitative evaluations of policies and programme implementation allow examination of the broader context, rather than specific measurements of compliance to policy elements or programmatic guidelines. This evaluation's extremely broad scope (18 interventions, 17 research questions, and investigation of 6 moderating factors) resulted in very lengthy interviews with respondents who often had time constraints. Consequently, many respondents gave only cursory information around the issues that we sought to explore more deeply.

Because nutrition interventions for pregnant women and children under 5 in the health sector far outweigh the number of nutrition interventions in the social development and agriculture sectors, the evaluation's sampling framework is biased toward respondents from health. In addition, at provincial, district, and local levels, most respondents were able to speak knowledgeably about nutrition interventions implemented by their specific government department, but few were able to comment on the adequacy of implementation for interventions outside their sector. Consequently, data collected from social development and agriculture is sparse compared to that collected from health, making generalisations on implementation in agriculture and social development more difficult.

## 1.5. Data Collection Challenges

Generally most respondents were very cooperative and participated enthusiastically in the evaluation. This was demonstrated by the time that they afforded the researcher for the interviews, as well as by the way that they answered the questions. There were a few cases where provincial and district managers were concerned about how their supervisors would react to their responses. Even though the researcher assured the respondents of confidentiality their concerns did not subside, for example, one manager requested that the data tool with his responses be sent to him for approval before his responses are included in the report. In two other instances, managers requested that their comments be off the record, and in these cases we didn't record their

comments, but because two other respondents made nearly identical comments, these views were eventually captured. Other fieldwork challenges experienced included: (a) issues related to the scheduling and timing of the evaluation, (b) communication about the evaluation to the provinces and districts, (c) respondent substitutions, and (d) collecting data at health clinics. These challenges are described in more detail in Appendix C.

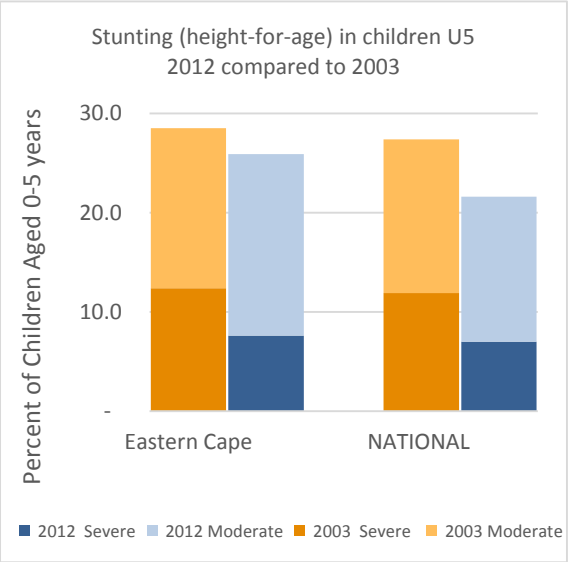
# 2. FINDINGS: NUTRITION CONTEXT

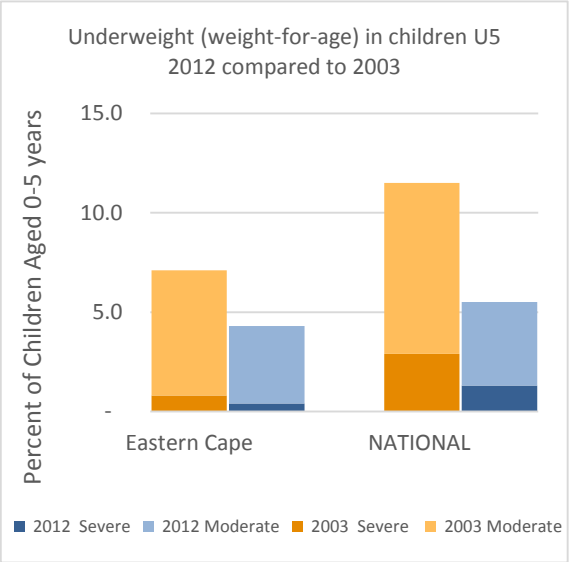
## 2.1. Nutrition Status of Young Children in Eastern Cape Province

Comparing the nutritional status of children under 5 in the Eastern Cape between two nutrition surveys – the 2003 Demographic and Health Survey (DHS) and the 2012 South African National Health and Nutrition Examination Survey (SANHANES) – shows that nutritional status has improved somewhat in line with national trends (Figure 4).

Overall, the proportion of EC children under 5 who are severely stunted or underweight has declined, although stunting still affects a large percentage of young children, and stunting rates are slightly higher than the national average. Encouragingly, slightly fewer children are underweight compared to the national average.

**Figure 4: Nutritional Status of Children under 5 Years of Age in EC Province (DHS 2003 and SANHANES 2012)**




## 2.2. Perceived Nutrition Needs in Eastern Cape

Encouragingly, many respondents recognise stunting as a common nutrition problem in the province (Figure 5). Most believe the main underlying reasons for poor nutrition are lack of knowledge, poor eating behaviours and unavailability food (Figure 6); however, there are noticeable difference in reasons given between the types of respondents.

- NGO respondents were the only ones that recognized health and illness factors as an underlying reason for malnutrition.
- Health managers /staff and NGOs were the only respondents who recognized poor or no breastfeeding as a contributing factor to poor nutrition.
- Only DOH INP (Integrated Nutrition Programme) Managers together with rural Tsitsikamma Clinic in the Chris Hani District indicated that overweight is a rising nutrition concern for the general population.
- Health managers and staff were the only respondents that noted behavioural factors as contributing to poor nutrition.

- All respondents noted lack of knowledge of nutrition and food security as contributing factors.

**Figure 5: Perceived Maternal-Child Nutrition Problems in the Eastern Cape**

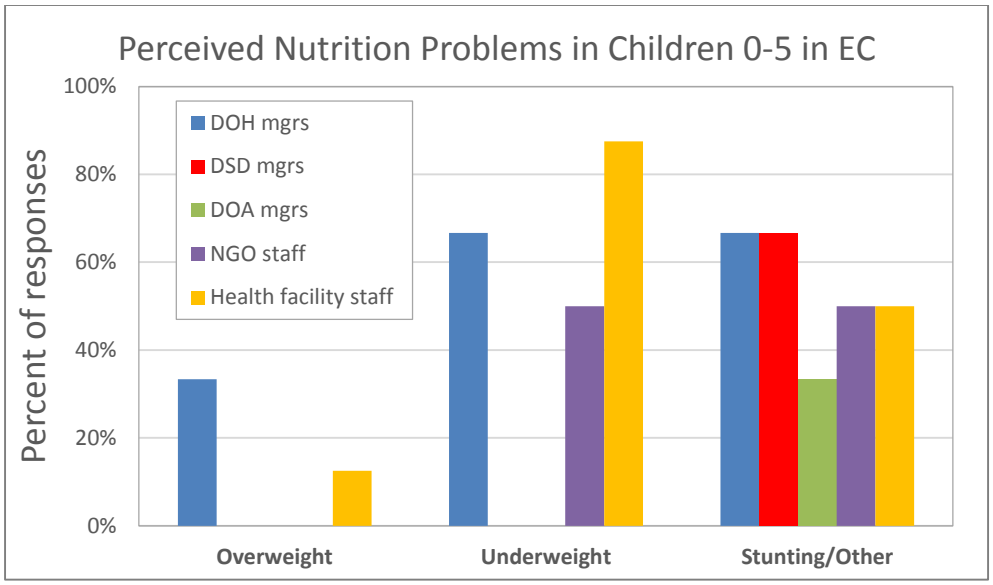
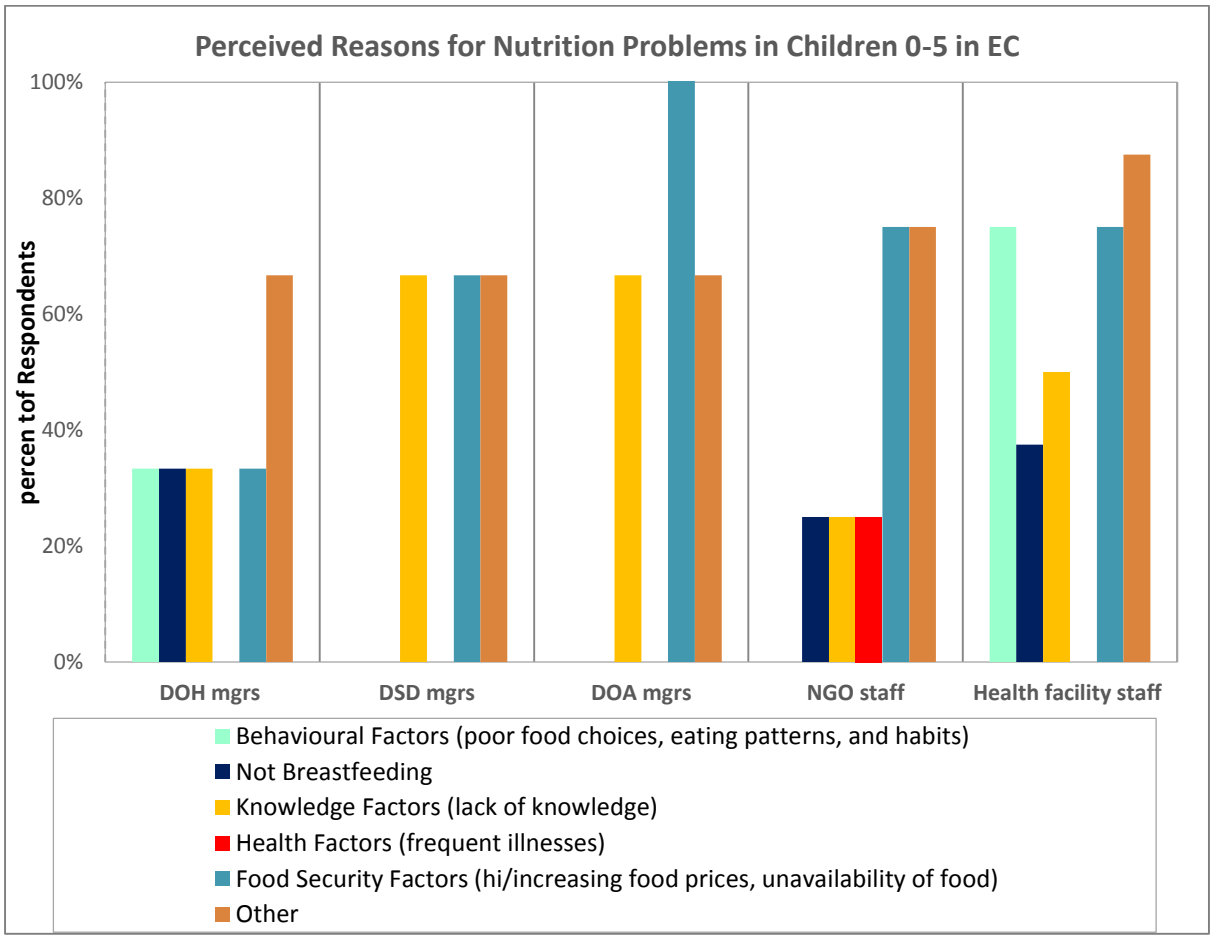



**Figure 6: Perceived Underlying Reasons for Maternal-Child Nutrition Problems in EC**



## 2.3. Nutrition Actors in the Eastern Cape

In the Eastern Cape, a wide range of Government and non-government actors are involved in implementing food and nutrition programmes. Government departments include Health (DOH), through its MCWH and Nutrition Directorate, Social Development (DSD) and its agency the South African Social Security Agency (SASSA), and Rural Development and Agrarian Reform (DRDAR). At community level, both government and non-government organisations deliver food and nutrition support to households and communities: DOH Community Health Workers, health facilities and growth monitoring sites, breastfeeding support groups, community care givers (CCGs), Philani Mentor Mothers, Early Childhood Development (ECD) centres, and various agricultural initiatives facilitated by the DRDAR and DSD through Extension Officers and Community Development Officers.

### 2.3.1. Eastern Cape Department of Health (DOH)

Nutrition in the provincial DOH is positioned in the INP Sub-directorate under MCHW and Integrated Nutrition Programme (INP) Directorates[7]. Three respondents (at provincial and district level) raised concern around the location of the INP at the sub-directorate level, as it was felt that this takes focus away from nutrition because managers focus mostly on other MCH interventions.

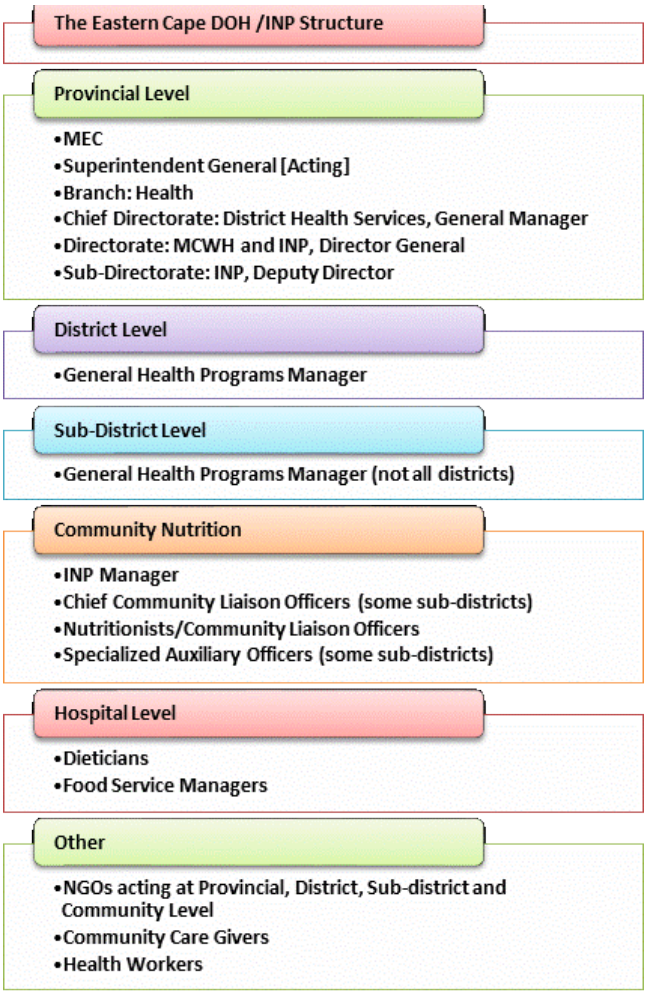
At district level, the General Health Programmes Manager is responsible for coordinating the INP as well as other health programmes. At sub-district level, nutrition structures consist of INP Managers, Chief Community Liaison Officers, Nutritionists and Community Liaison Officers and Specialized Auxiliary Services Officers.

At health facility level nutrition interventions are implemented by hospital based dieticians, nurses at Community Health Centres (CHCs) and in Primary Health Clinics (PHCs), and the CHWs[8] at community level (Figure 7).

The INP managers' main responsibilities include:

- Developing and monitoring the implementation of policies and guidelines governing the INP, including Infant and Young Child Feeding (IYCF) Programme, Maternal Nutrition Programme, and Youth and Adolescent Nutrition Programme;

**Figure 7: Organisational Structure for DOH Integrated Nutrition programme in EC**




[7] EC-DOH Visio Diagram on Directorate Organogram provided to researcher.
[8] However, the coverage of DOH CHWs could not be established during the evaluation.

- Ensuring implementation of disease-specific nutrition support, treatment and counselling;
- Implementing nutrition, education, promotion and advocacy;
- Ensuring implementation of the Micro-nutrient Malnutrition Control Programme;
- Participating in the activities of the Social Needs Cluster with a focus on comprehensive Nutrition.

There is a strong sentiment that nutrition is not considered as important as other health programmes by DOH leadership, and the INP is forced to compete with other programmes for resources (i.e. *"When we ask for someone to (be employed) to champion breastfeeding, it is opposed. Their focus is on HIV and TB – they don't understand the role nutrition can play"*.)

### 2.3.2. Eastern Cape Department of Social Development and Special Programmes (DSD)

Within the DSD, food and nutrition interventions are located within Programme 2 (Social Welfare) and Programme 3 (Research and Development) both of which are headed by General Managers (Figure 8). In addition, DSD's affiliate agency, SASSA, implements various food access interventions.

Programme 2: Social Welfare has a broad mandate to:

- Provide support services to children, youth and families who are vulnerable and in need
- Promote inclusion and integration of people with special needs through developmental social services
- Provide women and victim empowerment programmes to survivors and perpetrators of violence
- Provide preventative, advocacy and care giving programmes to people infected and affected by HIV/AIDS
- Promote preventative and awareness programmes on disaster and provide social relief of distress

Programme 2: Social Welfare includes the following nutrition-related interventions:

- **Short-term relief services** (i.e. the Social Relief of Distress programme) for families in distress. Social workers and ward committees identify qualifying families for this support, and DSD's agency SASSA provides food parcels for a period of 3 months.
- **Soup kitchens** for HIV programmes.
- **Financial support for Early Childhood Development** (ECD) centres. 1 283 ECD centres serving 57 183 children are financially supported, a portion of this earmarked for meals for children. The DSD also engages Provincial DOH to train ECD Practitioners on nutrition.
- **ECD Vegetable Gardens**. With UNICEF support, DSD is developing a new ECD strategy that includes, among other activities, "One ECD Centre, One Vegetable Garden." During the 2012/2013 financial year, four ECD Centres started vegetable food gardens; however, due to budget cuts, there are no plans to fund more gardens in 2013/14. DSD engages DRDAR to mentor ECD Centres on vegetable food gardens.

DSD also supports non-centre-based ECD programmes[9] with seedlings, wheelbarrows, and forks to start food gardens. DSD plans to fund 8 non-centre-based ECD programmes (one in each District) in the 2013/14 financial year, reaching an estimated 150 children per district with nutrition at their homes (i.e. food parcels for families with young children), totalling 1200 children in the Eastern Cape. One ECD centre visited in OR Tambo district as part of this evaluation had a well maintained vegetable garden (sweet potatoes, onions, spinach, carrots, and cabbages) to support food production and to supplement monthly grant received from DSD.

Additional UNICEF support for ECD covers (1) training of Family Care Workers, (2) mapping of ECD Programmes, (3) finalising the Integrated ECD Strategy, (4) developing Imizamoyethu ECD centre as a school of excellence, and (5) assigning of functions to Municipalities in terms of the Children's Act No 38 of 2005.

During a two year partnership with DSD which ended in 2012 (at the urging of the DOH), Nestle supported DSD funded ECD centres with wheelbarrows, spades and forks for gardens. Currently, World Vision provides wheelbarrows for 2 ECD centres. The National Development Agency (NDA) provides ECD centres with R5,000 per year for vegetable gardens.

Programme 3: Development and Research contains the Sustainable Livelihoods Programme, where DSD provides financial resources for household food production, with the following objectives:

- Provide food relief to vulnerable individuals, groups and communities;
- Capacitate poor communities to create own developmental initiatives;
- Establish cooperatives focusing on income generation activities; and
- Facilitate youth entrepreneurship development.

However, funding allocated for the Sustainable Livelihoods programme has

**Figure 8: Organisational Structure for DSD ECD and Food Access Programmes in EC**


[9] Non-centre-based ECD programmes are implemented by Social Auxiliary Workers (SAW) who provide ECD services in villages where registered ECD centres are not available. SAW also carry with them food parcels and educational materials, and they talk to mothers about the importance of exclusive breastfeeding in the first 6 months.

drastically decreased from R113m to R5m over the past 5 years.

Aside from the ECD programme, no other DSD food or nutrition interventions described above specifically target children under 5 or pregnant women.

### 2.3.3. Eastern Cape Department of Rural Development and Agrarian Reform (DRDAR)

The DRDAR aims to *eradicate poverty, increase food security, stimulate rural economies, support and ensure sustainable rural livelihood*[10]. The Department's 3 Strategic outcome oriented goals are:

1. A thriving farming sector and access to affordable food.
2. Improved rural economic livelihoods and creation of employment opportunities
3. A conducive environment to enhance service delivery

Toward this goal and Strategic Outcome number 1, DRDAR implements food security programmes under the Siyazondla Homestead Food Production and Siyakhula Step-Up Food Programmes at community level, but these do not specifically target pregnant women and children under five. The Food Security Programme is positioned within the Department's Programme 3: Farmer Support and Development. The division Food Security Services primarily focuses on:

- Engaging emerging farmers with exposure to massive food production methods;
- Empowering emerging farmers to become commercial farmers;
- Assessing food security in the sector;
- Developing and implementing food security programmes in the sector

The DRDAR's Food Security Programmes are presently under review in order to draft a new Provincial Food Security Policy, which is earmarked for completion in 2014. Provincial respondents indicated that for DRDAR to be more effective in addressing food security, NGOs and institutions of higher learning need to be engaged. The business sector is currently involved in addressing access to food through contracts with SASSA for provision of food for the food parcels and for distribution of food parcels, especially in rural areas.

Respondents at both provincial and districts levels identified the following elements as necessary for accelerating the scale up of food security interventions:

- Strong facilitation skills to work more effectively with communities and identify capable farmers.
- Clear understanding of market trends in order to provide farmers with useful information as well as sound advice on the ground.
- Improved quality of district level data, including reporting processes and data use.
- More coherence between political imperatives and actual implementation on the ground.
- More stability in political leadership - frequent changes in political leadership has led to abrupt changes in strategies and food security programme implementation.

Several DRDAR organisational needs were noted: (i) better and appropriately skilled management to

[10] Eastern Cape. Department of Agriculture and Rural Development. *Annual Performance Plan 2013/2014.* http://www.agr.ecprov.gov.za/modules/documents/download_doc.php?id=218

enable better administration of the programme and utilization of resources; (ii) better strategic planning which considers long-term versus short-term approaches to food security, and (iii) better methods of evaluating programme impact coupled with improving the quality of delivering services, "*we don't do things as well as we should.*"

As voiced by one respondent, *"Poor food security strategies and implementation leads to wastage of money, poor food security outcomes and undermines food security. For example R38 million was wasted because of poor planning in the last financial year (R9000 was invested per hectare and only R2000 was realised per hectare after harvest)."* District respondents also noted difficulties in implementing programmes , particularly because of poor planning which is not aligned with the planting season, and poor performance of contractors in delivering the agricultural ordered (e.g. fertilizers, implements), and therefore which lead to delays in planting, production, and harvesting.

Respondents also noted that DRDAR needs to streamline its programme offering and not "try *to do everything*" in agriculture, e.g. supporting commercial agriculture, community agricultural efforts, subsistence agriculture, or supplementary food production (e.g. home gardens).

### 2.3.4. Non-Governmental Organisations (NGOs) and Donor Support

A wide range of NGOs and other organisations are involved in food and nutrition work in the province.

#### Mzimvubu Nurseries, an Agriculture Home Gardening Project

Mzimvubu Nurseries, an Agriculture Home Gardening project, promotes and supports home vegetable gardens in villages around Port St Johns and Lusikisiki in the OR Tambo District. This support includes training communities in home food gardening, growing seedlings in the community nursery, supplying seeds, and providing continued support for successful food gardens. Mzimvubu assistance is targeted to pregnant women, mothers of children under 5 only when households are referred by the DOH, otherwise there is no specific targeting of such households. They are solely funded by private entities, such as Anglo-American which provided a grant for installing Jojo water tanks for home gardens. Mzimvubu highlighted the need for more programme funding to be able to pay fieldworkers and thus reduce high staff turn-over.

#### PATH

Provincial DOH respondents noted the contribution of PATH, a PEPFAR-funded health partner, in training (i) nurses, nursing assistants and CHWs on Infant and Young Child Feeding (IYCF) in 2011 in the sub-districts of Mbashe, Mnquma and KSD, and (ii) nurses, INP Managers, HIV Prevention Professionals and Community Health Workers throughout the province in Nutrition Assessment, Counselling and Support in 2012. Unfortunately, PATH closed its Eastern Cape office at the end of 2012 and relocated to Gauteng Province.

#### UNICEF

Provincial DOH respondents noted various forms of UNICEF support. In 2012 UNICEF sponsored senior managers to attend the International IYCF conference. During a review of the Mother Baby Friendly Institution (MBFI) Assessment Tool, UNICEF assisted EC-DOH staff with logistics support. UNICEF also supports EC-DSD in its ECD programme as described in section 2.2.2 above.

#### FHI 360

FHI 360 does not work directly with EC-DOH but provides various training support through the National DOH. Provincial DOH respondents reported that FHI 360 trained hospital doctors on the

IYCF policy and Management of Severe Malnutrition. There are plans to provide this training to the EC District Clinical Specialist Teams (DCST) in the future.

### Africare

Provincial, district and facility DOH respondents noted Africare provides technical support to the Chris Hani and Cacadu districts in HIV and nutrition with (i) training facility staff on nutrition, (ii) providing IEC materials (iii) redrafting (i.e. summarising) the Provincial Supplementation Protocol into a poster for health facilities, and (iv) conducting a situational analysis in the two districts.

### Small Projects Foundation

Small Projects Foundation support health facilities in OR Tambo district with the following: (i) seedlings and training to start clinic vegetable gardens, and (ii) training CHWs (NGO-established) on nutrition. The Foundation used to pay nutrition-trained CHWs a stipend, but this was withdrawn in the 2009/10 financial year. The withdrawal of this financial support is reported to have negatively affected the reach of nutrition and health interventions that the CHW covered, because the CHWs could not be retained by the DOH.

### Treatment Action Campaign (TAC)

In conjunction with health facility staff, TAC trains peer educators on nutrition and health promotion for people living with HIV/AIDS, including safe infant feeding in the context of HIV.

### Philani Zithulele Mentor Mothers (non-PEPFAR funded NGO)

Philani Zithulele Mentor Mothers is an NGO working in Coffey Bay, OR Tambo district, although their head office is in the Western Cape. Philani works closely with Zithulelele Hospital (a Mother Baby Friendly Institution) to provide postnatal breastfeeding education at the hospital, and to support mothers and family members in health and breastfeeding. Mentor mothers visit homes to assess the health and welfare of children. They weigh children to monitor their growth (using their own portable weighing scales), give nutrition counselling and support to mothers using Q cards with simple pictures and in the local language, and identify cases of moderate malnutrition and aid in their management. Mentor Mothers bring services to people who don't easily access the clinic because of distance and high unemployment. They attend community meetings, give talks on health education concentrating on exclusive breastfeeding, and use cell phones and SMSs to better reach the community. Philani's operations in Eastern Cape are funded by various private donors, and they do not receive any government support. At an organizational level, they have identified a need to hire a professional nurse as well as a social worker.

### HACCO [Horn of Africa Community Concern]

HACCO is an international NGO (based in Kenya) that funds health awareness campaigns and transportation for the campaigns by respondents at Lusikisiki Community Village Clinic.

### Umcunube

Umcunube NGO establishes clinic gardens and community gardens in the community of King Sabatha Dali Ndyebo (KSD).

### Wold Vision

World Vision, an international NGO, subsidised some unsubsidised ECD centres, and also provides garden implements for ECD gardens.

### 2.3.5. Private Sector

#### Nestle

In 2010, EC-DSD formed a public private partnership for improving the lives of children in ECD centres. The partnership had 3 focus areas: (1) to beautify the ECDs: "Beautify" refers to fencing, painting, equipping, etc.; (2) to assist in training ECD practitioners on how to cook nutritious meals for children; and (3) to develop food security through ECD vegetable gardens. Through this partnership, a 2-day training workshop in nutrition was conducted in November 2010 for 30 Social Auxiliary Workers (SAW) who came from throughout the province, and who are attached to ECD centres to monitor (amongst other things) how ECD centres perform in the area of child nutritional support. This was the primary reason they were selected as the target group for the training. In addition, Nestle also provided wheelbarrows, spades and forms for gardening at ECD centres.

#### ABSA

In 2012, in an effort to combat malnutrition of children under nine years and bolster community-driven food security activities, ABSA donated R900,000 to EC-DSD for the Orange Flesh Sweet Potato project, an initiative that empowers communities to achieve economic independence and food security through the production of orange sweet potatoes. The project is run through cooperatives in the districts of Amathole, Cacadu, Chris Hani and in Port Elizabeth and Uitenhage, with a focus on women producers.

# 3. FINDINGS: PROVINCIAL STRUCTURE

## 3.1. Nutrition Leadership and Management Arrangements in Eastern Cape Province

> *"… We have also finalised the Provincial Integrated Anti-Poverty Strategy, through which we seek to ensure coordination and integration of all anti-poverty initiatives, efficient and effective utilisation of limited resources and placing people's empowerment at the centre of their own development."* Premier N Kiviet, State of the Province Address, Feb 2013.

The Eastern Cape Provincial Government recently launched the Provincial Integrated Anti-Poverty Strategy (PIAPS)[11]. Conceptualised in 2011/12 and endorsed by various stakeholders at the Anti-Poverty Indaba on 1 November 2012, this strategy was ultimately approved by Cabinet in the 2012/13 financial year. The PIAPS brings together all provincial departments, national government departments and social partners with the expressed aim of *"…building consensus, solidifying understanding and eliminating duplication around planning, budgeting, implementing, monitoring and reporting."* The Departments of Social Development and Special Programmes (DSD-SP), Health, Education, and DRDAR are PIAPS primary implementing agents.

The Eastern Cape Integrated Anti-Poverty Strategy Is a people-centred strategy with **early childhood development** and **integrated food security and nutrition** initiatives taking a key role.

[11] Towards Integrated Planning for Provincial Integrated Anti-Poverty Strategy & Implementation Plan, Concept Document, 1 November 2012, East London.

An implementation principle for PIAPS[12] is joined-up and better targeting of interventions at all levels of government as shown in Figure 9. PIAPS seeks to integrate work that is being done by various sector departments, civil society organisations, and the business sector to ensure effectiveness intervention, coordination, utilisation and allocation of resources and avoid duplication of efforts.

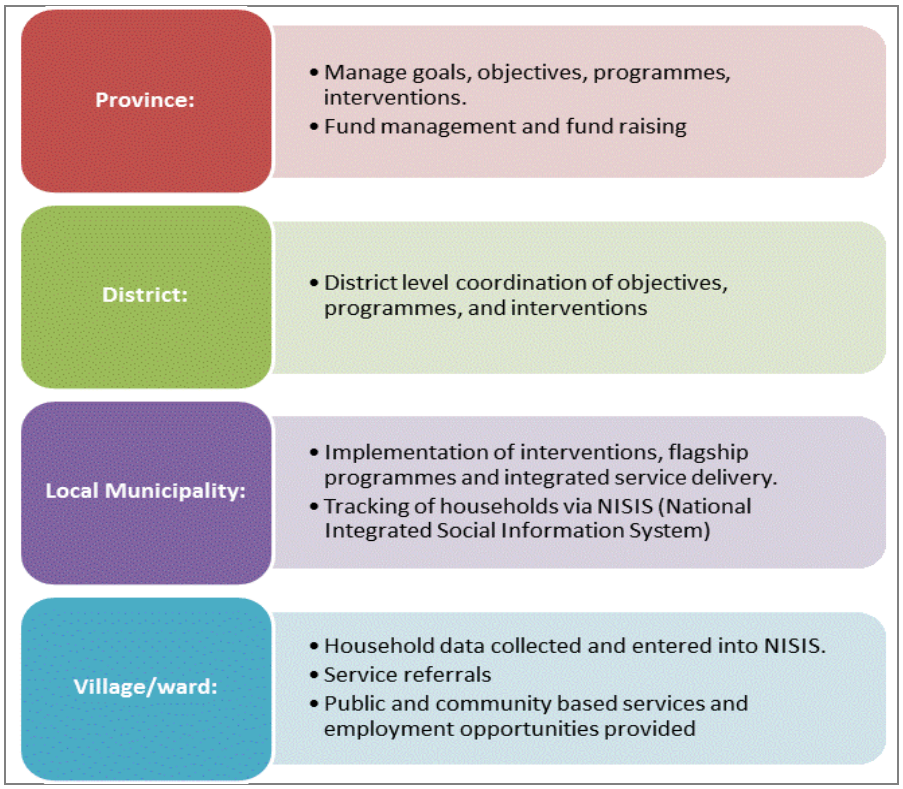
PIAPS is still at an early planning stage. DSD-SP, tasked as the lead department for implementation, recently held strategic planning sessions whose objectives were twofold:

1. To improve the implementation of effectively targeted interventions and integrated service delivery through better alignment of national and provincial government planning processes and outputs (strategic, annual performance and operational plans) within the context of the Provincial Anti-Poverty Strategy
2. To improve the capability of multi-stakeholder approach involving both government and its social partners to monitor and report on service delivery and performance targeting the identified sites for the Anti-Poverty Strategy.

In addition, a provincial Food Security and Nutrition Committee[13] was established and a Provincial Food Security and Nutrition Seminar was convened in March 2013 to focus on the food security and nutrition portion of the PIAPS. Sixteen sites (2 per district including metros) were identified by the municipalities themselves for phased implementation of PIAPS[14].

[12] Eastern Cape Integrated Anti-Poverty Strategy and Implementation Plan
[13] The DOH Deputy Director/INP represents the DOH on this Food Security and Nutrition Committee.
[14] For a list of the 16 sites see: Budget Speech 2013/14, Eastern Cape Province. *Policy Speech by Hon MEC for Social Development and Special Programmes, Dr. Pemmy Majodina in the Provincial Legislature*. 27 March 2013. http://www.gov.za/speeches/2013/EC_social_development.pdf

### Figure 9: EC Implementation Arrangement of PIAPS




## 3.2. Plans for Implementing Nutrition Interventions in Eastern Cape Province

The Annual Programme Plans (APP) for each of the Government departments provide varying levels of detail on nutrition.

### Table 8: Status of EC APPs in terms of Nutrition Interventions and Programmatic Targets

| | DOH | DSD | DRDAR |
|---|---|---|---|
| **Includes reference to Nutrition goals?** | **Yes** | **Partially**. directorate specific plans at province and district level detail food access interventions as part of service package | **Partially.** Goals reference food security without defining food security |
| **Includes reference to nutrition needs of children under 5 and pregnant women?** | **Yes** | **Partially**. Includes reference to nutrition needs of ECD learners. | **No** |
| **Includes specific programme targets for nutrition** | **Yes.** particularly in the sub-directorates APP | **Partially**. APP has a few indicators focused on No. households with access to DSD food access and food security interventions. The data largely comes from meetings with community members. | **No.** "Number of hectares planted to field crops towards the attainment of 300,000 ha established to produce food in order to support poor house-holds & smallholder farmers." |
| **Includes clear description of nutrition interventions** | **Partially** | **No** | **No.** Activities focus mainly on identifying food insecure households, maintaining a database on these households' benefits, and assessing |

| | DOH | DSD | DRDAR |
|---|---|---|---|
| | | | requirements for food production. |
| **Has separate budget line item for nutrition interventions** | **Yes** | **No.** | **Partially.** R38 million is allocated to achieve the food production target listed above. |

DOH and DSD respondents confirm the existence of a clear vision to implement nutrition/food access interventions in their respective departments; in contrast, DRDAR respondents were unclear about their department's vision for food security or the commitment of DRDAR senior managers and political leadership to food security.

## 3.3. Resource Allocation – Human and Financial

Respondents noted varying levels of financial and human resources allocated to nutrition interventions, depending on their departmental affiliation.

### 3.3.1. EC-DOH

The Provincial MCWH/INP Directorate has identified a strategy of community-based nutrition programmes and appropriate and adequate staffing, especially at sub-district levels where the INP is implemented. The approved sub-district structure ideally consists of 1 INP Manager, 2 Community Liaison Officers/Nutritionists, 4 Specialist Auxiliary Services Officers, and 1 Dietician per CHC. However, significant gaps exist in the staffing of nutrition posts at these levels, and managers state that poor staffing of the INP at sub-district level negatively impacts on implementation.

In 2011 the EC-DOH had a very small complement of nutrition staff accounting for only 0.06% of all posts, with the lowest ratio per 100,000 population of all cadres (0.36 nutritionists per 100,000 population), and a vacancy rate of 51.06%[15]. However, from the data collected in December 2012, this vacancy rate has increased to 66% over all nutrition staff (Table 9) with the greatest vacancies seen exactly where implementation is meant to occur – i.e. at sub-district and CHC/PHC levels. EC-DOH managers indicate that they have not been able to fill nutrition approved positions because of a moratorium placed on hiring new staff in the province since February 2012 due to budgetary constraints, the implementation of the Occupational Specific Dispensation (OSD), and failure to prioritise INP by DOH in relation to other programmes.

With respect to training, nursing staff in 5 of 8 facilities visited indicated that they had not received any training on nutrition in the past two years, although 2 facilities reported that staff were trained on nutrition assessment and exclusive breastfeeding policy in the past 2 years. Most DOH respondents indicated that staff need refresher training on all nutrition interventions, but especially on growing food gardens, training community liaison officers on IYCF policy, and growth promotion and monitoring.

[15] EC-DOH. *Annual Performance Plan for 2012/13 – Part A - STRATEGIC OVERVIEW.* http://www.EC-DOH.gov.za/EC-DOH/policies_and_legislation/319/Annual_Performance_Plan_201213201415_Part_A

### Table 9: DOH Human Resources for Nutrition in EC (December 2012)

| Level | Posts Approved | Posts Filled | Posts Vacant | % vacancy |
|---|---|---|---|---|
| **Provincial Nutrition Directorate** | 11 | 8 | 3 (Assistant Director: INP Infant and Young Child Feeding, 1 Financial Controller and 1 Accounting Clerk posts are vacant) | 27 % |
| **Sub-district** | 182 Nutrition positions are approved for 26 DOH Sub-districts (1 INP Manager; 2 Community Liaison Officers/ Nutritionists; and 4 Specialist Auxiliary Officers per sub-district) | From the information that was provided it appears that only 18 Nutrition vacancies were filled in the province | 165 Nutrition positions need to be filled according to the approved INP stricture (6 Sub-district INP Managers, 24 Nutritionists, 64 Nutrition Assistants positions were currently not ) | 90% |
| **Hospital/ CHC** | 106 Hospital Dietician post are currently funded | 83 Funded Hospital Dietician posts are filled | 23 Funded Hospital Dietician posts are vacant | 21 % |
| **CHC / PHC** | 37 CHC Dietician posts per CHC were approved for all 26 Sub-districts. Exact numbers of approved, filled and vacant CHWs/Nutrition Advisors and CHC Dieticians have not been made available)[16] | 3 CHC Dietician are employed (seconded) in Nelson Mandela Metro | 1 Approved CHC Dietician post is In Nelson Mandela Metro. The province is short of 34 CHC Dieticians | 91% |
| **TOTAL** | **336** | **112** | **225** | **67%** |

[16] Several attempts were made to source/access data from DOH on the number of CHW funded posts, employed and trained in nutrition from INP sub-directorate to no avail.

The nutrition knowledge of EC nurses is poor to that of other provinces (Figure 10), and in nearly every measure (Figure 11 to Figure 14) nurses were limited in their ability to provide comprehensive answers to questions around management of mothers with breastfeeding difficulties, growth faltering, or the benefits of micronutrient supplementation. There was no significant difference between the knowledge of nurses in urban areas (22%) compared to rural areas (24%), or in high performing districts (20%) compared to low performing districts (30%).

**Figure 10: EC Nurses' Average Nutrition Knowledge Compared to Other Provinces**

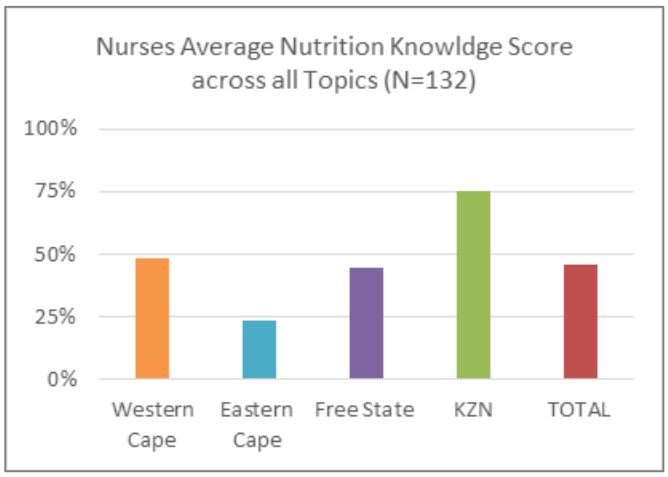
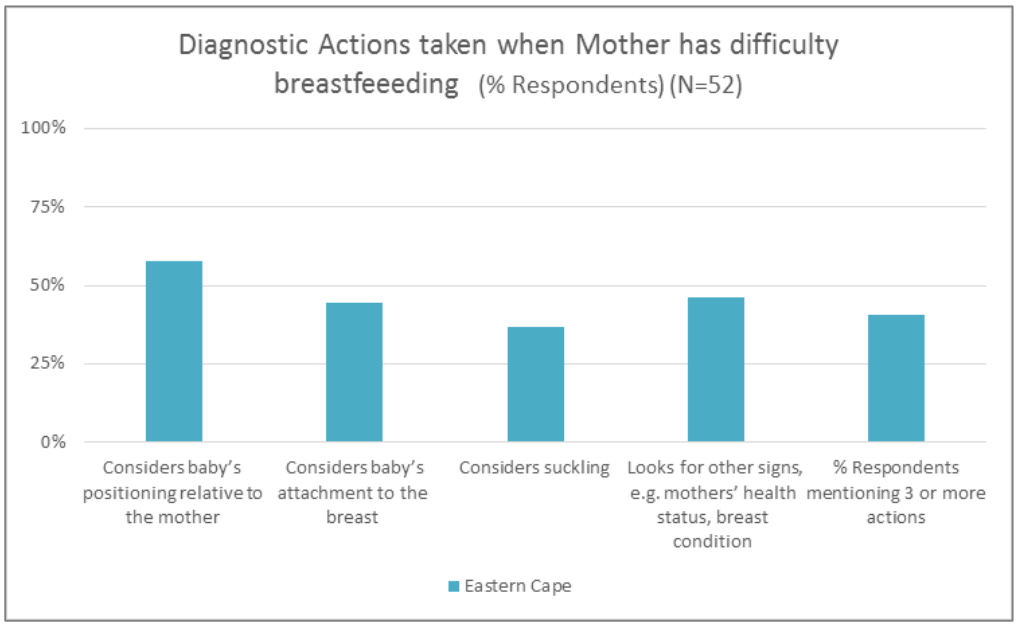
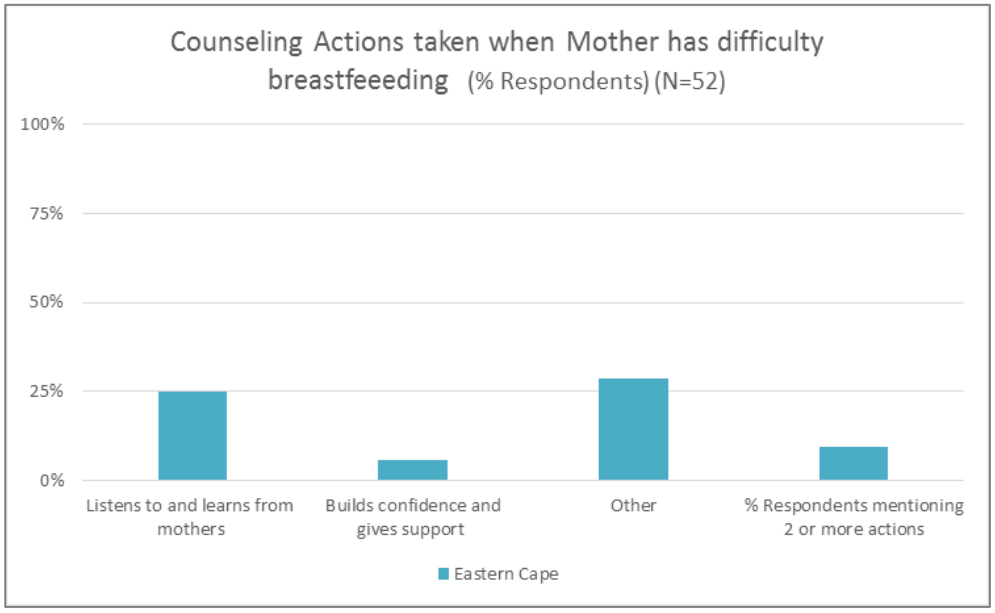


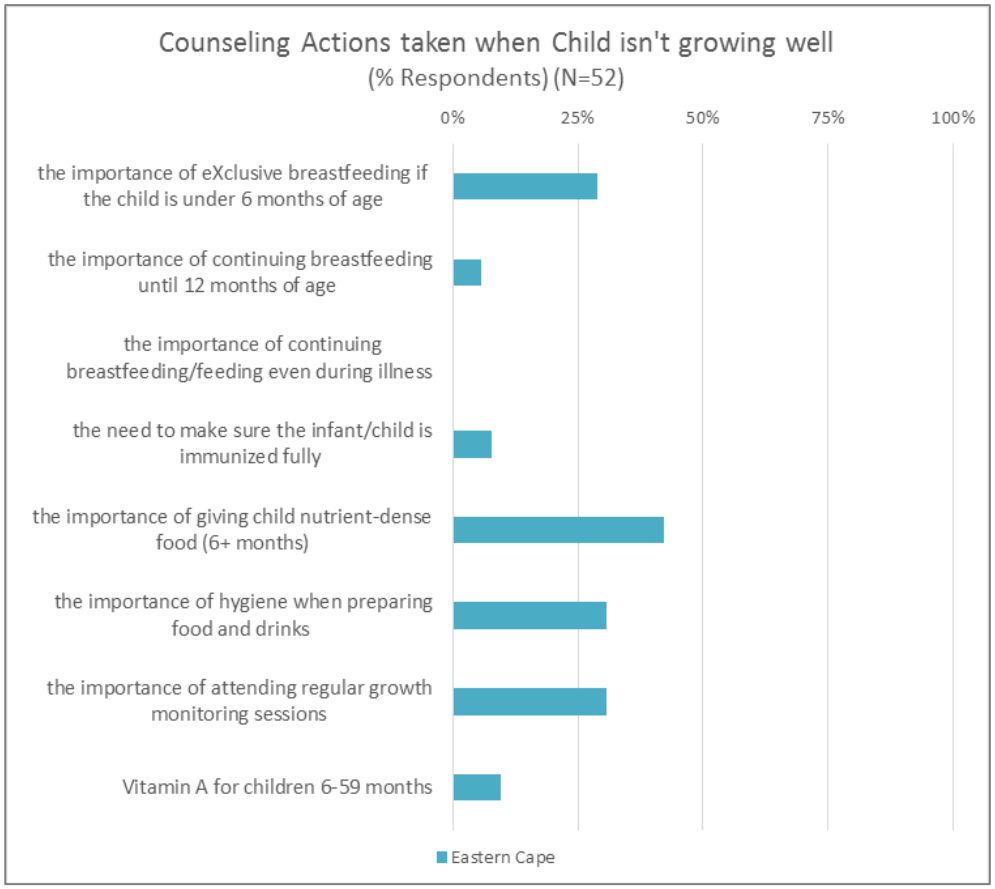

**Figure 11: EC Nurses' Knowledge around Diagnosing Breastfeeding Difficulties**



## Figure 12: EC Nurses' Knowledge around Counselling Mothers with Breastfeeding Difficulties




## Figure 13: EC Nurses' Knowledge around Counselling Mothers when Children aren't growing well



### Figure 14: EC Nurses' Knowledge of the Benefits of Micronutrient Supplementation

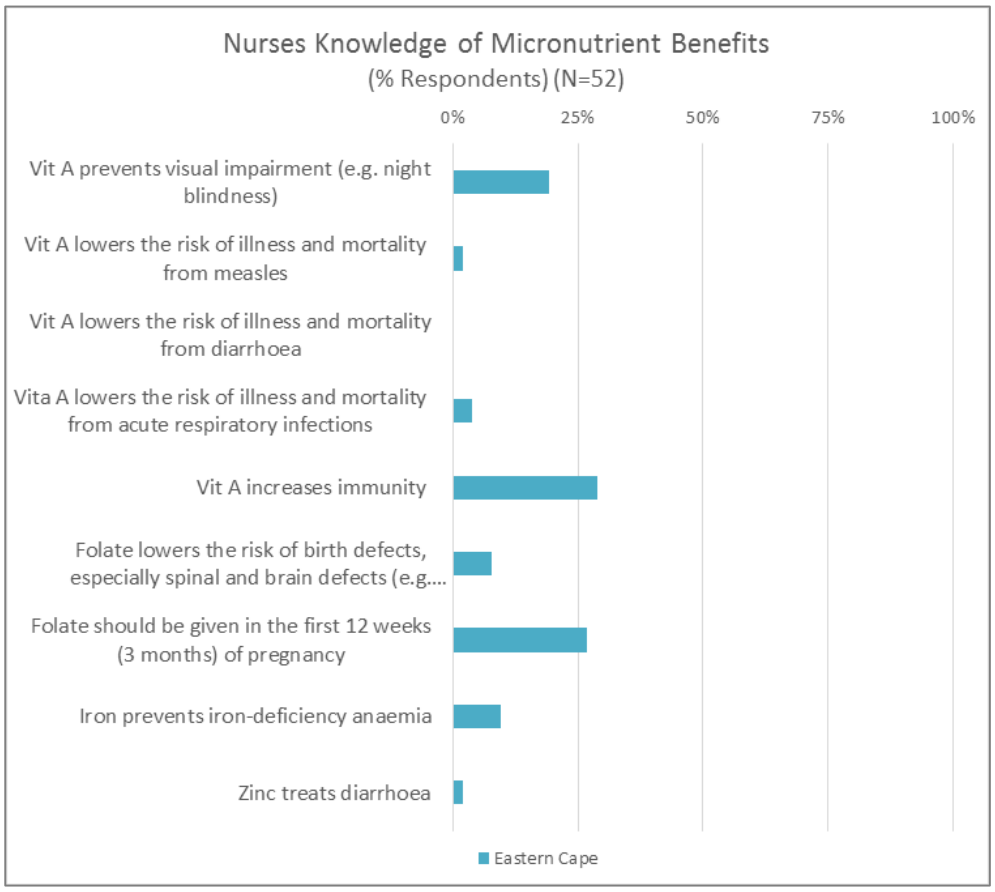



Table 10 presents the status of materials and infrastructure related to the delivery of nutrition interventions in the health facilities assessed. Although the sample is small, it is clear that key micronutrient supplements (vitamin A, Iron-folate, and Zinc) and nutrition IEC materials were not available in approximately half the facilities. No facility had any Zinc tablets available during the field visit. More than half the health facilities (52%) reported stock outs of some nutrition products in the 6 months prior to data collection, and 6% of clinics had expired Folic acid and Vitamin A on the shelves at facilities during fieldwork.

### Table 10: Status of Materials and Infrastructure in EC Health Facilities (N=10)

| Element | % of EC facilities |
|---|---|
| **Infrastructure** | |
| sufficient no. consultation rooms | 80% |
| sufficient space for counseling | 70% |
| sufficient no. counseling rooms | 50% |
| **IEC Materials (Posters or Pamphlets available in the health facility)** | |
| Vitamin A | 80% |
| Promotion of EBF | 80% |
| Breastfeeding in the context of HIV | 80% |
| Healthy Eating/Dietary Guidelines | 70% |
| Handwashing Posters at basins | 70% |
| Complementary Feeding | 60% |
| Management of Severe Malnutrition | 50% |
| Nutrition During Pregnancy | 20% |
| Feeding of the Sick Child | 20% |

| Element | % of EC facilities |
|---|---|
| Handwashing Posters at toilets | 20% |
| **Policies, Protocols, Guidelines (available in the health facility)** | |
| Malnutrition Supplementation Register | 80% |
| IYCF Policy | 70% |
| HIV and Infant Feeding | 70% |
| Nutrition Supplementation Guidelines | 70% |
| Vitamin A Supplementation | 60% |
| PHC Tick Register | 60% |
| Management of Severe Malnutrition | 20% |
| **Equipment, Drugs, Supplies (available in the health facility)** | |
| functioning baby weighing scale | 100% |
| Folic Acid | 90% |
| functioning adult weighing scale | 80% |
| MUAC Tape | 80% |
| Vitamin A Capsules 200,000 | 80% |
| Iron | 70% |
| TSF Porridge | 70% |
| Road to Health Cards - Boys | 60% |
| Oral Rehydration Salts | 60% |
| Vitamin A Capsules 100,000 | 60% |
| Road to Health Cards - Girls | 50% |
| Vitamin A Capsules 50,000 | 50% |
| Iron-Folic Acid (combined) | 50% |
| Length measuring boards | 10% |
| Zinc | 0% |
| Food Parcels | 0% |

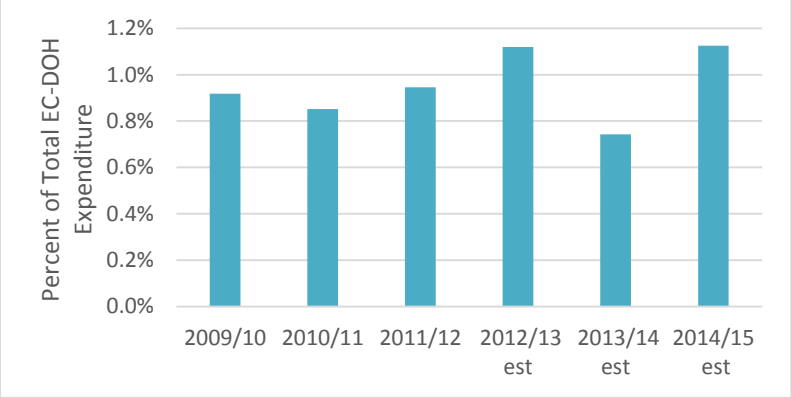
With respect to financial resources, DOH has a separate budget line item for nutrition in its Annual Performance Plan (Table 11). Although overall expenditure nutrition declined from 2008-2011, it has increased slightly since then; however over the period 2008-2015, funding for nutrition accounts only for around 1% of total DOH expenditure (Figure 15).

The actual 2013/2014 budget allocation for nutrition is less than that indicated in Table 11. The provincial DOH allocated only R60 million – a reduction of 27.6% from the previous financial year's R83 million. Provincial DOH respondents attribute the budget cut to under-spending resulting from chronic INP staff shortages in sub-districts and CHCs/PHCs.

### Table 11: EC-DOH: Trends in Provincial Expenditure for Nutrition 2008-2015[17]:

| Programme | District Health Services | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Sub-programme | 2008/09 | 2009/10 | 2010/11 | 2011/12 | | | 2012/13 | 2013/14 | 2014/15 |
| | Audited | | | Main appropria-tion | Adjusted appropria-tion | Revised estimate | Medium-term estimates | | |
| District Management | 366,854 | 439,552 | 480,908 | 529,343 | 553,190 | 610,053 | 572,592 | 624,752 | 664,493 |
| Community Health Clinics | 1,179,062 | 1,208,032 | 1,449,290 | 1,366,643 | 1,378,583 | 1,474,553 | 1,397,185 | 1,492,768 | 1,564,395 |
| Community Health Centres | 451,098 | 547,561 | 630,687 | 610,266 | 615,617 | 764,385 | 629,398 | 669,908 | 694,184 |
| Community Based Services | 273,054 | 291,050 | 340,632 | 357,212 | 360,728 | 388,213 | 407,577 | 480,804 | 500,034 |
| Other Community Services | 7,370 | 33,932 | 120,450 | 99,959 | 100,950 | 98,079 | 198,906 | 190,155 | 191,142 |
| Hiv/Aids | 396,384 | 478,952 | 705,802 | 884,376 | 935,676 | 935,676 | 1,088,150 | 1,295,202 | 1,495,554 |
| Nutrition | 62,369 | 51,263 | 56,254 | 96,513 | 73,366 | 71,493 | 83,008 | 93,622 | 96,735 |
| Coroner Serivces | 96,688 | 57,684 | 63,081 | 73,506 | 87,018 | 87,018 | 77,185 | 81,431 | 85,502 |
| District Hospitals | 2,082,828 | 2,473,875 | 2,759,919 | 2,734,771 | 2,855,558 | 3,131,332 | 2,959,037 | 3,152,047 | 3,301,675 |
| Total | | 5,581,901 | 6,607,023 | 6,752,589 | 6,960,686 | 7,560,802 | 7,413,038 | 8,080,689 | 8,593,714 |

### Figure 15: EC-DOH Nutrition Expenditure as a % of Total DOH Budget[17]




## 3.3.2. EC-DSD

In general, provincial and district DSD respondents report insufficient human resources, but sufficient financial resources for all programmes except ECD.

DSD respondents in OR Tambo district indicated that there are not enough staff to cover the vast areas they have to service. A minimum of 10 Community Development Practitioners are required per local municipality, but it operates with only 3.

The South African Social Security Agency (SASSA) provides 3-months of food parcels as part of the Social Relief of Distress Programme. For this intervention, SASSA respondents indicated that they had adequate financial and human resources to implement its interventions.

The DSD Sustainable Livelihoods Programme experienced a decreasing budget R113m to R13m per

[17] EC-DOH. *Annual Performance Plan for 2012/13 – Part C (Programme 2: District Health Services).* http://www.EC-DOH.gov.za/EC-DOH/policies_and_legislation/321/Annual_Performance_Plan_201213201415_Part_C

annum over the past five years. In its 2013-17 Implementation Plan, R15 million is allocated for Food Security which covers the following objectives (i) Household Food Security, (ii) Social Mobilization and Conscientisation, (iii) Human Development and (iv) Income Security. Many DSD respondents noted that while there are sufficient people to implement the intervention at ground level, management at provincial level lacks sufficient staff to drive the Programme (there is currently only one newly-appointed manager), and that additional staff with agricultural, nutrition and facilitation skills are needed. Additionally, all DSD Sustainable Livelihoods management staff need more exposure to successful similar practices of other countries.

ECD Managers believe the ECD budget needs to increase in order to reach more ECD centres. "*The children population in the province is estimated at around 600,000 and the department is only subsidising 57,000 children*", said one respondent (confirmed by the Premier's speech[14]). The EC-DSD's 2013/14 Operational plan has a budget of R694 million for the Child Care and Protection Services sub-Programme, of which R188 million (27%) is earmarked for ECD centres, and R1.6 million (0.2%) for non-centre based ECD programmes.

ECD respondents further indicated that with additional funding, a more programme-based allocation could be followed instead of one based simply on attendance. Programme-based funding would allow spread from child to caregiver to parent and community, allowing for cross-cutting services to be provided. ECD respondents also believe the subsidy apportioned for nutrition is too little (R6 per child a day) to provide three nutritious meals per day for each child. Budgetary constraints apparently prevent EC-DSD to meet the national nutrition target of R18 per child per day. It was also indicated that World Vision (NGO) subsidises some unsubsidised ECD centres.

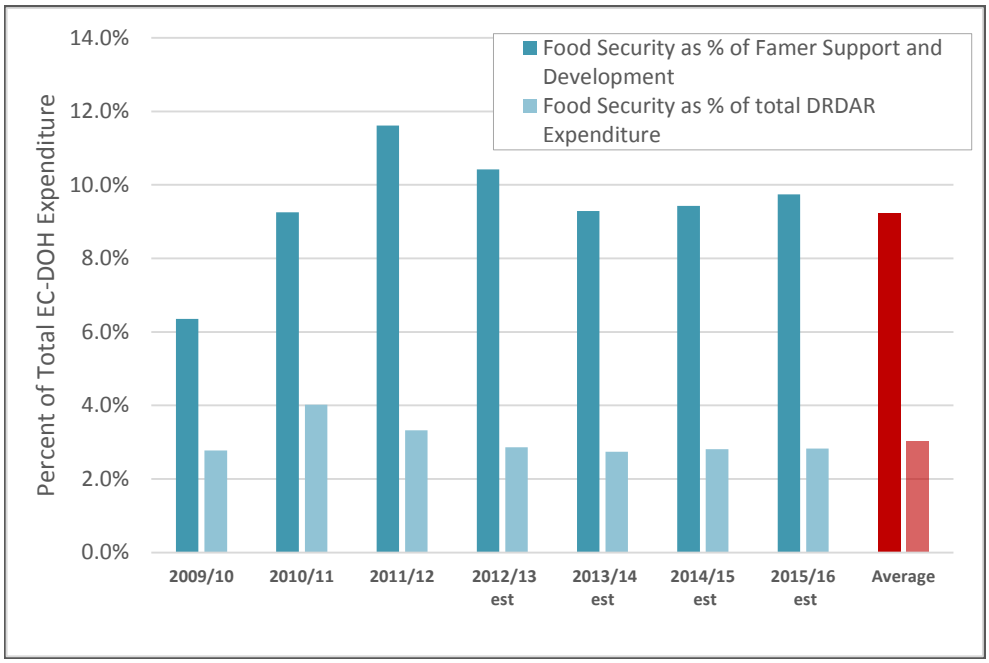
Finally, within the same operational plan, social relief programmes are allocated R6.8 million for food support to families affected by undue hardships and affected by disasters.

### 3.3.3. EC-DRDAR

DRDAR respondents generally indicated that financial resources are limited and reducing for implementing food security programmes. Figure 16 shows that although Food Security's share of the Programme and Departmental budget increased from 2009 to 2012, it has been reduced for this financial year and for forthcoming financial years. Indeed, respondents reported that the DRDAR Food Security programme used to get R220 million but now gets only R7 million from province and R42 million from national government.

In terms of human resources, DRDAR respondents unanimously confirmed that there are sufficient staff to implement programmes.

**Figure 16: Food Security Expenditure as a Percentage of the Farmer Support and Development and Programme and DRDAR[10]**




### 3.3.4. NGO Resources

Many NGOs engaged in delivering nutrition interventions lack sufficient funding or staff to scale their interventions. Mzimvubu Nursery indicated a challenge in paying fieldworkers, which has resulted into high staff turn-over. They also identified the need for a qualified agriculturalist for their programme. Philani's Zithulelele Mentor Mothers programme indicated that it had adequate funding to run the programme in EC; however, it would like to receive direct financial support from the provincial DOH, like their Western Cape programme. Philani has adequate staff at the moment, but to expand it would need additional management and field staff.

## 3.4. Coordination between Government Departments

Many respondents mentioned the PIAPS, with its political and administrative mandate of the "Eastern Cape Attack on Poverty: *Gwebindlala*" campaign, as guiding the coordination of resources across government departments. A Provincial Cluster system has been established to coordinate planning, budgeting and reporting for the PIAPS. Nutrition, Food Security and School Nutrition will be housed under the Household Food Security thematic area with DRDAR as the lead agent and DOH as a support institution.

No additional resources have been allocated for PIAPS, but rather individual government departments are asked to commit some of their funding for achieving the goals of the PIAPS and Gwebindlala. Some financial coordination between government departments is evident. For instance, DOH has pledged R2m to the PIAPS for the Food Security Programme to cover food gardens at clinics and hospitals, educational demonstrations on how to cook vegetables, growth monitoring and promotion training for child minders at ECDs, and the provision of vitamin A. DRDAR has pledged R1.8m to organise training on the Food Security Profiling Tool. DSD-SP and the National Development Agency (NDA) have generally pledged R1.5 million and R2 million respectively, while the Department of Education pledged R2.4 million for food security programmes.

Respondents spoke of the former Interdepartmental Integrated Food Security (a provincial nutrition coordinating structure) and the Nutrition Task Team, which resided within DRDAR but which collapsed due to lack of proper coordination. At the present time, the newly-established (in 2012) Integrated Food Security and Nutrition Committee under PIAPS has a multi-stakeholder membership base, including numerous government departments (DOE, DOH, DSD, DRDAR, DLGTA[18], DRPW), NGOs, the Independent Development Trust (IDT), the NDA, Eastern Cape Rural Development Corporation, Traditional Leaders, and Academic Institutions (Rhodes, Fort Hare and Walter Sisulu universities). This mechanism is expected to provide better coordination of nutrition interventions in the province. The committee has met monthly since its establishment last year.

Despite the pledges and establishment of the Nutrition Task Team, there is little evidence of coordination or integration in planning or implementing nutrition interventions among Government departments. Several respondents noted the need for better collaboration between government departments, who work in silos often with duplication of effort. An example is Chris Hani district where both DSD and DRDAR have food security programmes serving the same communities, as the criteria for selecting target beneficiaries appears to overlap.

In addition, there is a clear sentiment expressed by DSD respondents that Local Government should play a stronger role in defining areas of intervention and clarifying roles. The starting point for this coordination is the Integrated Development Plan (IDP) where policy, strategy and financial alignment between local government and provincial departments ought to be carried out. Currently, IDPs are devised without input from provincial departments and this poses a challenge for programme implementation, monitoring, and reporting. Local municipalities work with DSD, DOH, and DOE to identify and select people who are affected by food insecurity.

Mzimvubu Nurseries also highlighted the importance of government funding to NGOs in the agricultural sector for promoting agriculture and home gardens for nutrition.

## 3.5. Coordination between Government and Private Sector

Most respondents at facility, district and provincial level appeared positive about the role of NGOs in nutrition and food access interventions. However, a few respondents raised a concern about depending on NGOs for supporting and funding health campaigns as this removed the authority from the government. Otherwise, many respondents believed that there is need to scale up funding for NGOs and to improve coordination between the NGOs and departments of DOH, DSD, and DRDAR.

There is only sparse evidence of linkages or coordination between government and the private (for profit) sector around nutrition. Deliberations from the Food Security and Nutrition Seminar in March 2013 included discussions on mobilising the participation of business, but there is little indication how this would occur, or which government department would lead this effort.

Milling and food companies were mentioned as an area of regulation for food fortification, but there was no indication of direct interaction by EC-DOH INP managers with these companies.

EC-DOH gives Road to Health booklets to private hospitals, are introducing the Mother Baby Friendly Initiative (MBFI) to private hospitals, and used to provide vitamin A to private hospitals (but this stopped in 2012). Chris Hani district is in the midst of establishing working relationships with local

[18] The Department of Local Government Traditional Affairs (DLGTA), Department of Roads and Public Works (DRPW), and Department of Education (DoE)

private hospitals, and they indicated collaborating with private doctors on immunization and providing them with Road to Health booklets.

As mentioned earlier, DSD partnered with Nestle in 2010 for a 2-day nutrition training workshop for 30 SAWs, and Nestle also provides wheelbarrows for ECD gardens.

# 4. FINDINGS: FOCUS INTERVENTIONS

## 4.1. Breastfeeding Support

Promotion of exclusive breastfeeding (EBF) in the first 6 months of life is strongly supported by all respondents interviewed (health personnel and beneficiaries alike). Most respondents stated that this is an adequate intervention to meet the nutritional needs of children under the age of five (5) years. However, respondents at all levels of the health system noted that despite good training not all nurses and CHWs had bought in to the new EBF policy, in part because they didn't fully understand how HIV+ mothers could breastfeed without risking transmission to the child, and in part because of their own conflicting cultural practices and beliefs. This combined with irregular or inconsistent attendance by pregnant mothers at ANC and PMTCT services further hampers successful breastfeeding support.

Plans are underway to introduce the Milk Bank initiative and the NDOH has identified Frontier Hospital, in Chris Hani district, as the facility for rollout.

### 4.1.1. Delivery Channels

Breastfeeding is promoted mainly in the health sector from the provincial level right through to primary health care facilities. In the DSD's non-centre based ECD programme, SAWs conduct nutrition awareness and education at home level, and at these sessions, the importance of exclusive breastfeeding is emphasised. Otherwise, there was no evidence of DRDAR or other DSD nutrition interventions promoting breastfeeding.

Information, education, and communication (IEC) around breastfeeding is offered to pregnant mothers as early as possible in the antenatal period at primary health care clinics and then again post-delivery in post natal care at hospitals. Pregnant mothers are educated on the benefits of exclusive breastfeeding in one-on-one counselling, at group education and awareness sessions, and also during growth monitoring sessions run at the health facility. HIV positive mothers are counselled and educated on the benefits of exclusive breastfeeding as part of PMTCT services. This pattern of services delivery is consistent at most health facilities visited during the fieldwork.

Communication on exclusive breastfeeding is clear, using simple terminology in a language (isiXhosa) that is understood by beneficiaries. When formula milk was removed from health facilities in 2012 as part of the new breastfeeding policy, the province found that building awareness through radio broadcasts was particularly useful to prevent backlash with regards to the change in policy. Indeed, DOH respondents stated that the withdrawal of formula from clinics has encouraged the more breastfeeding.

CHWs provide community outreach for this intervention by giving direct support to mothers at their homes. EC-DOH promotes outreach as part of its response to implementing PHC re-engineering. CHWs help mothers with correct positioning of the baby for latching to the breast, expressing milk; and cooking and general home hygiene.

At one facility in Chris Hani district, there is an exclusive breastfeeding support group that meets

monthly although attendance is reported to be low when schools are open. As a result of these meetings, the clinic reports that there are fewer cases of children aged of 0-6 months presenting with diarrhoea.

To further this intervention, Baby Friendly Hospitals support breastfeeding immediately upon delivery.

Practical messages given to mothers to encourage exclusive breastfeeding are:

- It promotes bonding immediately after birth.
- Colostrum is important to baby's immune system.
- Mothers should breastfeed on demand and for a minimum period of six months.
- Mothers are to exclusively breastfeed and not mix feed, not even water or traditional medicine.

Although the messages around breastfeeding are clear and consistent, health workers reported that most mothers exclusively breastfeed only for the first 3 months and thereafter practice mix feeding. Mothers interviewed echoed the views of health workers, in terms of the adequacy of the breastfeeding message given at health facilities and their subsequent practice. Mothers, as well as DOH and DSD respondents, cited numerous social, cultural, and structural barriers or challenges that impede successful breastfeeding practices (see page 36).

One opposing view on the present delivery channel was that PHC, CHC and maternity hospitals were not the most effective delivery channels for breastfeeding promotion although they are the first point of education. Rather, much more focus should be given to community outreach directly to homes. This direct support would ensure better adherence to education, better monitoring, and better support of mothers, especially within the critical 7 days post delivery period. There is hope that PHC re-engineering will improve community support for exclusive breastfeeding.

**NGO Support**

Philani Zithulele Mentor Mothers works in OR Tambo district in Coffee Bay. Philani works closely with Zithulelele Hospital (a Mother Baby Friendly Institution) to provide postnatal education at the hospital, and to establish direct relationships with mothers or family members. Mentor mothers attend community meetings and give talks on health education concentrating on exclusive breastfeeding. Mentor Mothers use cell phones and SMSs to enable them to better reach the community.

### 4.1.2. Guidelines, Protocols, and Policies

The most common Standard Operating Procedures (SOPs) or guidelines used to implement this intervention within the EC-DOH are:

- Infant and Young Child Feeding Policy Guidelines (although this still needs to be prepared into protocols and guidelines);
- Tshwane Declaration;
- Practical guide for optimal infant and young child feeding;
- South African Code of Marketing Breast Feed Substitute (compulsory)
- International Code of Marketing Breast Feed Substitute (this is voluntary)
- MCWH Strategic Plan Document

The Philani Mentor Mothers use their own IEC materials which are structured in line with government guidelines.

One DOH clinic (out of 8) reported to not be in possession of any of these SOPs or guidelines. In addition, due to high volumes of work and time constraints, respondent noted that nurses do not read policy guidelines; therefore, it would be better to have them converted into protocols and SOPs to facilitate implementation.

### 4.1.3. Human, Material, and Financial Resources

Clinics, hospital staff, and CHWs are seen as champions of breastfeeding promotion because they prepare pregnant women during BANC, delivery, and post natal visits. However, implementation is impeded by insufficient numbers of these staff as well as nutritionists at district, sub-district, and facility levels. Frequent staff changes due to attrition or rotation were noted as a potential threat to continued and smooth service, and to accreditation of MBFIs who risk losing their status when staff change.

Awareness campaigns and trainings were reportedly conducted to sensitise District Managers, facility staff, and community-based NGOs on the new breastfeeding policy. Ongoing training is also done to ensure that health personnel are thoroughly equipped to handle questions on breastfeeding and quell any inherent cultural beliefs surrounding this intervention.

Materials for this intervention such as breast pumps for lactating women to express milk are reported to be insufficient, and IEC materials need to be translated in the local language. In addition, there is a need for audio visual equipment or solutions for demonstrating breastfeeding at CHCs and hospitals, and computers, especially for sub-district managers.

Finally, there is a shortage of transport for programme officials to conduct community outreach; dedicated vehicles are needed.

### 4.1.4. Monitoring and Evaluation (M&E) Systems

There are no indicators in the District Health Information System (DHIS) specific to breastfeeding, and therefore, no data is being collected on the extent to which the service is being provided. Most information about breastfeeding is gathered from special population based surveys, and little information is available on how the DOH implements the breastfeeding promotion interventions. However, Chris Hani district DOH is in the process of developing a tool for monitoring both breastfeeding promotion and breastfeeding practice.

### 4.1.5. Linkages and Referrals

The Philani Zithulele Mentor Mothers in OR Tambo district was the only NGO mentioned as assisting the EC-DOH with breastfeeding support. In the DSD's non-centre based ECD programme, CCGs conduct nutrition awareness and education at home level, and at these sessions, the importance of exclusive breastfeeding is emphasised. Otherwise, it appears that there are few referral end-points or linkages for the breastfeeding support programme.

### 4.1.6. Beneficiary Participation and Responsiveness

The focus group discussions held with beneficiaries at facility levels in both districts (OR Tambo and Chris Hani) uncovered some information pertaining to beneficiary perceptions on exclusive breastfeeding. The respondents were a mixture of young mothers, women with more than two children, and grandmothers.

## Respondents' views on Barriers / Challenges to Breastfeeding Practice

**Lack of attendance at ANC and PMTCT**

- Late booking of mothers for Basic Antenatal Care (BANC).
- Mothers do not access services at the clinic after their children have been immunized at 6 months.
- Many mothers do not have means for transportation and that their villages are too far from the clinic.

**Non-adherence to, or poor understanding of, health education provided by the health facility**

- Mothers do not follow PMTCT guidelines, they mix feed which increases the risk of HIV infection.
- HIV positive mothers are hesitant to breastfeed because they are unsure if their child will be infected with HIV, so by and large they choose not to breast feed.
- Women mix feed because they say their children "don't get satisfied".

**Stigma surrounding HIV and AIDS**

- Women who breastfeed exclusively are suspected to be HIV positive by those who mix feed because it is "known" that HIV positive women should not mix feed. This makes HIV positive women reluctant to exclusively breast-feed.
- People don't like support groups because they associate them with HIV and AIDS (HIV stigma).

**Lack of support groups**

- There are inadequate breastfeeding support groups for mothers.
- Teenage mothers often lack access to support groups, and may not know how to deal with engorged breasts or mastitis.

**Lack of nutritional support for lactating mothers**

- Widespread unemployment and poverty may mean that mothers themselves are malnourished

**Lack of transport, geographical location, and migrant labour**

- Shortage of transport for CHWs to get to distant villages impedes service delivery.
- Given high migrant labour in many areas of the province, many mothers leave their children with grandparents; these children have no choice but to be formula fed.
- Mothers are not allowed adequate maternity leave for them to continue to breastfeeding exclusively.

**Peer pressure amongst young mothers**

- Young women might be concerned about breastfeeding changing their looks (i.e. breasts); 16 year olds struggle with breastfeeding for this reason.
- Teenage mothers are not interested in breastfeeding.

**Cultural factors**

- If the baby was delivered at home, mothers do not come to the clinic or hospital until 6 days later, due to beliefs around the prescribed period before a mother takes the baby out of the house ('efukufukwini').
- Strong use of traditional medicines among newborns and young children especially in rural communities in direct contradiction to health education.
- A myth that a snake will suckle from a lactating breast generates fear of breastfeeding amongst mothers.

**Social influence and incorrect feeding practices**

- Family members and other influence mothers as to what to feed their children, often countering what is taught in clinics. Sometimes mothers are discouraged from exclusively breastfeeding their children.
- Expressing breast milk and keeping in the fridge is considered taboo or might be talked about negatively amongst the elderly.
- Makotis (daughters-in-law) say that mothers-in-law insist that the baby be given sweet water (sugar and water) so that the baby can pass a black stool.
- Mothers from Kerstel in Chris Hani District give their children sour liquid porridge called 'inqathi' which can lead to their babies being malnourished if not fed at the right time or prepared in a nutritious way.
- Alcohol abuse, as it leads to neglect of children and poor breastfeeding habits by mothers.

Most beneficiary respondents felt that the information given by nurses on exclusive breastfeeding was useful as they found that their children were not sick often and had fewer episodes of diarrhoea. Respondents confirmed that breastfeeding information was given during ANC, post natal at the hospital; and during PMTCT. Many said that the message to exclusively breast feed for six months and not mix feed was clear and that they were also told not to give babies traditional medicine (izicakathi).

Various reasons were given for not following the advice about exclusive breastfeeding:

- One mother stopped breastfeeding because her baby stays with the grandmother and she therefore could not continue with the practice.
- Another said she stopped when she developed breast sores.
- One mother stopped exclusive breastfeeding after 4 months as the baby was not getting full and she then started to feed him porridge and Nestum.
- One mother said she struggled to produce enough breast milk and found that her baby was getting hungry.
- One mother said the child did not like breast milk so she opted for formula milk (Lactogen).

In the area of HIV and exclusive breastfeeding generally respondents were confident of messages and it can be summed up by the following comment from a respondent: *"If you're HIV positive you can exclusively breastfeed for six months and not mix feed, thereafter get formula milk (Melegi) to feed your baby."*

## 4.2. Targeted Supplementary Feeding (TSF)

The Targeted Supplementary Feeding programme aims to manage moderate malnutrition and to prevent severe malnutrition among children and adults alike. The programme is expected to be available all the time at health facilities.

There is a strong view that this intervention can be strengthened by being extended to community level.

### 4.2.1. Delivery Channels

The TSF intervention is offered at PHCs, CHCs, hospitals, and through mobile clinics in more remote areas. Only one clinic in the OR Tambo district mentioned the use of support groups to channel the delivery of this intervention.

Most respondents believe TSF is effectively implemented and is adequate to address nutritional needs of children under 5 years and pregnant women. However, the intervention also targets patients on ART and TB medication, who are the main beneficiaries of this intervention.

Moderately malnourished pregnant women are identified during the BANC nutrition assessment. Those who are underweight or malnourished receive one-on-one counselling and the supplementation product (Soya Life Plus) according to guidelines.

Malnourished children are identified through growth monitoring and promotion at the clinic. In cases of moderate malnutrition or slow/no weight gain, health facilities provide the TSF product (soya porridge) and milk (Melegi) for children under 2 years. Juice (Deo Volante) is given children over 2 years of age. Cases of severe malnutrition in children are hospitalised and given supplementation products upon discharge from hospitals.

Community outreach helps identify malnutrition cases. Respondents spoke of CHW who identify undernourished or underweight children in the community through home-to-home visits and refer them to the clinic. The CHW then follows up to monitor progress after the clinic has intervened. As part of outreach activities, the CHW also gives community talks on nutrition, and at times advises mothers what to cook for the children.

Nkanunu Clinic in the OR Tambo district reported identifying nutrition problems in both adults and children using a BMI calculator (a wheel) provided by the South African Food Based Dietary Guidelines. On the back of the 'wheel' are drawings of various foods. The EC-DOH, through the INP, provided the guidelines for the back of the BMI calculator.

One clinic in Chris Hani mentioned actively promoting TSF at community level through campaigns and outreach programmes (e.g. messages on nutrition abuse were included in the 16 Days of Activism Against Women and Children Abuse campaign; World Breastfeeding Week). Local radio stations were also mentioned in relation to broadcasting talks on nutrition, but because these are infrequent, there is little scope for focusing and customising messages for beneficiaries.

Several challenges were cited that can impede service delivery efforts:

**Material Resources**

- Lack of computers for sub-district managers is a challenge to implementation.
- Transport for community outreach teams limits their ability to identify and monitor cases.

**Stigma**

- *"A stigma has developed around this porridge because it is given to HIV and TB patients as well; people call it AIDS pap."*
- *"Not having a back exit for people who receive the service exposes them to gossip and stigma."*

**Stock Availability**

- Stock is sometimes unavailable to due to delays in tender processes or failure to order food supplementation materials on time by nurses
- *"Children's meal supplementation has been out of stock for six months."*

**Social Factors and Beneficiary Uptake**

- *"Parents who abuse alcohol normally don't bring their children to the clinic"*
- *"CHWs are trained to identify moderate malnutrition when they visit homes but the cases they refer to the clinic may not get attention because the parents don't bring the children and when the CHWs follow-up they don't find the children."*
- Migrant labour activity was mentioned as a barrier as parents and/or caregivers do not bring the children to the clinic.
- *"Mothers stop bringing their children to the clinic for growth monitoring and promotion after 9 months as a result moderate malnutrition may not be detected early enough for intervention, before it becomes severe."*

**NGO Support**

Philani Zithulele Mentor Mothers, an NGO that works in OR Tambo district in Coffee Bay, was the

only NGO mentioned to support this intervention. Mentor Mothers build strong relationships in their communities and are able to visit homes and assess the health and welfare of children. They weigh children to monitor their growth and give nutrition counselling to the mothers using Q cards with simple pictures and in the local language. Mentor Mothers bring services to people who don't easily access the clinic because of distance and high unemployment. They help pick up cases of moderate malnutrition and aid in their management.

Mentor Mothers also works with the local clinic and hospitals, DSD and SASSA who provide food parcels.

### 4.2.2. Guidelines, Protocols, and Policies

The following guidelines were mentioned for the TSF intervention.

- The Nutrition Supplementation Programme Guidelines
- Maternal Nutrition
- Food Supplementation Guideline

Most health care practitioners at district and facility level were unable to make specific reference to a policy, guideline, or protocol used for this intervention, and in some instances they indicated that they were not in possession of any SOP or guideline. On the other hand, one respondent said that communication on this intervention was adequate and that *"most of the time nurses don't know where the guidelines are, and they need to read the guidelines."*

As with the intervention on breastfeeding support, it was said that policy guidelines need to be converted to protocols and SOPs for ease of implementation.

### 4.2.3. Human, Material, and Financial Resources

Most facilities visited indicated having adequate TSF products to give to beneficiaries; however, there were cases of product stock-outs mentioned. Half the facilities interviewed had recent stock-outs of TSF products – 2 clinics in rural Chris Hani district and 2 other clinics in OR Tambo. One clinic in Chris Hani district experienced a 6-month stock-out of children's supplementary meal. At district level, stockouts were explained as due to delays in tender processes and the failure of facilities to place timely orders.

Health personnel in Integrated Management of Childhood Illnesses (IMCI) and Antenatal Care (ANC) as well as Dieticians are trained to implement the TSF intervention. However, numerous respondents indicated that more staff are needed for greater effectiveness. Most common staff needs were a director or manager for nutrition programmes at district level, to more dieticians.

One clinic in OR Tambo said they feel that the technical leadership is adequate as the sub-district nutrition structure includes an INP Manager, Community Liaison Officer and Auxiliary Services Officer.

Most respondents believe the budget for the programme is sufficient as they were able to procure food supplements in the quantities required. The financial constraint was mentioned with regards to employment of health personnel.

### 4.2.4. M&E Systems

The nurse who decides to provide TSF should make notes in the child's Road to Health card. In addition, a register is maintained at facility level, and from this monthly reports are made to the

districts using the DHIS. However, M&E is not consistent and provincial DOH respondents highlighted poor recording of malnutrition data at PHCs/CHCs as a challenge for effective monitoring of implementation:

- *"The challenge is that the malnutrition register is not recorded all the time to give us information on the effectiveness of the intervention."*
- *"Nurses just don't record on the register all the time, but food supplementation is provided. Because they don't record all the time, we can't see exactly whether the children that have been on the supplementation programme have been discharged or they stay on the programme for a long time."*

Respondents indicated that one solution is to place Nutrition Advisors at health facilities.

Programmatic reviews are said to occur through supervision visits by districts, and through management reviews at sub-district level. Provincial quarterly review meetings also serve intervention performance.

#### 4.2.5. Linkages and Referrals

No respondents mentioned any linkages or referral between the TSF intervention at the DOH and DRDAR, and only 1 clinic (of 9) mentioned having a referral relationship with DSD for this intervention. One constraint is poor transportation systems for DSD social workers to follow-up on moderate malnutrition cases identified by DOH. No NGO partnership was mentioned for this intervention.

#### 4.2.6. Beneficiary Participation and Responsiveness

Most beneficiaries at health clinics were unfamiliar with the TSF products (Soya Life Plus Porridge and Deo Volante juice) when they were shown during the focus group discussion. The few that could identify the products or state their use said they were given the products in Johannesburg or Port Elizabeth. They also seemed to have been given one instructions in how to prepare the products (i.e. "add boiling water to the porridge and give it to the baby").

In as far as service uptake for this intervention is concerned, most beneficiaries said that they would take their children to the local clinic or a CHW if they discovered no weight gain. However, one respondent observed that communities don't recognise the signs of poor growth, and that there is need for more intensive awareness and education on malnutrition: *"People do not see moderate malnutrition; i.e. if a child loses weight it could be said that they're just growing up. This requires clinics to go out to the community and educate them."*

### 4.3. Food Access

#### 4.3.1. Delivery Channels

Food Access interventions are implemented by the DSD, SASSA, ECD, and Home and Community Based Care (HCBC) sites. Targeted beneficiaries for Food Access interventions are children below the age of 5 years, pregnant women, women, child headed households, and people living with HIV and AIDS and TB. DSD food access intervention consists of three (3) key activities:

1. Support to ECD programmes for food to children. DSD signs 1-year Service Level Agreements with individual ECD centres. R15 per child attendant per day is provided and payable at the beginning of each month based on the previous month's expenditure and quotations submitted. The main conditions for funding are that R6 per child per day (40% of the grant) shall be spent

on nutrition, with the rest for administration and stimulation. DSD provides various guidelines, including nutrition and menu guideline, to ECD centres, as well as subsidies and funding for vegetable gardens (using NDA funding of R5000 per centre per annum for vegetable gardens).

DSD has identified several needs for the ECD support programme: (i) ensuring that children receive adequate nutrition at funded and non-centre based ECD centres (ii) providing Early Childhood Development to children in deep rural areas (iii) and nutrition training for ECD practitioners.

2. Food parcels are given for 3 months by SASSA to people in distress. Identification of people eligible for food parcels is done by DSD social workers, CCGs, ward committees, and NGOs/CBOs. The value of food parcels are equivalent to R1260 for adults and R290 for children. Respondents at Nkanunu Clinic reported that DSD identified OR Tambo district as an area where there is increasing malnutrition. SASSA uses private service providers to deliver food to beneficiaries as per specifications. HCBC programmes also provide food parcels to people who are infected and affected by HIV and AIDS.
3. Soup kitchens for HIV programmes are run at district level mainly by CBOs/NGOs. Few government respondents (managers or service providers) mentioned this intervention, and the managers for Food Access and Sustainable Livelihoods couldn't comment on this intervention.
4. SASSA's Ministerial Malnutrition Programme commissions doctors to assess the nutritional status of children. When found to be malnourished, the children given food parcels and supplements. The children are examined again after 6 months to see whether their health has improved. Through this intervention, 1500 children were identified last year and they all received food parcels and supplements.

### 4.3.2. Human, Material, and Financial Resources

Human resources to carry out these interventions are reportedly inadequate for rural areas of the province. In OR Tambo district, a minimum of 10 Community Development Practitioners are required per local municipality, but DSD operates with only 3 for the entire district. In comparison, Chris Hani district DSD indicates adequate human resources.

Financial resources are reportedly adequate, except for the ECD programme budget which was noted as far less than required to reach all young children (see page 30). However, material resources (such as vehicles and laptops for fieldworkers) and infrastructure inadequacies hamper implementation of the interventions. For example, in Lusikisiki there are no offices to hire and the poor supply of electricity hampers services delivery in the area.

### 4.3.3. M&E Systems

Although home based care workers and Social Workers collect various data on DSD nutrition services, little data is reported at provincial or national level on the reach or nutritional effects of the food parcels, soup kitchens, or ECD interventions[19]. Only 2 indicators (of 40+) concern the performance of these interventions:

[19] Department of the Treasury. *Provincial In year Publication (PIP) 2012/13- 4th Quarter. Eastern Cape. Sector: Social Development.* http://www.treasury.gov.za/publications/PiP/2012_13/Q4/Provincial%201st%20Q,%202nd%20Q,%203rd%20Q%20(validated)%20and%204th%20Q%20(preliminary)%20Perf%20Report%20-%20Soc%20Dev.pdf

- "Number of individuals who benefited from social relief of distress programme", and
- "Number of children 0-5 years old accessing registered ECD programmes"

Social Workers monitor ECDs on a monthly basis using an ECD monitoring tool that looks at spending on nutrition, environmental issues, and how food is cooked at the ECD centres. SASSA reported that it has no internal management review process for the Social Relief of Distress programme but does collect data on the intervention. Through its Management Information System, SASSA receives relevant information for reporting to national SASSA.

DSD does not appear to have a formal programme review process that focuses on nutrition issues or outcomes in its food access interventions.

#### 4.3.4. Linkages and Referrals

The researcher did not detect clear or consistent linkages between DSD Food Access interventions and other government food/nutrition interventions. Theoretically, when the DOH identifies cases of malnutrition, they should also be enrolled in the DSD / SASSA Social Relief of Distress programme and given food parcels; but among the clinics visited for this evaluation, only Nkanunu Clinic in OR Tambo district reported working closely with Social Workers when referring malnutrition cases for social assistance.

This was confirmed by DSD who noted that generally weak linkages between its department and other government departments around nutrition; i.e. lack of follow-up or feedback between hospitals and social workers (DSD), and lack of coordination and integration between DSD, DOH, and DRDAR at district level. Local government should be linked through the IDP Forum, however this structure is reportedly not functional.

ECD appears to have better integration of its work with other government departments. ECD centres have mechanisms to refer children from ECD centres to SASSA and the DOH. ECD centres also benefit from SASSA support (food parcels to poor families in distress identified at ECD centres), DRDAR support (assistance with vegetable gardens and other food security interventions, and DOH support (vitamin A, weighing and education, and oral hygiene). A dedicated nurse visits ECD centres monthly in OR Tambo district.

#### 4.3.5. Beneficiary Participation and Responsiveness

To raise awareness around this intervention, DSD uses a variety of communication channels: community meetings, Imbizo and Awareness Campaigns, CCGs who go door to door, Radio Advertisement, and Masupa Tsila Youth Volunteers who work in ward structures to raise awareness about its food access initiatives and to reach eligible beneficiaries. However, DSD stressed the difficulty in reaching people who living in remote rural areas because of the province's vast terrain and inaccessible roads. DSD also noted the clients' difficulties in accessing transportation when they seek services. SASSA however, reported no barriers in getting beneficiaries enrolled for social grants.

Food in ECD centres, social grants, and food parcels appeared to be widely known by most beneficiaries and respondents interviewed during this evaluation.

### 4.4. Household Food Production and Preservation (Home Gardening)

During fieldwork, the researcher saw many gardens in rural areas at clinics, and in communities. Approximately half the clinics visited had gardens. Most homesteads in rural areas (e.g. in OR

Tambo district) had gardens or small plots, but most of these seem to be growing maize rather than vegetables. But participants in the Umzimvubu Home Gardening Project were growing a variety of foods, including fruit, leafy green vegetable (spinach and cabbage), yellow vegetables (pumpkin varieties), root vegetable (sweet potato, anecdotally the Orange Flesh Sweet Potato, carrots, onions, potatoes), tomatoes, green peppers, and even herbs. The researcher found little observable evidence of food gardens in urban or peri-urban areas visited.

### 4.4.1. Delivery Channels

Under the Food Security intervention, DRDAR implements Siyazondla (Home Food Gardening/Community Food Gardens) and Siyakhula (crop growers up to 9ha), while DSD implements its Sustainable Livelihoods programme, both targeting food insecure homes and communities to enhance their food security and to increase their access to market for selling excess produce.

- Siyazondla Homestead Food Production targets poor, vulnerable and food insecure households who have access to a small piece of land (homesteads, school or church) to garden. DRDAR stopped implementing this programme in 2009/2010, but recently (during the 2012 Food Security Programme review) decided to re-introduce the programme in the 2013/14 financial year. Siyazondla reportedly addresses nutritional problems because it revives families' participation in agriculture for both feeding themselves and for income generation (by selling excess produce). The primary target group for Siyazondla are beneficiaries of Food Access interventions (food parcels and soup kitchens), unemployed breadwinners, HIV infected and affected families, households earning less than the accepted minimum social grant level, child-headed households (age 15 years and upwards) and physically challenged people. The secondary target group are micro community projects aimed at youth development.
- Other DRDAR food security initiatives include promoting food preservation methods (using indigenous methods). DRDAR with Fort Hare University established two Agri-parks for commercial food processing and preservation, but the linkage with Siyazondla failed because supply from the home food production programme was inadequate.
- DSD also trains communities on basic food preservation techniques.
- DSD Sustainable Livelihoods uses its Community Development Officers and ward-based Masupa Tsila Youth brigade[20] to organise communities into cooperatives, assess community needs, and establish the household or communal vegetable gardens and other income generation projects. DSD Community Development Officers conduct awareness campaigns, profile the communities to establish the needs and assist the community with their project plan for food security. DSD provides communities with fencing, gardening implements, tractors, water tanks and other necessary infrastructure as well as assists beneficiaries get their produce to market. DSD initially funded communal food garden projects; however, the strategy changed to focusing on smaller homestead food gardens because it discovered that the money was going into buying equipment such as tractors rather than inputs for growing food.
- DSD/ECD (with support from DRDAR) drives and supports the establishment of food gardens at ECD centres. ECD centres are mentored and supported to maintain vegetable gardens.

[20] Youth Volunteers who work in the community as the first point of service, communicating and assisting communities access DSD's programmes, hired by DSD and paid a stipend.

DSD/ECD's 2-year partnership with Nestle, and its partnership with World Vision, help with some costs for implements (wheelbarrows, spades and forks). DSD/ECD also engages NGOs and the Health and Welfare SETA to assist non-centre-based ECD centres with seedlings and garden implements for their food gardens.

- EC-DOH promotes clinic and hospital vegetable gardens to support the HIV, TB and MCWH programmes. Information on home vegetable gardens are included in DOH nutrition counselling for pregnant women and mothers of children under 5. EC-DOH has pledged R2 million for the 2013/14 financial year as part of the EC Provincial Integrated Food Security and Nutrition Plan to be spent on food gardens at clinics and hospitals, educational demonstrations on how to cook vegetables, growth monitoring and promotion and provision of vitamin A, and training for Child Minders at ECD centres.

Common challenges that reportedly impede the delivery of home garden services include:

- Government procurement processes hamper implementation because appointed suppliers reportedly fail to meet contractual obligations.
- The timing of annual budget allocation negatively affects the implementation of gardening programmes because it does not coincide with the planting season.
- Political interference in appointing service providers threatens the implementation of food security programmes; it creates tension between programme staff and political interests.
- On-going changes in the food security programme affects the uptake by the public, who are slow to learn the new programme.
- Abuse by community members who enrich themselves from community projects.
- Under-expenditure.

Philane also indicated a need for both DSD and DRDAR to more actively promote community gardens.

### 4.4.2. Guidelines, Protocols, and Policies

EC-DRDAR is reviewing its Provincial Food Security Policy which is expected to be completed before 2014. As such, the current guidelines may not be relevant under the new policy.

DSD respondents confirmed that there are systems, guidelines, norms, standards and procedures to implement the Sustainable Livelihoods programme, but no details of these were provided to the researcher, and there is no evidence that these target children under 5 or pregnant women who have food security or nutrition problems.

### 4.4.3. Human, Material, and Financial Resources

DRDAR's limited and decreasing budget for the Food Security programme (from R220 million to R49 million in the last 5 years), limits its ability to implement broad based home gardening in the project. One respondent said, *"With the budget we get we cannot even serve half the district. We cannot support as many people who qualify for the programmes as we would like"*. Perhaps related to the diminishing financial resources, DRDAR Food Security programme has frequent shortages of material resources such as tractors, storage facilities, and infrastructure such as irrigation schemes. Staffing of the Food Security programme is mainly by extension officers, agricultural scientists, engineers, and administrators who work at field level, but as mentioned earlier in this report, provincial level needs a well-trained management team. In terms of skills, field level extension officers reportedly

need numerical, facilitation and intermediate computer skills to effectively implement Food Security interventions.

In comparison, DSD's Sustainable Livelihoods respondents at district level mentioned a shortage of Community Development Officers to effectively monitor this intervention. Related to this is a shortage of vehicles for field work. Social workers also need training on implementing economic projects, because this initiative aims to transform community gardening projects into sustainable livelihoods projects.

DSD Sustainable Livelihoods has also experienced a diminishing budget over the last five years (from R113 million to R13 million). One respondent said, *"The budget is not equal to the scope of work that needs to be achieved"*, and "*Financial resources are sufficient in some respect and in others not; we are able to kick start people but not sustain their communal food production projects"*. Some suggested that the budget for Food Security be ring-fenced and made into a conditional grant so that it will not be touched.

Various respondents raised concerns that youth were not keen to start home vegetable gardens because of social grants provided a means for purchasing food. However, DSD indicated that there was a strategy to link beneficiaries of social grants to sustainable livelihoods so that communities can begin the process of exiting from the social grants.

### 4.4.4. M&E Systems

Each month, the EC-DOH reports on the number of vegetable gardens started at hospitals and clinics; however there was no evidence the DOH monitors the impact of the intervention or counts the number of beneficiaries of this intervention.

EC-DRDAR does not have adequate M&E systems and processes to monitor the home food production intervention. The most relevant DRDAR indicators reported – (i) number of beneficiaries trained, (ii) number of verified food insecure households, (iii) the beneficiary group size of women, youth and disabled people, and (iv) number of homes supported – have no reference to household food production or the nutrition effects of interventions. However, there is a monitoring tool for Food Security site visits to households, but that tool contains only basic demographic and agricultural/food security information is collected, and there are no fields to indicate if children under 5 live in the home. District DRDAR officials submit monthly and quarterly reports to provincial DRDAR. Quarterly DRDAR reviews for the Food Security programme include presentations from districts on the programmes.

DSD has not yet established a management review process for its Sustainable Livelihoods programme. Assistant Community Development officers monitor activities in the field, and prepare monthly district reports. Districts submit quarterly reports to province. There has been no evaluation of the Sustainability Livelihoods Interventions.

### 4.4.5. Linkages and Referrals

DRDAR assists the DOH in establishing vegetable gardens at clinics and hospitals. DSD and local government are meant to refer communities and households with food security and food access problems to the DRDAR Food Security programme for assistance with household and communal food production. In addition, DRDAR provides training to beneficiaries of DSD Sustainable Livelihoods programmes, and under the Antipoverty Strategy coordinated by DSD, ECD centres will be establishing vegetable gardens programme with support from the DRDAR.

However, as indicated in section 4.3.4 above, DSD noted generally weak linkages between its department and other government departments around nutrition; i.e. lack of coordination and integration between DSD, DOH, and DRDAR at district level.

Other linkages include financial contributions from municipalities through IDPs to the Food Security programme projects in their areas to co-finance irrigation schemes or buying tractors for communities.

### 4.4.6. Beneficiary Participation and Responsiveness

DRDAR respondents reported that buy-in to the Siyazondla programme by communities was high until it stopped, and that it still gets enquiries about Siyazondla from communities.

In the Mzimvubu Agricultural Home Gardens Project in OR Tambo district, beneficiaries reported assistance in their home gardening projects by DRDAR with tractors and training; one beneficiary received R30,000 from a regional competition organized by DRDAR to promote home vegetable gardens in the province.

However, in the focus group discussions held at CHC and PHC facilities, there was no evidence that respondents were aware of DRDAR's home food production programmes. Most who established home vegetable gardens indicated that they were encouraged by DOH staff, Community Health Workers, and Mentor Mothers.

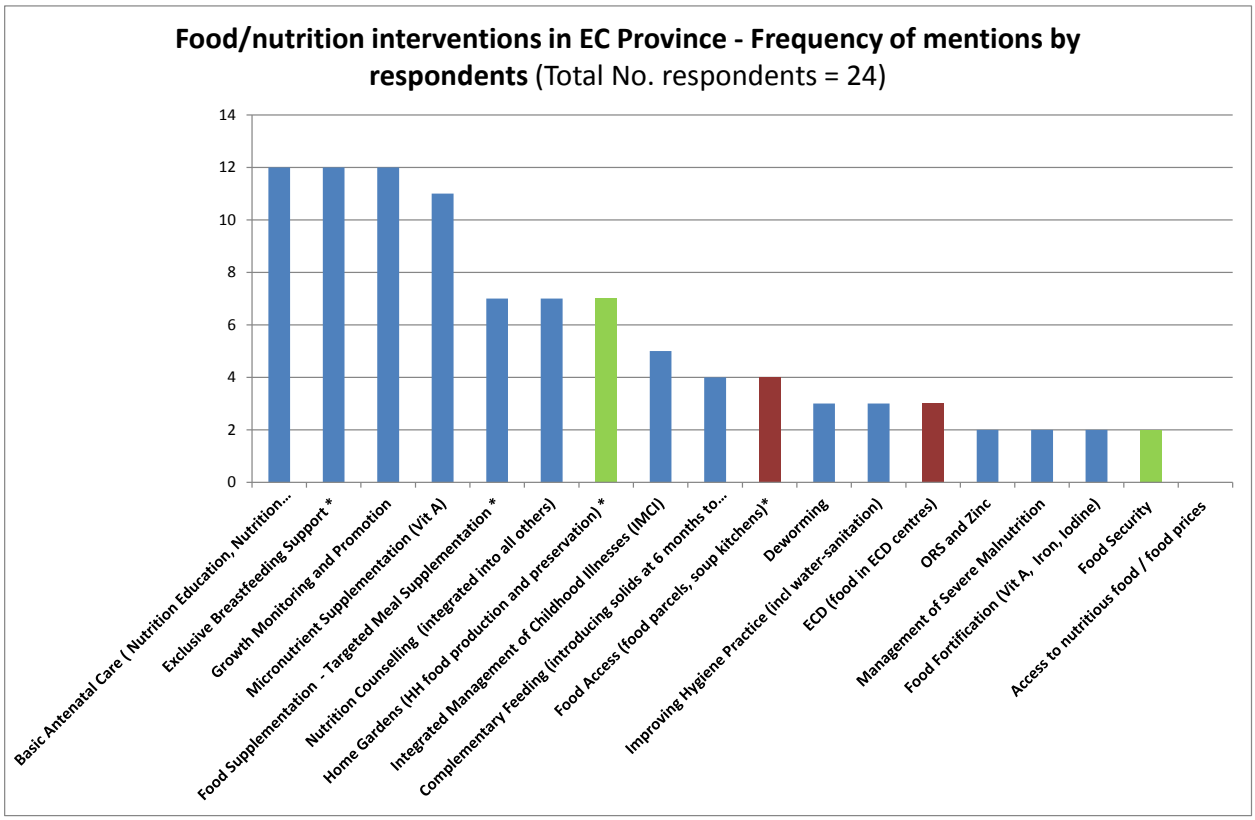
There isn't any evidence that DSD or DRDAR garden intervention are targeted to households with pregnant women or children under 5; rather the criteria for targeting is largely based on poverty, food insecurity, HIV, or child-headed households.

# 5. FINDINGS: OTHER FOOD/NUTRITION INTERVENTIONS

Without being prompted, respondents were asked to list main nutrition interventions that were being implemented in the province. Figure 17 presents the frequency with which nutrition interventions were mentioned. Blue in the figure represents health interventions, green represents agricultural interventions, and red represents DSD interventions. Health related nutrition interventions were more often mentioned, but this is partly because of the large number of respondents from the health sector. Encouragingly, home gardens were also mentioned frequently. Complementary feeding, an important intervention in the first 1000 days of life, was not frequently mentioned by respondents.

Table 12 (starting on page 48) presents some of the strengths and weaknesses found with the other food and nutrition interventions that are part of the INP.

**Figure 17: Principal Nutrition Interventions in EC -- Frequency of Mentions**




## 6. FINDINGS: THE FOOD INDUSTRY IN THE PROVINCE

At provincial DOH level, respondents indicated a relationship with the food industry on products and services other than formula milk. *"We're working with companies that manufacture formula milk because they manufacture other products. We provide formula milk for those children that need it through the tender system"*, the respondent said. DOH also indicated that formula-producing companies organise Continued Professional Development (CDP) activities for dieticians and nutritionists, *"Companies approach us to say what type of CDP activities we need. When we work with formula companies we observe the code (International Code of Marketing of Breast Milk Substitutes)*.

There was no evidence of any food company sponsorship at district level. However, evidence of food company materials was found at one clinic – Middleburg Clinic had a Nestle-branded plastic bed mat, but this was said to be 10 years old.

DSD ECD's 2 year partnership with Nestle ended in 2012 as per instruction from DOH.

No beneficiary reported having received formula milk from their nearby clinic or from elsewhere in the previous three months at the time of the evaluation.

## 7. RESULTS

Table 13 below summarises the principle strengths and weaknesses of the implementation of nutrition programmes in the Eastern Cape.

## Table 12: Health Professional's Views' on Implementation of Other Nutrition Interventions

| Nutrition Intervention | Reported Main Delivery Channel | Reported Guidance / Protocols | Respondent's General Perceptions on effectiveness of the service in addressing Nutrition |
|---|---|---|---|
| **Basic Antenatal Care** | PHC Clinics<br>Mentor Mothers<br>Outreach teams and CHWs | BANC Guidelines<br>Various IEC materials for pregnant women<br>Dietary and Food Based Guidelines | ADEQUATE because pregnant women are educated on a daily basis at facilities. BANC guidelines have a checklist of what needs to be done during pregnancy including using MUAC tapes to check for malnutrition and which micro-nutrient supplements are to be given, nutrition counselling, testing of HIV, TB and monitoring baby's growth.<br>DOH noted that there was still a big challenge with late booking for BANC by pregnant women. Outgoing teams and community work by Community Health Workers will improve early booking for BANK.<br>Researcher note: Most pregnant women and mothers of children under 5 did not know what micro-supplements were given. Health workers, and in some cases professional nurses, showed low knowledge levels of micro-nutrient supplementation. Refresher training is required to improve the knowledge levels of health workers |
| **Complementary Feeding** | PHC Clinics<br>Mentor Mothers<br>Outreach teams and CHWs | Infant and Young Child Feeding Policy Guidelines<br>Mother, Child Health and Nutrition Handbook | This is promoted at facilities and by Community Health Workers who conduct home visits. However, solid foods are introduced incorrectly by mothers for various reasons including poverty, cultural practices and pressure by older women in the family. DOH noted that developing the community component as a delivery channel for both breastfeeding support and complementary feeding would improve the effectiveness of both interventions. |
| **IMCI** | IMCI nurses and doctors at PHC, CHC and Hospitals | IMCI guidelines | ADEQUATE to address health needs of children under 5. DOH training is training of health professionals and community members (chiefs) on IMCI. There is a schedule of training qualifying nurses.<br>District level cited loss of IMCI trained staff and training staff in clinics where there's sever staff shortages as a challenge for effectively implementing IMCI at facility level.<br>IMCI training, guidelines and protocols were noted as enablers in effectively implementing the intervention at facility level. |
| **Oral Rehydration Salts (ORS) /Zinc** | IMCI Nurses<br>ORS corners at PHC<br>Community Health Workers<br>Mentor Mothers | IMCI guidelines | ADEQUATE to address the health needs of children under 5. Facilities have ORS corners with posters containing instructions on how to prepare the home solution at home. Mothers and community members are educated on how to prepare the home solution at the clinic and by CHWs during home visits. |

| Nutrition Intervention | Reported Main Delivery Channel | Reported Guidance / Protocols | Respondent's General Perceptions on effectiveness of the service in addressing Nutrition |
|---|---|---|---|
| | | | Researcher notes: Zinc tablets were not found at most facilities. Only one facility had stock of Zinc syrup |
| **Micronutrients Supplements Including Vitamin A** | PHC/CHC Clinics<br>Vitamin A campaigns<br>Community Health Workers<br>ECD Centres<br>Post-natal wards in Hospitals<br>BANC | Vitamin A protocol<br>Road to Health Booklet | ADEQUATE to address the needs of pregnant women and children under 5. Vitamin A coverage for ages 6-11 months through the CHC/PHC delivery channels was reported as high and effective by most respondents. For children of ages 12-59 months, the coverage and the channels used were reported as low and ineffective. DOH is targeting households (particularly in the rural areas), ECD centres and pre-schools to close the gap (coverage is not at 80%, it is still under 50%).<br>DOH approved CHWs to administer vitamin A and has plans to improve growth promotion and promotion at health facilities and in communities which should increase vitamin A coverage. It is hoped that the implementation of PHC re-engineering with teams going out to the community will benefit vitamin A coverage. CHWs are being trained on vitamin A supplementation, as part of PHC re-engineering, since NDOH gave approval for CHWs to administer vitamin A to children. DOH hires Community Service Nurses for a contract term of 6 months to do vitamin A catch-up but not in all districts. Poor recording of vitamin A supplementation at facility level in the DHIS registers was cited as a challenge towards tracking the effectiveness of vitamin A programmes.<br>During 2011 and 2012 DOH conducted a province wide Vitamin A Catch-up Campaign to improve coverage. DOH budgeted R1.5m for the campaign which was used for logistics, materials and to pay staff. It is reported that all ECD centres were targeted and as a result the campaign improved vitamin A coverage in the province from 30% to 40%, and now at 43%. DOH provincial respondent reported that, although UNICEF had promised to provide IEC materials and to support with logistics (vehicles) for the campaign UNICEF did not follow through with the promise.<br>Chris Hani District requires hospital nurses to do the services that are done at the clinic so that no opportunity is missed to address health and nutritional needs of pregnant women children under 5. Vitamin A supplementation and other MCWH services are administered at OPDs and stats from hospitals are collected and reported by the sub-districts.<br>At facility level Community Health Workers outreach into communities to monitor vitamin A supplementation of children and the availability of vitamin A at facilities was seen is the main enablers of the intervention. |

| Nutrition Intervention | Reported Main Delivery Channel | Reported Guidance / Protocols | Respondent's General Perceptions on effectiveness of the service in addressing Nutrition |
|---|---|---|---|
| | | | Researcher note: some nurses raised reservations about the approval for Community Health Workers to administer vitamin A since CHWs were not trained health professionals as well as the data capturing challenges that might result from such an operational plan change.<br>Respondents at the Philani Clinic mentioned that Africare, Buhle Bezwe and Ukhahlamba NGOs were involved in community outreach programme to schools for vitamin A, immunization and deworming |
| **Growth Monitoring And Promotion** | PHC/CHC clinics<br>Weighing sites/Community Health Posts<br>Hospital OPD (Chris Hani District)<br>ECD Centres<br>Well-baby clinics<br>Mentor Mothers<br>Community Health Workers | Growth monitoring guidelines in a form of a poster<br>Road to Health Booklet | INADEQUATE to address the health and nutritional needs of children under 5. DOH monitors the weighing coverage on an annual basis. DOH has established health post and community growth monitoring sites to reach communities in rural areas. However this strategy does not cover all areas with poor access to health facilities yet.<br>Philane noted a need for clinics to improve their growth monitoring and promotion service, as some clinics have equipment that is outdated, for example, weighing scales are old and some of the scales are in pounds instead of kilograms. Furthermore, there is a need for: more nutrition education and awareness at community level and school health promotion; sub-district staff skilled in nutrition; mobile clinics; adequate stocks of medicines at the local clinics, and proper recording and control of nutrition programmes.<br>To strengthen the growth monitoring DOH plans to have ECD centres do growth monitoring. The plan is to be implemented from 2013/14 financial year and has been discussed with DSD ECD.<br>Mothers of babies below the age of 2 are encouraged to bring babies to the clinic on a monthly basis. The intervention is strengthened by the community outreach work of the CHWs.<br>Researcher note: At some facilities growth monitoring and promotion equipment such as weighing scales is outdated or not functioning. DOH needs to ensure that all facilities have equipment, ensure that the equipment is in functioning order, train nurses on plotting weight against height on the new road to health booklets.<br>It was mentioned that the child's length/height is not always measured at clinic level, and this leads to under-reporting for stunting. |

| Nutrition Intervention | Reported Main Delivery Channel | Reported Guidance / Protocols | Respondent's General Perceptions on effectiveness of the service in addressing Nutrition |
|---|---|---|---|
| **Management of Severe Malnutrition** | PHC/CHC clinics<br>IMCI nurses<br>District and Regional Hospitals<br>Community Health Workers and Mentor Mothers<br>SASSA's EC Region doctors as part of their Ministerial Malnutrition Programme | WHO 10 Steps to management of severe/acute malnutrition | DOH has trained doctors and dieticians in hospitals on the management of severe malnutrition. Therapeutic nutrition is offered by dieticians at hospital. Community is educated on severe malnutrition through community outreach programmes and the Community Health Workers. Regular regional meetings in Child Problem Identification Programmes (ChiPIP) are held wherein cases of severe malnutrition are presented and reviewed. Chris Hani District cited recruiting and retaining doctors for the rural health facilities as a challenge.<br>Lack of, or poor, downward referral practice by hospitals to facilities for follow-ups on cases of severe malnutrition, weak on non-existent referral mechanisms to food access/security programmes of DSD and DRDAR, as well as late presentation of children for treatment due to poor access to health facilities by rural communities was cited as the main challenges by DOH respondents. "Children are readmitted to hospitals for malnutrition because after they are discharged they are not assisted with food. Supplementation alone does not address malnutrition", commented one of DOH respondents.<br>SASSA's Ministerial Malnutrition Programme identifies and assesses children for treatment of severe and moderate malnutrition through coordination with doctors, DOH, DSD and DOE. SASSA's respondent indicated that the assessment rates by doctors were very low in the last financial year but that plans were put in place to increase the assessment rates in the 2013/14 financial year. |
| **Deworming** | Community Health Workers and Mentor Mothers<br>ECD Centres (School Health Services)<br>Routine PHC services<br>Campaign together with Vitamin A | IMCI guidelines and EPI programme | The intervention is implemented together with Vitamin A at six (6) months intervals from the age of six months as part of monthly growth monitoring and promotion at PHC clinics.<br>The intervention is also delivered through community outreach programmes as well as home and ECD centres visits by CHWs. Deworming can be checked easily on the road to health booklets by CHWs when they visit home and ECD centres. Health promotion initiatives and outreach activities contribute to effective implementation of the intervention. However, Nutrition Managers and facilities in the rural areas cited the lack of transport to reach deep rural areas and not having budget for campaigns as an inhibitor.<br>Respondents at the Philani Clinic mentioned that Africare, Buhle Bezwe and Ukhahlamba NGOs were involved in community outreach programme to schools for vitamin A, immunization and deworming |

| Nutrition Intervention | Reported Main Delivery Channel | Reported Guidance / Protocols | Respondent's General Perceptions on effectiveness of the service in addressing Nutrition |
|---|---|---|---|
| **Nutritional Counselling** | PHC and CHC<br>Hospital OPD (Chris Hani district)<br>IMCI/ANC<br>Community Health Workers<br>Mentor Mothers | IMCI guidelines<br>BANC<br>PMTCT<br>IYCF Policy and Dietary and Food Based Guidelines<br>Mother and Child Health and Nutrition Book | INADEQUATE to address the needs of pregnant women and children under five. While theoretically, nutrition counselling is integrated in BANC, MCWH, PMTCT, HIV, and Health Promotion, provincial respondents noted that nutrition counselling is inadequate at facility level. In contrast, District and facility level respondents report that nutrition counselling was adequate.<br>Shortage of staff and inadequate/insufficient consulting rooms, expanding health programmes (in relation to human resources) and the tedious task of recording registers were reported by nurses to be inhibitors in doing nutrition counselling properly. Nutrition training for nurses and in-service training for CHWs is seen as critical to improving the intervention by respondents at facility level.<br>Furthermore, there is a need for more nutrition education and awareness at community level; sub-district staff skilled in nutrition; mobile clinics; adequate stocks of medicines at the local clinics, and proper M&E of nutrition counselling interventions. |
| **Improving Hygiene Practice** | CHCs/PHCs/Hospitals<br>Community outreach services and education campaigns<br>Community Health Workers and Mentor Mothers | Hand Washing and Hygiene IEC | This intervention is promoted at the clinics and hospitals as part of daily health talks, one-on-one counselling during consultation sessions (BANC and Growth Monitoring and Promotion), and through outreach programmes including Community Health Workers and Mentor Mothers during home visits, school visits, community education programmes<br>Researcher note: 50% of facilities had no hygiene promotion materials such as hand washing posters in the toilets. Facilities in the rural areas toilets did not work properly due to unavailability of running water, with one clinic without any toilet facilities for both staff and patients because it had no physical structure |
| **Food Fortification** | Environmental Health Officers monitor food fortification<br>Millers and food manufacturers | Regulations | Provincial respondents confirmed that Fortification and Iodization Regulations guides the implementation of this intervention. Respondents at facility level did not know about the intervention.<br>Researcher note: not enough is done to educate health workers and the community about the intervention in the province. Education campaigns should also target small traders in the rural areas so that they stock fortified products for their communities |

## Table 13: Principle Strengths and Weaknesses in the Eastern Cape

| Implementation Factor | Implementation Strengths / Enabling Factors | Implementation Weaknesses / Inhibiting Factors |
|---|---|---|
| **Institutional Culture and Context**<br>Includes readiness to change and the extent of commitment at all levels through which the policy passes | • Nutrition and Food Security is being prioritised by the Eastern Cape Government as evidenced by the implementation of the PIAPS which brings together six government departments, civil organisations and academic institutions.<br>• The DSD and Special Programmes (DSD SP) was appointed as the champion and lead department, and tasked to coordinate implementation of the Eastern Cape Integrated Food Security and Nutrition Strategy.<br>• The DSD MEC has made Early Childhood Development (ECD) a priority and the strategy on ECD is being developed in partnership with UNICEF. | • Coordination of the PIAPS is mainly at provincial level, there's poor coordination at district and municipality levels between the various government departments and all implementers of nutrition and food security<br>• There appears to be a lack of role clarity with regards to implementing nutrition and food access intervention, which results in the duplication of effort between departments.<br>• All government implementers expressed a need to strengthen monitoring and evaluation of the nutrition intervention.<br>• DRDAR – There is a disconnect between political imperatives and actual implementation on the ground; of great concern expressed is the frequency of change in political leadership that gives rise to abrupt food security strategy and implementation changes. |
| **Implementation Strategies Used**<br>The various implementation strategies (i.e. models) devised for carrying out the policy | • There are nutrition intervention policies and guiding documents at all departments.<br>• There appears to be a strong community outreach component for DOH, supported by a cadre of CHW for the breastfeeding support intervention.<br>• DSD uses the IDP forums to profile and raise awareness of the departments' programmes to the wider communities.<br>• DSD has the Youth Pioneer volunteers who work at ward level to profile household and facilitate the provision of services to qualifying people. | • The DOH policy guidelines need to be converted into protocols and SOPs to ease their implementation by nurses at facility level as they do not have the time to read them<br>○ Targeted supplementary feeding – The majority of respondents were unable to make specific reference (i.e. naming) to a policy, guideline or protocol used for this intervention and in some instances they indicated that they were not in possession of any SOP or guideline.<br>• Although breastfeeding is an accepted practice in the community, exclusive breastfeeding in the first 6 months of life is relatively new and therefore requires far much more focus.<br>• DSD Sustainable Livelihoods programme (Food Security Intervention) is reported to be implemented on an ad hoc basis as beneficiaries are not receiving quality food in the quantities needed.<br>• There is little evidence pointing to linkages and coordination between government and the private sector in nutrition throughout all departments interviewed at provincial, district or health facility levels.<br>• NGO linkages across all government departments also appeared to be |

| Implementation Factor | Implementation Strengths / Enabling Factors | Implementation Weaknesses / Inhibiting Factors |
|---|---|---|
| | | lacking this is evidenced by the few NGOs mentioned as support institutions in implementing nutrition interventions. |
| **Participant Responsiveness**<br>facilitation processes and interactions that influence participant responsiveness | • The majority of beneficiaries indicated having received information on exclusive breastfeeding from the local clinic.<br>• Generally beneficiaries said to seek assistance from local clinic if they saw no weight gain in their children. | • There various social, cultural, and economic factors that hamper beneficiaries' ability to practice what they are taught about nutrition<br>• In addition, the various programmes' abilities to reach beneficiaries – or conversely, the beneficiaries' poor or inconsistent use of programmes (e.g. ANC and child health clinics) – hampers the programmes' abilities to achieve their goals and the desired effects at household and community level. |
| **Capacity to Implement**<br>Adequacy of financial, material, and human resources to implement the policy | • DOH reported to have adequate financial resources to carry out nutrition programme interventions. | • Across the various nutrition interventions transport, logistics, and IT infrastructure were reported as inhibiting factors for implementation in the EC.<br>• DOH's structure at sub-district level lacks the human resources required for promoting the INP. Very few sub-districts have filled their Nutrition positions. Most sub-districts operate with one INP Manager and this hampers implementation<br>o The community level nutrition programmes does not have enough people to drive implementation at that level.<br>o Only two District Hospitals were reported to have Dieticians in Chris Hani District<br>o It is reported that Nutrition Managers are unable to visit all the health facilities in a month due to understaffing and corresponding high workloads, and lack of vehicles.<br>• Medicine stock-outs impede implementation of the TSF intervention.<br>• All departments noted weak M&E systems (including poor management review processes) as hampering implementation. For example, DOH respondent cited poor recording of malnutrition data at PHC/CHC health facility level as a challenge in programme implementation which leads to the inability to effectively monitor performance of the intervention. |
| **Communication** | • Messages about exclusive breastfeeding from 0-6 months appear to be well known by all respondents and beneficiaries | • Some IEC materials need to be printed in the local language.<br>• Poor communication channels to deliver key programmatic messages at DRDAR resulting in poor programme outputs |

| Implementation Factor | Implementation Strengths / Enabling Factors | Implementation Weaknesses / Inhibiting Factors |
|---|---|---|
| | • Nutrition education and awareness done at both the facilities (DOH) and in the community are said to be culturally sensitive, and disseminated in the local language – this applicable to all government implementers. | |

# 8. CONCLUSIONS

Integrated food security and nutrition is an emphasis for the EC's new provincial anti-poverty strategy (i.e. PIAPS). Although there is clear commitment from all departments towards ensuring that this strategy takes effect and achieves intended impact, implementation is in its infancy, and its success in reducing hunger and malnutrition in the province remains to be seen.

Of the 18 food and nutrition interventions (listed on page 2) that were generally examined in this evaluation, only food access, breastfeeding promotion, and supportive PHC interventions stand out as being mainstreamed into day-to-day services delivery. These appear to be widely implemented, although their reach could be increased even more with more staff and/or better engagement of NGOs in implementation. Supportive PHC interventions are also mainstreamed (e.g. basic ante-natal care, PMTCT, Vitamin A, de-worming, IMCI, health education/nutrition counselling, and management of severe malnutrition), and no doubt these assist in addressing the underlying disease factors of poor nutrition. Indeed, of the 7 high impact nutrition interventions (all implemented by the DOH), 5 are being implemented adequately in the EC – breastfeeding promotion, micronutrient supplementation (Vitamin A), ORS/Zinc, and management of severe malnutrition, and management of moderate malnutrition (Targeted Supplementary Feeding). However, implementation is not without its challenges, among which are stockouts of necessary materials (e.g. zinc, ORS, vitamin A) which hamper the effectiveness of services delivery.

Effective targeting of nutrition interventions is uneven across EC government departments. Many DOH nutrition interventions are specific to pregnant women and young children, but utilisation of these services can decline rapidly after the child is older than 6 months of age. In contrast, no DSD or DRDAR nutrition interventions specifically target needs of young children or pregnant women; rather poverty or food insecurity is used as the main criterion for enrolling individuals and households into these programmes. But to achieve greater nutrition effect, more specific targeting of young children is necessary for all nutrition and health services. This means the DOH must to find ways to reach children older than 6 months with health services, and DSD/DRDAR must use the presence of pregnant women or children under 5 in a household as a criterion for targeting their food and nutrition interventions. Using ECD centres is not a sufficient targeting mechanism for DSD as most of the children in these centres are 3 years and older, and miss out on the critical 0-2 age group.

The work that is to be done to effectively coordinate nutrition interventions across all departments is significant. Findings from this evaluation point to an apparent fragmented approach in implementing nutrition activities within and between departments, with each department silo'd in its implementation efforts. While the new Integrated Food Security and Nutrition Committee is a welcome mechanism to remedy this, it is too early to tell if it will effectively leverage the nutrition-related efforts of individual departments into meaningful coordinated nutrition impact.

Likewise, at district and community level, there is only a small degree of coordination / linkages / integration between each departments' various nutrition programmes. Insufficient linkages between DSD food access programmes, DRDAR food security programmes, and DOH health/nutrition interventions results in at times duplication or missed opportunities for sharing and leveraging resources. All this points to the need for more and better coordination, either through local governments or municipalities or through some other mechanism. One example is linking social grants with nutrition education and the DOH's health programmes, particularly for children 0-3 years old, as suggested by a SASSA respondent.

But managing the "supply" of the food and nutrition interventions only helps address part of the nutrition story in the province. Wide ranging cultural, social, and economic factors hinder the ability of mothers to practice what they have been taught about good nutrition, particularly around the breastfeeding and complementary feeding practices that profoundly influence nutrition in the first 1000 days of life. Little attention is given to effectively providing complementary feeding support, and even though the EBF message is being received by mothers, they do not put the message into practice. Accordingly, there is need to intensify the messages around exclusive breastfeeding and complementary feeding as well as to scale up regular and consistent growth monitoring to have a positive impact on child nutritional status – particularly in reducing stunting and the growing prevalence of overweight in very young (ages 0-3) children. Implementing these interventions requires extensive community outreach into the homes of mothers and children, but HR and transportation limitations, poor referral and linkages, outdated growth monitoring equipment, poor IEC materials hamper these efforts. PHC reengineering, with its focus on community-based services delivery holds promise for improving nutrition care practices at homes.

Finally, staffing across all 3 government departments suffers from vacancies and a lack of sufficient knowledge of nutrition and skills in programme management and implementation.

# 9. RECOMMENDATIONS

1. Establish formalised and dedicated coordination structure(s), either separately or within PIAPS, to engender greater responsibility and accountability across and within government departments (DOH, DSD, DRDAR) for achieving common nutrition objectives, and to contribute to better improvement of nutritional status of the population at large.
2. Fill all vacant DOH food and nutrition posts especially at provincial and sub-district levels to ensure full implementation of each food and nutrition programme.
3. Address lack of referrals / integration / linkage at community and sub-district level. Encourage sharing of transportation resources where possible.
4. Give training on IYCF to all food and nutrition personnel in all departments, and provide on-going refresher training to counteract frequent staff changes due to attrition or rotation.
5. Develop schematics and flowcharts to replace bulky policies and SOPs, guiding staff in the steps to follow for managing nutrition interventions. These charts or schematics should be posted on the walls in all the consultation rooms.
6. Consider emphasising "nutrition-led agriculture" in its new Food Security Strategy with a focus on nutrition objectives and targeting pregnant women and households with young children.
7. Address within the PIAPS the steady decrease in programme funding for household food production interventions within DSD and DRDAR.
8. Urgently expand M&E systems to include additional data points on the delivery of food and nutrition interventions to the women and children under 5 and to include outcome level data that indicates the effects of these interventions (e.g. stunting rates).
9. Explore how each department can better engage and fund CBOs and NGOs for delivering a comprehensive package of community level food and nutrition interventions (e.g. growth monitoring, micro-nutrient supplementation, home gardens, nutrition counselling, IYCF support groups, food parcels, ECD meals, etc.) to better realise nutritional impact for pregnant women and children under 5.

# APPENDIX A TERMS OF REFERENCE



DEPARTMENT OF PERFORMANCE MONITORING AND EVALUATION

THE PRESIDENCY

## Terms of Reference for Diagnostic/Implementation Evaluation of Nutrition Interventions for Children from Conception to age 5

**RFP / Bid number:** 12/0287

**Compulsory briefing session**
Date: 27 August 2012
Time: 11.00-13.00
Venue: Room 222, East Wing, Union Buildings

Please note that security procedures at the Union Buildings can take up to 30 minutes.

**Bid closing date:**
16.00 19 September 2012 with provision of an electronic and 6 hard copies.

### 1 Background information and rationale

#### 1.1 Background to the intervention being evaluated

South Africa is in a nutrition transition which includes the coexistence of under- and over-nutrition which is evident between and within populations and across age groups. Under-nutrition has stayed roughly constant in South Africa since the early 1990s. Despite our relatively high per capita income, the country has rates of child stunting comparable to other lower-income countries in its region, and higher rates of stunting than lower-income countries in other regions. While some indicators show improvement, several conditions seem to have worsened over the past decade. In addition, children's nutritional status varies considerably among the nine provinces and possibly within each province. This has bearing on targeting and prioritization for interventions and resource allocation. Malnutrition undermines progress towards the Millennium Development Goals (MDGs) directly to those goals related to poverty, maternal health, child mortality and education, and indirectly to the remaining MDGs. Nutrition is critical for, inter alia, the improvement of maternal and child health, as underscored in the Negotiated Service Delivery Agreement

Since the democratisation of South Africa, the Government has remained consistently committed to reducing malnutrition in children and mothers. The appointment of the Nutrition Committee by the Minister of Health in August 1994 to investigate an Integrated Nutrition Strategy for South Africa was the beginning of a new chapter in nutrition in South Africa. In considering the sectoral and multi-faceted causes of malnutrition, the Committee recommended an Integrated Nutrition Strategy (INS) with three components, namely health facility-based services, community-based nutrition programmes and nutrition promotion. Instead of the fragmented and mostly food-based approaches of the past, the INS was to implement complementing strategies and follow an integrated approach to address nutrition problems. The INS was adopted in the Department of Health's White Paper for the Transformation of the Health System in South Africa (1997) and served as the basis for the Integrated Nutrition Programme (INP) for South Africa.

Priority interventions for the Integrated Nutrition Programme for children under five are as follows:

- Infant and young child feeding, which include promotion of safe infant feeding practices;
- Micronutrient malnutrition control-supplements, fortification and food diversification;

- Facility-based nutrition interventions including management of severe malnutrition;
- Growth monitoring and promotion;
- Disease-specific interventions such as nutrition interventions for children living with TB, HIV&AIDS and other debilitating conditions;
- Maternal nutrition which includes provision of micronutrients.

The beneficiaries of nutrition-related interventions and the coverage are as follows:

- Vitamin A provided to post-partum women = 760 000 (current coverage is 94%);
- Vitamin A provided to children from 6 to 59 months – 3 673 584 (current coverage 6-12 months = 90%, and 12-59 months = 41%;
- Nutritional interventions provided to people infected with TB, HIV and AIDS – 640 281;
- Malnourished children ( including moderate and severely malnourished) – 134 832;
- School going children through the school nutrition programme – 7 125 273;
- Exclusive breastfeeding promoted to all children under six months old – current coverage of 25% of children from zero to six months.

The health sector is leading and harnessing the efforts to achieve Outcome 2: "A long and healthy life for all South Africans". The Strategic Plan of the National Department of Health (NDOH) provides a framework of the implementation of the 10 Point Plan of the health sector for 2009-2014, which is aimed at creating a well-functioning health system capable of producing improved health outcomes. The outcome-based approach adopted by government to accelerate the implementation of the NDOH Strategic plan guides the development of specific strategies in the sector. The four key outputs that the health sector should produce to achieve Outcome 2 are: increasing life expectancy; decreasing maternal and child mortality; combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis; and strengthening health systems effectiveness.

Improving the nutritional status of the population should benefit the health system and reduce the economic burden of medical treatment and care in a number of ways. It can reduce the demand for curative treatment, and thus the number of patients, shorten the duration of hospital stays and improve recovery rates. Reduced patient loads at primary health care facilities can facilitate improved delivery of nutrition and other preventive and promotive services. Therefore, implementing proven nutrition interventions at scale will contribute in achieving Outcome 2 of the health sector.

The expected outcome of nutrition-related interventions is improving the nutritional status of the South African population, with specific reference to the most vulnerable groups, namely; pregnant women and children under the age of five. The desired outcomes are mainly:

- Reduction of stunting in children;
- Reduction of underweight in children;
- Reduction of case fatality rate due to severe acute malnutrition;
- Reduction of micronutrient deficiencies especially Vitamin A, iron, zinc and iodine;
- Promoting healthy eating amongst the children and adults to combat chronic diseases of lifestyles such as diabetes, cancers and cardiovascular diseases;
- Improving nutritional status of individuals living with chronic and other debilitating conditions.

Recent reports from government, notably the diagnostic report from the National Planning Commission also reflected the need to address the problem of child malnutrition in South Africa. The 2008 input paper from the Development Bank of Southern Africa on "Combating Malnutrition" also highlighted the need to act with speed in tackling malnutrition. The contribution of malnutrition as an underlying cause and major contributor to infant mortality in South Africa has been highlighted through various reports. This has prompted the Minister of Health to urge government to scale-up key child survival interventions such as breastfeeding to contribute in reducing infant mortality rate.

The economic costs of under-nutrition are substantial: productivity losses to individuals are estimated at more than 10 percent of lifetime earnings, and losses to gross domestic product may be as high as 2–3%. The estimated budget allocation for nutrition related interventions in provinces under the health budget vote is R320 million. Therefore the evaluation is important because of the investment that government is making on nutrition related interventions for under-five children. Identifying bottlenecks in scaling up nutrition related interventions targeting children under five will contribute better programme planning and resource allocation.

In order to understand problems of malnutrition and resources and systems needed at different levels, the "UNICEF Conceptual Framework (1990) should be used as a guide. The conceptual framework outlines in diagrammatic form the multiple causes of malnutrition operating at various levels in society. The framework also focuses on the processes, programmes and policies that need to happen at the higher level to ensure that reductions in maternal and child under-nutrition will not only be achieved in the short term, but will be maintained in the long term, will be sustainable, and will be transmitted from one generation to another. Public and private sector interventions need to influence household decision-making to influence nutrition.

The multi-sectoral nature of nutrition requires various government departments, donor agencies and the industry to work together. The following stakeholders within and outside government are critical in the successful implementation of various nutrition related interventions: Departments of Basic Education, Social Development, Agriculture, Trade and Industry, Treasury, Water Affairs, Rural Development and Land Reform, United Nations agencies, food industry, NGOs and other development partners. The Integrated Nutrition Programme became operational in 1994.

Various nutrition interventions are currently being implemented. Table 1 shows a list of the interventions to include in this evaluation.

**Table 1: Nutrition interventions to be covered by this evaluation (*= high impact interventions drawn from Copenhagen Consensus of 2012 and the Lancet Series 2008)**

| Interventions to cover | Department responsible |
|---|---|
| Breast-feeding support* | Health |
| Complementary feeding* | Health |
| Food fortification (Vitamin A, Iron and Iodine)* | Health |
| Micronutrient inc Vitamin A supplementation* | Health |
| ORS and Zinc* | Health |
| Management of severe malnutrition* | Health |
| Management of moderate malnutrition inc targeted supplementary feeding* | Health |
| Deworming | Health |
| Growth monitoring and promotion including the use of MUAC | Health |
| Nutrition education and counselling (part of all of these) | Health |
| Improving hygiene practice (including in relation to water and sanitation) – should be in all | Health |
| BANC (Basic ante-natal care) – education and supplements, timing | Health |
| IMCI (integrated management of childhood illnesses) | Health |
| Household food production and preservation (home gardening) | DAFF |
| Access to (nutritious) food, food prices | DAFF |
| Food security (output 2 of outcome 7) | DRDLR/DAFF |
| Food access (eg food parcels, soup kitchens) (DSD) | DSD |
| ECD (food in ECD centres) (DSD) | DSD |

The evaluation should feed into other government priorities that are geared towards the reduction of infant mortality in South Africa, especially policy initiatives such as re-engineering of Primary Health care

that are pioneered by the Department of Health. The recent review of the ECD interventions also provides an opportunity to address issues of nutrition comprehensively, focus on the most vulnerable members of the society. Malnutrition is an underlying cause of the death of children in one-third of the total of children's deaths in South Africa. Malnutrition undermines economic growth and reduces the productivity of people trying to work their way out of poverty. It is estimated that 2-3% of the national income of a country can be lost to malnutrition. Therefore it is imperative that South Africa act now to address problems of malnutrition, since we have been identified as one of the 36 countries where 90% of the world's stunted children resides.

### 1.2 Purpose of the evaluation

The evaluation will focus on identifying the critical system and implementation issues inhibiting or enabling people's access to nutrition-related interventions targeting children from conception to below the age of five, how these should be addressed and scaled up where appropriate.

The evaluation will provide the opportunity to re-focus interventions targeting children under five.

## 2 The focus of the evaluation

### 2.1 Evaluation questions

The key evaluation questions that this evaluation will address include:

- Do relevant **policies** exist for these interventions (those in table 1), have they been adopted by appropriate departments/levels of government, are they funded, and are they coherent across sectors?[1] Are there policy gaps?
- Does government have the appropriate policy and **regulations** to avoid inappropriate marketing of products affecting child nutrition? What are the gaps in monitoring and enforcement? How consistent is this across government? Why are some regulations not being applied effectively, or not enforced? Is there sufficient capacity in regulatory agencies? What type of partnership with industry is appropriate to promote child nutrition and development?[2]
- To what extent are nutrition interventions from different agencies (government and non-government) influencing household decisions and **reaching under 5 children** across the country (from secondary data and facility monitoring) and which are being carried by government and which by non-government agencies?
- Are **high impact interventions** being prioritised in practice? See Table 1 for a list of high impact interventions.
- What interventions are being **implemented effectively**, what aren't?
- Why are some interventions not being implemented effectively and efficiently and what is needed to strengthen, upscale and sustain them? Sub-questions include:
    - How far is nutrition **mainstreamed** into the work of relevant services which impact directly on children? These services should be defined in the inception report.
    - Are there appropriate **plans** to implement these nutrition interventions, are they included in departmental strategic plans, APPs and operational plans?
    - Is there appropriate **leadership** for nutrition at the respective levels and are they empowered to play that role?
    - Are there **relevant workers** (not necessarily professional dieticians or nutritionists) to address nutrition-related interventions?
    - Do key staff (government and non-government) at different levels have the skills to play the roles they need to play and deliver the services needed?

[1] A list will be provided
[2] Note some work has been happening in terms of food control agencies

- Do the PHC and other service facilities have the necessary equipment, guidelines, protocols and supplies to deal with nutrition in under-five children?
- Do service standards/norms exist for relevant interventions?
- Are resources allocated appropriately and sufficiently (this would draw on international evidence of cost-benefits)
- In terms of the service delivery model operating in practice, do we have appropriate systems and structures operating at community level to have effective outreach to communities (eg community-based services such as nutrition advisors, and platforms for community involvement). How extensive are these?

➢ What institutional arrangements are currently in place within and across departments and agencies (government, private sector, community actors) to address child nutrition and what is needed to improve the effectiveness of nutrition interventions?

➢ What monitoring and evaluation systems are in place and needed to monitor and improve the evidence base for and implementation of nutrition-related interventions?

## 2.2 Intended users and stakeholders of the evaluation

The key potential users of the evaluation results and how they may use it are shown in Table 2.

**Table 2: Users and their use of the evaluation results**

| User | Key question | How they may use the evaluation results |
|---|---|---|
| Political leadership at national and provincial levels | • What do we need to do to ensure that our children are well nourished and able to use their full potential?<br>• What institutional arrangements and M&E is needed across departments and agencies (government, private sector, community actors) to improve the effectiveness of nutrition interventions for children? | • Reprioritise resources<br>• To strengthen intergovernmental cooperation (and with civil society) around child nutrition and development? |
| All departments and provinces | • What interventions are being implemented effectively, what aren't and where are the gaps?<br>• Why are some interventions not being implemented effectively and efficiently and how can we strengthen, upscale and sustain them?<br>• How does each department's role need to be strengthened to address this? | • Overcoming blockages and improving implementation<br>• Reprioritise resources<br>• Collaborate more effectively with other agencies |
| Development partners and NGOs | As above plus:<br>• Where are the key gaps where our support can make a difference? | • Prioritise funding and support to programmes |
| Staff at facility or community level | • What skills and support do we need to ensure we can deliver services appropriately | • Recognising their shortcomings<br>• Motivate for the support they need Allocating their time differently<br>• Motivating and mobilising the community more appropriately |
| Industry | • How can industry's products and services be more appropriate in addressing child | • Refocusing products and services |

| User | Key question | How they may use the evaluation results |
|---|---|---|
| | nutrition<br>• What type of partnership with government is appropriate to promote child nutrition? | • Appropriate partnerships established |

### 2.3 Scope of the evaluation

Table 3 shows the issues which are to be covered, and those to be excluded.

**Table 3: Scope of the nutrition evaluation**

| To be included | To be excluded |
|---|---|
| System issues include policy, the design of programmes, budgets, how processes work in practice | |
| Period from conception to age 5<br>Women pregnant/caring for children under 5 | Exclude children >5<br>Women of child-bearing age who are not pregnant, and are not caring for children under 5 |
| Link with HIV | |
| Main intervention programmes targeting under 5s across government | Indirect issues such as Child Support Grant. Build on existing CSG evaluation. |
| Underweight and overweight | |
| ECD | Don't cover what already covered by ECD Diagnostic Review |
| Public health interventions including at community level | Exclude tertiary and district hospitals except for management of severe acute malnutrition (SAM). Main focus not on clinical interventions |
| Budget for wider nutrition interventions beyond the Integrated Nutrition Programme, but will also look at previous INP budget for infant formula. | |
| Role of industry and how government engages with industry | |
| Relate to international experience eg in middle income countries | |

## 3 Evaluation design

The key elements of the design include:

1. Good literature review to draw together existing research and evaluation (a set of core documents will be provided at the bidders briefing).
2. Review of existing national and provincial policies, regulations and interventions to show how these cohere or not and govern provision (bearing in mind that most nutrition action is taken at household level).
3. Some comparison with other middle-income countries, especially where data is limited. The countries should be suggested in the inception report.
4. Overview of all the interventions and the progress/not and challenges using secondary data.
5. Four provinces selected for detailed case studies to explain what is occurring and why (including those working well, those working less well). This should include KwaZulu Natal where there is

extensive community-based nutrition work happening, Western Cape, Free State/North West and Eastern Cape. These should cover urban to remote rural communities and facilities, perhaps 6 per province, covering a relatively well performing district and a poorly performing. See Annex 2.

6. Some high impact interventions selected for detailed case studies (probably breast-feeding support, targeted meal supplementation, management of severe malnutrition and possibly Vitamin A supplementation) as well as household food production and preservation (home gardening). These should show the linkages and value chain between household and the decisions made, community, facility, district, province and national level including the private sector. This should explain and illustrate implementation challenges and proposals to strengthen.
7. Thorough institutional analysis to understand how within and across departmental systems, structures, capacity, organisational culture and leadership is facilitating or limiting impacts. This will build on the landscape analysis.
8. Recommendations should take a short/medium/long term perspective.

# APPENDIX B METHODOLOGY

## LITERATURE REVIEW

The starting point for this evaluation was a literature review that provided the context for this implementation evaluation. The literature review examined the following relevant topics:

1. Current health and nutrition status of children under 5 and pregnant women in South Africa;
2. South Africa's policy framework on maternal and child nutrition;
3. A review of nutrition policies and interventions from 5 countries that have successfully improved their nutrition performance (Brazil, Colombia, Malawi, Mozambique, and Malaysia). These countries were selected by the Evaluation Steering Committee as comparisons to South Africa based on one of the following two reasons:
    - the country has similar economic or infrastructure characteristics to South Africa but much better nutrition performance at a national level (i.e. Brazil, Colombia, and Malaysia), or
    - the country is geographically proximate to South Africa and thus has similar environmental and cultural characteristics, but again better nutrition performance (i.e. Malawi and Mozambique);
4. An analysis of implementation issues present in the literature.

## SAMPLING

Before we began fieldwork, the Evaluation Steering Committee identified the geographic areas where fieldwork was to be carried out and the important subgroups or categories of people to be sampled. The four stages involved are further described below.

### Stage 1: Selection of Provinces

Aside from data collection at national level, the Evaluation Steering Committee identified 4 provinces (purposefully-selected) for the reasons indicated below:

JUSTIFICATION FOR THE PROVINCES SAMPLED

| Province | Justification |
|---|---|
| **KwaZulu-Natal** | Its emphasis on community nutrition |
| **Western Cape** | The general perception that nutrition and health programmes are well implemented in the Western Cape |
| **Free State** | The general perception that nutrition and health programmes are well implemented in the Free State |
| **Eastern Cape** | Its unique development profile and its challenges in implementing government programmes |

### Stage 2: Selection of Districts

In each province, 2 districts were purposefully selected based on their levels of performance (i.e. high performing and low performing). We obtained recommendations from provincial nutrition focal persons regarding the names of high-performing districts in their province. Selection of the poor-performing districts were identified with the Evaluation Steering Committee using the following criteria:

- NDOH score for district's performance in child health indicators
- NDOH pilot districts for implementing the NHI (these tend to be districts with vulnerable population and have a high burden of disease, and have demonstrated poor performance in 27 socio-economic, health service and financial and resource management indicators).
- Rural Development scores for district performance
- Agriculture scores for district performance
- DSD district performance scores

Two of the poor-performing districts chosen with the Evaluation Steering Committee (in FS and WC) were revised, with the final sample of districts being presented in the table below.

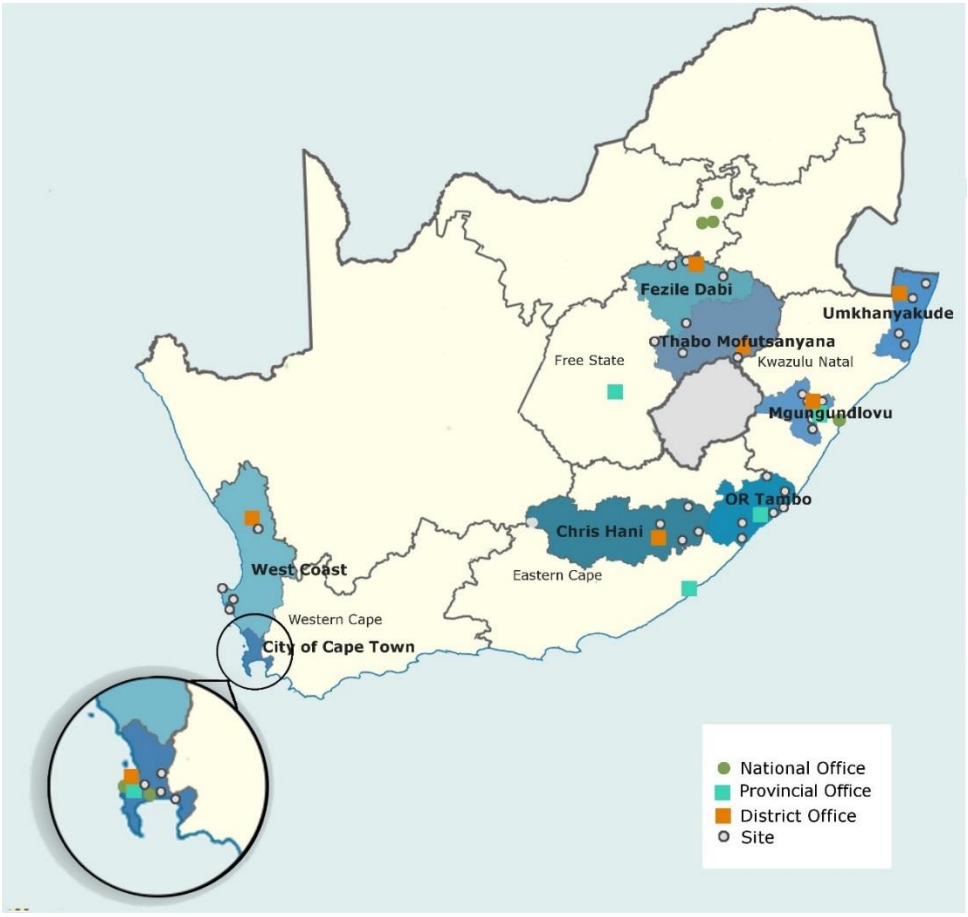
**DISTRICTS INCLUDED IN THE SAMPLE**

| PROVINCE | HIGH PERFORMING DISTRICTS | | POOR PERFORMING DISTRICTS | |
|---|---|---|---|---|
| | District Name | Justification | District Name | Justification |
| **Eastern Cape** | Chris Hani | Recommendation from the EC nutrition focal person. | OR Tambo (Umtata) | NHI pilot site<br>Poor Child Health indicator score<br>Poor Rural Development indicator Score |
| **KZN** | Umgungundlovu | Recommendation from the KZN nutrition focal person. | Umkhanyakude (Mkuze / Jozini) | Poor Child Health indicator score<br>Poor Rural Development indicator Score<br>High poverty levels based on DSD indicators |
| **Free State** | Thabo Mofutsanyane | Recommendation from FS nutrition focal person | Fezile Dabi | Recommendation from Nutrition Manager in FS province |
| **Western Cape** | West Coast | Recommendation from WC nutrition focal person. | City of Cape Town | Recommendation from Nutrition Manager in WC province |

## Stage 3: Selection of Facilities/Organisations

In each district, Khulisa randomly selected 4 health facilities according to their geographic status (urban/rural), and purposefully selected 4 NGOs that work in food/nutrition. This resulted in a total sample of 32 health facilities and 16 NGOs as across the 4 provinces.

**FIELDWORK LOCATIONS**




## Stage 4: Selection of Individual Respondents

Key informant respondents were purposefully sampled based on a list of stakeholders provided by the Evaluation Steering Committee. The sampling strategy for beneficiaries was based on a convenience sample obtained during site visits to health facilities and NGOs. The method for data collection in each group in the sample is indicated in brackets in the box below.

**Proposed Respondents (and method of data collection)**

1) **National Level Respondents** *(in-depth interviews)*
   - National DOH nutrition managers
   - National DSD managers
   - National Rural Development food/nutrition managers
   - National Agriculture food security managers
   - National ECD managers
   - Bilateral Donors: USAID, CDC
   - Multi-lateral Donors: UNICEF, WHO
   - Relevant local and international health/development organizations:
   - Relevant food industries
2) **Provincial Level Respondents in WC, EC, FS, and KZN** *(in-depth interviews)*
   - Provincial DOH nutrition managers
   - Provincial DSD nutrition managers

- Provincial Rural Development food/nutrition managers
- Provincial Agriculture food security managers

**3) District Level Respondents** *(in-depth interviews or focus group discussions)*

- District DOH nutrition managers
- District DSD nutrition managers
- District Rural Development food/nutrition managers
- District Agriculture food security managers

**4) Health Facility Respondents** *(in-depth interviews or focus group discussions)*

- MCH nurse or nursing assistant
- Counsellors for pregnant women and/or mothers of young children
- Community health workers attached to health facilities

**5) NGO Respondents** *(in-depth interviews or focus group discussions)*

- Programme or Site Manager
- Community workers

**6) Beneficiary Respondents** *(focus group discussions)*

- Pregnant women and mothers of children under 5 years present at health facilities
- Beneficiary participants in NGO programmes

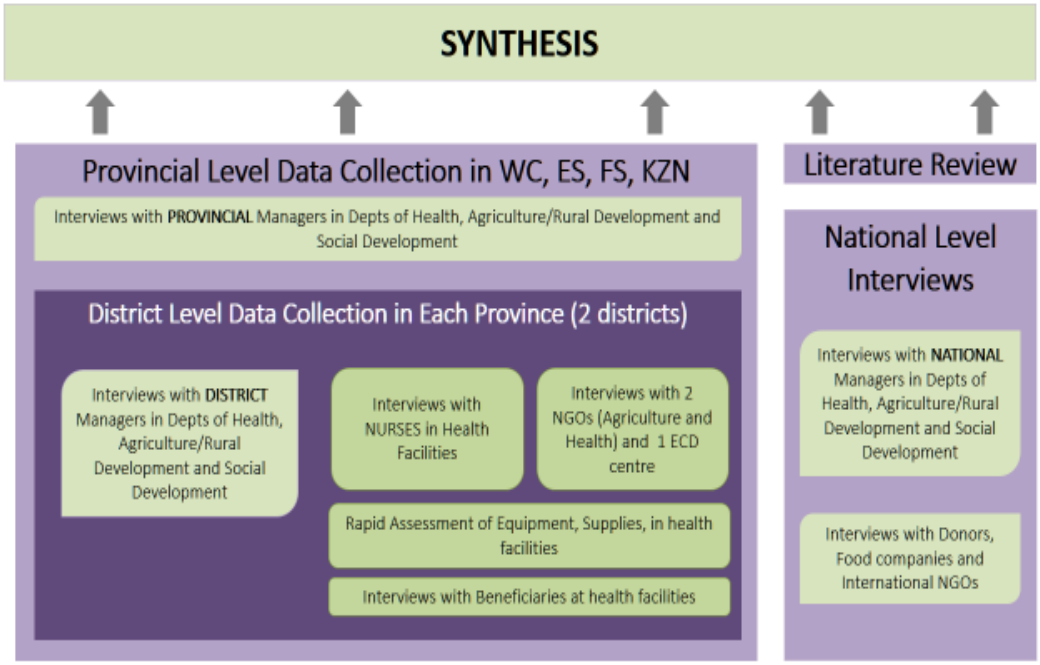
## DATA COLLECTION METHODS

Data collection methods used in the evaluation are as follows:

1. Semi-structured Key Informant Interviews
2. Focus Groups with beneficiaries
3. Rapid Performance Assessments of health facilities
4. Assessment of Health Worker Knowledge around nutrition

The figure below summarises the data collection components of the evaluation.

### Summary of Data Collection Components of the Evaluation




The table below presents the data collection methods used, the target respondents for each method, as well as the content explored.

### Data Collection Methods and Target Respondents by Content

| Method | Target Respondents | Content explored |
|---|---|---|
| **Key informant interviews** | Relevant Government managers at national, provincial, and district levels | • Perceptions on current needs and practice around nutrition<br>• Moderating factors (i.e. policy content and fit, organisational context and culture, commitment, capacity, facilitation processes that affect participant responsiveness, and communication)<br>• Institutional arrangements<br>• M&E for food/nutrition<br>• Funding levels |
| | Food industry representatives | |
| | Bilateral and multilateral donors and international health/development NGOs | |
| | Health facility staff or managers | |
| | Representatives from CBOS/NGOS involved in food/nutrition programmes | |
| | Programme managers at district level, groups of health staff at facility level | |
| | Representatives from community-based projects and services (ECD, agriculture, health) | |
| **Focus Group Discussions** | Beneficiaries | • Experiences with food and nutrition programmes and services<br>• Satisfaction with services<br>• Need for food/nutrition support |
| **Rapid Performance Assessment** | Health Facilities | Review of relevant infrastructure, equipment, and supplies for delivering nutrition interventions |

| Method | Target Respondents | Content explored |
|---|---|---|
| **Assessment of Health worker Knowledge** | Nurses, counsellors, or others providing nutrition services | Knowledge of diagnostic steps and counselling around breastfeeding difficulties, growth faltering, and knowledge of the benefits of micronutrient supplementation |

## PLANNED VS. ACTUAL DATA COLLECTION

The fieldwork was conducted in 100 of the intended 104 intended locations (96%). The missing locations include: one national level interview (not conducted because of difficulties in scheduling or refusals), two district level offices (not interviewed in the Western Cape (DOA for West Coast district and DOH for City of Cape Town Metro)), and one health facility in the Free State.

As shown in in the table below, 143 interviews and Focus Group Discussions (FGDs) were conducted across these 100 locations. Half of these were held at Government offices or health facilities, 30% were Beneficiary FGDs, and the remaining 20% were with NGOs or other (donor representatives, international agencies, and private companies). Many interviews were conducted with more than 1 respondent, resulting in the total number of respondents being more than 400 people.

Two additional assessments were conducted at health facilities: (i) a rapid assessment of relevant equipment and supplies for delivery of nutrition interventions, and (ii) an assessment of health worker's knowledge around nutrition interventions.

### FIELDWORK PLANNED AND ACTUAL

| Data Collection Method and Stakeholders Group | No. of Interviews / FGDs | | | Total No. Persons interviewed |
|---|---|---|---|---|
| | Planned | Actual | % | |
| **Individual or Group Interviews** | | | | |
| National Government Managers | 4 | 5 | 125% | 7 |
| Representatives of International NGOs | 4 | 7 | 175% | 8 |
| Donors | 3 | 4 | 133% | 5 |
| Private Food Companies | 4 | 4 | 100% | 8 |
| Provincial Government Managers | 12 | 15 | 125% | 22 |
| District Government Managers | 24 | 21 | 88% | 37 |
| Health Facilities | 32 | 31 | 97% | 61 |
| Local NGO | 8 | 8 | 100% | 18 |
| ECD Centre | 4 | 5 | 125% | 12 |
| **Focus Group Discussions** | | | | |
| Beneficiaries FGDs at health services and community projects | 48 | 40 | 83% | 267 |
| **TOTAL** | **143** | **140** | **98%** | **445** |

| Other Assessments | Planned | Actual | % | No. Persons Reached |
|---|---|---|---|---|
| Health Facilities Rapid Assessments | 40 | 36 | 90% | -- |
| Health Worker's Assessment of Nutrition Knowledge | 76 | 132 | 174% | 136 |

A breakdown of the number of respondents per province can be seen in in the table below.

**ACTUAL NO. INTERVIEWS AND FGDS CONDUCTED BY PROVINCE**

| | Western Cape | | Free State | | Kwa-Zulu Natal | | Eastern Cape | | National Level | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. Interviews / FGDs | No. Resp. | No. Interviews / FGDs | No. Resp. | No. Interviews / FGDs | No. Resp. | No. Interviews / FGDs | No. Resp. | No. Interviews / FGDs | No. Resp. | No. Interviews / FGDs | No. Resp. |
| **DOH Mgmt** | 2 | 2 | 4 | 5 | 3 | 4 | 3 | 7 | 1 | 2 | 13 | 20 |
| **DSD Mgmt** | 2 | 4 | 5 | 6 | 3 | 7 | 4 | 6 | 2 | 3 | 16 | 26 |
| **Ag Mgmt** | 1 | 1 | 3 | 5 | 3 | 7 | 3 | 5 | 2 | 2 | 12 | 20 |
| **Donors, companies** | -- | -- | -- | -- | -- | -- | -- | -- | 14 | 21 | 14 | 21 |
| **NGOs (local) /ECD** | 1 | 1 | 4 | 7 | 4 | 15 | 4 | 7 | -- | -- | 13 | 30 |
| **Health Facilities** | 8 | 9 | 7 | 7 | 8 | 31 | 8 | 14 | -- | -- | 31 | 61 |
| **Beneficiary FGDs** | 7 | 21 | 10 | 69 | 11 | 106 | 12 | 71 | -- | -- | 40 | 267 |
| **TOTAL** | **21** | **38** | **33** | **99** | **32** | **170** | **34** | **110** | **19** | **28** | **139** | **445** |

NB: *No. Resp* = Number of respondents across the interviews and focus group discussions. Because interviews were often conducted with more than one person, the number of respondents is often greater than the number of interviews or FDGs held.

## DATA RECORDING AND CAPTURING

During each interview or assessment, the researcher took extensive notes on the instruments specific to the interview. An interview guide provided researchers with further guidance on when to probe for answers and when not to. The notes were then captured in Excel for data analysis and then coded according to themes.

## DATA ANALYSIS

Quantitative data collected in the KIIs, FGDs, Health Facilities Rapid Assessments, and Health Worker's Assessment of Nutrition Knowledge were analysed using descriptive statistics.

Qualitative data collected under the KIIs and FGDs were analysed using content analysis, from the notes that had been transcribed into Excel. The following criteria were utilised to determine the 'reliability and validity' of the data.

1. Truth value/Credibility: Truth value describes the level of confidence the researcher has with the truth of the findings based on: research design, informants and context.
2. Consistency/Dependability: Due to the non-experimental and complex nature of qualitative research, variability is expected and consistency is explained as dependability. Dependability requires that variability is tracked and explained and informant's range of experience from typical to atypical experience explained.
3. Neutrality: Neutrality in qualitative research involves neutrality in relation to data rather than the investigator.

Once the qualitative notes were checked for reliability and validity, these were coded for themes. These themes were tabulated and reported on according to the KII and FGD questions.

## REPORTS PRODUCED

Case Study reports were prepared for each of the four provinces where fieldwork took place, as well

as for each of the four priority interventions. In all, 11 reports for dissemination prepared for this evaluation as listed below:

1. Literature Review
2. Breastfeeding Case Study
3. Targeted Supplementary Feeding Case Study
4. Home Gardens Case Study
5. Food Access Case Study
6. KwaZulu-Natal Provincial Case Study
7. Eastern Cape Provincial Case Study
8. Free State Provincial Case Study
9. Western Cape Provincial Case Study
10. Final Evaluation Report
11. Summary of Final Evaluation Report (1-5-25)

## LIMITATIONS OF THE EVALUATION

By their nature, qualitative evaluations of policies and programme implementation allow examination of the broader context, rather than specific measurements of compliance to policy elements or programmatic guidelines. This evaluation's extremely broad scope (18 interventions, 17 research questions, and investigation of 6 moderating factors) resulted in very lengthy interviews with respondents who often had time constraints. Consequently, many respondents gave only cursory information around the issues that we sought to explore more deeply.

Because nutrition interventions for pregnant women and children under 5 in the health sector far outweigh the number of nutrition interventions in the social development and agriculture sectors, the evaluation's sampling framework is biased toward respondents from health. In addition, at provincial, district, and local levels, most respondents were able to speak knowledgeably about nutrition interventions implemented by their specific government department, but few were able to comment on the adequacy of implementation for interventions outside their sector. Consequently, data collected from social development and agriculture is sparse compared to that collected from health, making generalisations on implementation in agriculture and social development more difficult.

Data collection in the WC was significantly delayed due to the need to secure ethics clearance from the province before the commencement of field work. This delay led to time constraints on the part of the researcher which in turn resulted in less complete data for the WC compared to that for the other 3 provinces.

# APPENDIX C FIELDWORK CHALLENGES

In general, fieldwork challenges experienced in the Eastern Cape can be classified into the four categories:

**A. Scheduling and Timing:**

- The timing for initiating data collection in late November/early December 2012 was hampered by the festive season, resulting in non-availability of respondents who had taken leave. Most provincial, district and some health facility respondents became available only after the second week of January 2013, others even later in January or early February.
- Timing of the evaluation was particularly a challenge for the DRDAR managers in OR Tambo because the evaluation was being carried out at their busiest time (the planting season) to the extent that an interview with the one manager who was available could not be completed. The researcher could not make another appointment to complete the interview because of schedule constrains and logistics challenges.

**B. Communication about the evaluation to the provinces and districts:**

- The DSD Head of Department (HOD) indicated that she had not received communication about the evaluation and therefore questioned the method used in selecting respondents. DSD respondents at district who the researcher had contacted cancelled agreed appointments until the HOD's office had received the letter sent to province about the evaluation and issued a go-ahead for them to participate. The researcher had to send the DPME letter; and only then did she give approval for the interviews to be conducted.
- DOH managers questioned the rationale for the selected sites for the evaluation as they were of the opinion that better sites could have been chosen.
- Communication about the evaluation to facilities by district officials (nutrition programme managers) created some apprehension, at a few facilities it was understood to be a performance evaluation. Delaying to get to the facilities contributed further to the apprehension of facility respondents, particularly in the Chris Hani District because approval to visit facilities had to be given by the District Manager as per protocol. The researcher reassured the staff at the visited health facilities that evaluation was DPME initiative and not a performance evaluation.

**C. Respondent substitutions:**

- DOH senior managers in OR Tambo were not available for interviews partly because of leave and other research commitments (Harvard and Fort Hare University research study that they were engaged in). Only one Sub-district INP Manager and Coordinator could be interviewed. In addition, district level INP Managers could not make it to the district office for the interview because of logistical challenges. This was the case for both Chris Hani and OR Tambo district.
- DRDAR and DSD managers in OR Tambo and Chris Hani substituted respondents because of leave or in respect of seniority. These abrupt changes negatively affected the researcher's schedule as entire district logistics had to change.
- Donald Woods Foundation, the NGO selected for the evaluation, directed the researcher to Philani's Zithulele Mentor Mothers (a non-PEPFAR Funded NGO) because they felt that nutrition was a very small component of their programme. Philani Zithulele Mentor Mothers was very eager to participate in the evaluation. Philani's Zithulele Mentor Mothers is a localized

programme in Zithulele, a rural area near Coffee Bay in OR Tambo district. They have a bigger operation in the Western Cape.

- Africare (PEPFAR funded NGO) insisted that the interview tool would best be answered by the DOH Facility Operations Manager at a selected health facility site that they support because the managers at the Africare office were not familiar with nutrition.

**D. Collecting data at health clinics:**

There were three challenges in collecting data at clinics, namely:

1. Getting nursing staff respondents during on-going work for interviews at health facilities that were understaffed. This required the researcher to wait until 3 or 4pm at times in order to hold interviews with suitable respondents.
2. Holding focus group discussions (FGD's) with beneficiaries who were requested to leave their spot in the queues especially at rural facilities. Some the beneficiaries left during the focus group discussions to get back to the queue because they had travelled from far. Clinic staff was supportive in many instances, they helped the researcher organize beneficiaries for the FGDs on the day and assured participants that they would get services.
3. Unavailable beneficiaries to be interviewed from the target group:

- There were no beneficiaries from the target group to interview at Lusikisiki Village Clinic (a tent structures set-up) because the clinic was running only HIV and TB programmes on the day of the visit.-
- In the Mzimvubu Agricultural Project most participants in the home garden project were elderly women at the village that was visited. Therefore, no beneficiaries from the target group could be interviewed.

# APPENDIX D LIST OF PEOPLE INTERVIEWED BY LOCATION

| | |
|---|---|
| **Provincial Respondents:** | |
| 1. Mrs N. Sodlula: | DOH Director Mother and Child Health and Integrated Nutrition Programme |
| 2. Mrs N. Kama: | DOH Deputy Director Integrated Nutrition Programme |
| 3. Ms N. Nkalitshana: | DSD ECD Manager |
| 4. Mr Nkatsha: | DSD Social Work Manager |
| 5. Mr C. Maleki: | DSD Sustainable Livelihoods Manager |
| 6. Mr A. Sonandi: | DRDAR Food Security Manager |
| 7. Mr F. Hobson: | DRDAR Senior Manager Implementation and Management |
| 8. Mr M. Rasmussen | SASSA General Manager Grants Administration |
| **District Respondents:** | |
| 9. Mrs. N. Kizza | DOH District Manager |
| 10. Mrs. F.F. Konzeka | DOH District Clinical Specialist |
| 11. Ms. B Babalwa | DOH INP Sub-district Manager |
| 12. Mrs. L. Ntsibande | DOH Community Liaison Officer |
| 13. Mrs. N.N. Mosholele | DOH Specialist Auxiliary Services Manager |
| 14. MS. Dawethi | DSD Social Work Manager |
| 15. Mr. Makhalane | DSD Community Development Manager |
| 16. Mr. A. Zono | DRDAR Regional Director Food Security |
| 17. Mr. Ndaba | DRDAR Food Security Manager |
| 18. Mr. Ndikolo | DRDAR Assistant Food Security Manager |
| 19. Ms. L. Golimpo | DOH INP Sub-district Manager |
| 20. Ms. N. Majova | DOH Nutrition Coordinator |
| 21. Mr. Dondolo | DRDAR Assistant Manager: Extensions Advisory and Coordinator of Food Security Programme |
| 22. Ms. N. Titus: | DSD District Senior Manager |
| 23. Ms. N. Sawula: | DSD Community Development Manager |
| **Facility Respondents:** | |
| 24. Sister N. Plaaitjie: | Mzintlava Clinic Operations Manager |
| 25. Sister E.N. Meza | Mzintlava Clinic Professional Nurse |
| 26. Sister N. Deyi | Lusikisiki Village Clinic Acting Operations Manager |
| 27. Sister E.N. Sodinga | Port St. Johns CHC Operations Manager Outreach Programmes and Under 5 |
| 28. Sister N. Badula | Nkanunu Clinic Matron |
| 29. Sister L. Khave | Mahlubini Clinic Sister in Charge |
| 30. Ms. M. Duqumana | Mahlubini Clinic Assistant Nurse |
| 31. Sister R. van der Waal | Middelburg Operations Manager |
| 32. Sister N. Nene | Philani Clinic Professional Nurse-under 5 |
| 33. Sister A. Koti | Philani Clinic Professional Nurse-ANC |
| 34. Sister VM Sisilana | Tsitsikama Clinic Operations Manager |
| 35. Sister NP Cwala | Tsitsikama Clinic Professional Nurse |
| 36. Ms.VI Kashe | Tsitsikama Clinic Assistant Nurse |
| **NGO Respondents:** | |
| 37. Mrs. S. Gouws | Zithulele Mentor Mothers (Philani NGO-Non PEPFA Funded) Project Manager |
| 38. Mrs N. Fono: | Sivumile ECD Center Principal |
| 39. Ms. Thema: | Sivumile ECD Center Teacher |
| 40. Mr. M. Maqhanqa: | Mzimvubu Nursery and Home Gardening Project Manager |
| 41. Professional Nurse (declined to give name) | Nomonde Clinic Africare (PEPFA Funded NGO) supported |
| 42. Assistant Nurse (declined to give name) | Nomonde Clinic Africare (PEPFA Funded NGO) supported |

# APPENDIX E DOCUMENTS CONSULTED


- Eastern Cape, Department of Social Development. Socio Economic and Demographic Profile, Vol 3, 2010 (Page 20)
- Africare website: http://www.africare.org
- Budget Speech 2013/14, Eastern Cape Province. *Policy Speech by Hon MEC for Social Development and Special Programmes, Dr. Pemmy Majodina In the Provincial Legislature*. 27 March 2013. http://www.gov.za/speeches/2013/EC_social_development.pdf
- Copy of DSD Sustainable Livelihoods Budget Allocation 2012/13
- DOH MCWH & INP, DSD and DRDAR Organograms
- DOH Nutrition Staff Appointed 2013/Nutritionist Vacant Post 2011
- DOH Road to Health Booklet for Boys and Girls
- DOH. Integrated Nutrition Programme – Broad Guidelines for Implementation. March 2000. http://www.doh.gov.za/docs/policy/norms/part2c.html
- Donald Woods Foundation website: www.donaldwoodsfoundation.org
- Eastern Cape Department of Agriculture: Organogram Approved in March 2009
- Eastern Cape DOH Operational Plan for MCWH & INP 2012-13
- Eastern Cape Integrated Anti-Poverty Strategy and Implementation Plan
- Eastern Cape Integrated Anti-Poverty and Implementation Plan, Final Draft April 2012
- Eastern Cape. Department of Agriculture and Rural Development. *Annual Performance Plan 2013/2014.* http://www.agr.ecprov.gov.za/modules/documents/download_doc.php?id=218
- EC-DOH. *Annual Performance Plan for 2012/13 – Part A - STRATEGIC OVERVIEW.* http://www.EC-DOH.gov.za/EC-DOH/policies_and_legislation/319/Annual_Performance_Plan_201213201415_Part_A
- EC-DOH. *Annual Performance Plan for 2012/13 – Part C (Programme 2: District Health Services).* http://www.EC-DOH.gov.za/EC-DOH/policies_and_legislation/321/Annual_Performance_Plan_201213201415_Part_C
- EC-DOH Visio Diagram on Directorate Organogram.
- HACCO website: http://haccoorg.com/
- Integrated Food Security Strategy Implementation Plan 2013-2017
- Mercedes de Onis, Monika Blossner, and Elaine Borghi. *Prevalence and trends of stunting among pre-school children,1990–2020*. Public Health Nutrition. 2011. doi:10.1017/S1368980011001315. http://www.who.int/nutgrowthdb/publications/Stunting1990_2011.pdf
- Nutrition booklets for mothers and babies
- Philani website: www.philani.org.za
- Resolutions Food Security Planning Sessions , 12 Mar 2013
- SASSA Close Up Report: SRD Zero Hunger Project Report On DSD Month 2012

- Small Projects Foundation: http://www.spf.org.za/
- Strategic Plan for Maternal for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa
- Treatment Action Campaign website: http://www.tac.org.za/community/node/2354
- The Department of Local Government Traditional Affairs (DLGTA), Department of Roads and Public Works (DRPW), and Department of Education (DOE)
- Towards Integrated Planning for Provincial Integrated Anti-Poverty Strategy & Implementation Plan, Concept Document, 1 November 2012, East London.
- UNICEF. *Levels & Trends in Child Mortality. Report 2011*. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf.