



**Khulisa Management Services (Pty) Ltd**

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## **FOOD ACCESS**

### **Case Study Report**

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

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South Africa Department of Performance Monitoring and Evaluation (DPME)

Nutrition SLA 12/0287

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## LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
BANC	Basic Antenatal Care
CBO	Community Based Organisation
CCG	Community-based Care Givers
CD	Community Development
CNDCs	Community Nutritional Development Centres
KZN-DAEA	KZN Department of Agriculture and Environmental Affairs
DAFF	National Department of Agriculture, Forestry, and Fisheries
FS-DARD	Free State Department of Agriculture and Rural Development
DIS	District Information System
DOH	Department of Health
DPME	Department of Performance Monitoring and Evaluation
EC-DRDAR	Eastern Cape Department of Rural Development and Agrarian Reform
DSD	Department of Social Development
EC	Eastern Cape
ECD	Early Childhood Development
FBSA	Food Bank of South Africa
FS	Free State
HCBC	Home and Community based Care
HIV	Human Immunodeficiency Virus
HR	Human Resources
IDP	Integrated Development Plan
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
INP	Integrated Nutrition Programme
INS	Integrated Nutrition Strategy
IYCF	Infant and Young Child Feeding
KFC	Kentucky Fried Chicken
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
MEC	Member of the Executive Committee
MTEF	Medium Term Expenditure Framework
MUAC	Mid-Upper Arm Circumference
NDA	National Development Agency
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
ORS	Oral Rehydration Salts
OSS	Operations Sukuma Sakhe
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care



PLWHAs	People Living With HIV/AIDS
PPP	Private Public Partnership
SAG	South African Government
SANHANES	South Africa National Health and Nutrition Examination Survey
SASOL	South Africa Synthetic Oil Liquid
SASSA	South African Social Security Agency
SAW	Social Auxiliary Workers
SP	Special Programmes
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
WC	Western Cape
ZAR	South African Rands

## GLOSSARY

<b>Ante-natal</b>	Before birth; during or relating to pregnancy
<b>Basic Antenatal Care (BANC)</b>	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.
<b>Beneficiaries</b>	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.
<b>Breast milk substitute</b>	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.
<b>Breastfeeding Protection, Promotion and Support.</b>	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.
<b>Complementary Feeding</b>	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.
<b>ECD food support</b>	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.
<b>Exclusive Breastfeeding</b>	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." <sup>1</sup> 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. 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.
<b>Food Access</b>	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.

<sup>1</sup> WHO. Accessed in January 2014. [http://www.who.int/elena/titles/exclusive\\_breastfeeding/en/](http://www.who.int/elena/titles/exclusive_breastfeeding/en/).

<b>Food Fortification</b>	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.
<b>Food prices/zero-VAT rating</b>	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
<b>Food Security (output 2 of Outcome 7)</b>	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).
<b>Growth Monitoring and Promotion (GMP)</b>	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.
<b>Household Food Production and Preservation</b>	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.
<b>IMCI (Integrated Management of Childhood Illnesses)</b>	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.
<b>Improved Hygiene Practice</b>	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.



<b>Indicator</b>	A monitoring and evaluation term for an objectively verifiable measurement which reflects the activity; assumption, or effect being measured.
<b>International Code of Marketing of Breast Milk Substitutes</b>	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.
<b>Intra-partum</b>	During childbirth or during delivery.
<b>Lactation</b>	The secretion or production of milk by mammary glands in female mammals after giving birth
<b>Mainstreaming Interventions</b>	Mainstreaming an intervention involves planned action, including legislation, policies or programmes, in any area and at all levels <sup>2</sup> . 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 <sup>3</sup> . 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 <sup>2</sup> .
<b>Malnutrition</b>	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.
<b>Management of Moderate Malnutrition</b>	See Targeted Supplementary Feeding.
<b>Management of Severe Malnutrition</b>	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.
<b>Micronutrient deficiency</b>	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.
<b>Micronutrient supplementation</b>	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.

<sup>2</sup> Anon. International Labour Organization (ILO). 2013.

<http://www.ilo.org/public/english/bureau/gender/newsite2002/about/defin.htm>

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



<b>Mixed Feeding</b>	Feeding breast milk along with infant formula, baby food and even water.
<b>Moderate malnutrition</b>	A growth measure between minus two (-2) and minus three (-3) standard deviations from the median of the standard reference population.
<b>Morbidity</b>	Refers to the state of being diseased or unhealthy within a population.
<b>Mortality</b>	Refers to the number of deaths in a population.
<b>Nutrition</b>	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.
<b>Nutrition Education and Counseling</b>	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.
<b>Obesogenic</b>	Causing and leading to obesity.
<b>ORS (Oral Rehydration Salts)</b>	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.
<b>Over nutrition</b>	A form of malnutrition which occurs if a person consumes too many kilojoules.
<b>Overweight</b>	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.
<b>PHC Re-engineering</b>	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.
<b>Post-partum</b>	After childbirth.
<b>Prioritised Nutrition Interventions</b>	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.
<b>Regulations</b>	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.
<b>Sanitation</b>	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.

<b>Severe acute malnutrition</b>	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 <sup>4</sup> .
<b>Stunting</b>	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.
<b>Supplementary feeding</b>	Additional foods provided to vulnerable groups, including moderately malnourished children.
<b>Targeted Supplementary Feeding (TSF)</b>	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.
<b>Under nutrition</b>	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).
<b>Underweight</b>	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.
<b>Wasting</b>	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).
<b>Zinc</b>	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.

<sup>4</sup> 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 frequent infections and intake of low nutrient or energy dense diets, consisting predominantly of starch-rich staples. Linear growth (i.e. height) and brain development are especially rapid during the pregnancy and the first 2 years of life. 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 children under the age of five and pregnant women.

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<sup>1</sup> (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)<sup>2</sup> 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).

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 children under the age of 5 and pregnant women.

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**

<b>Nutrition Intervention</b> (NB: the first four interventions (bolded) are the main focus of the evaluation)	<b>Responsible Department</b>
<b>1. Breastfeeding support*</b>	Health
<b>2. Management of moderate malnutrition including Targeted Supplementary Feeding*</b>	Health
<b>3. Household food production and preservation (home gardening)</b>	DAFF
<b>4. Food access (e.g. food parcels, soup kitchens)</b>	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. Micronutrients 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

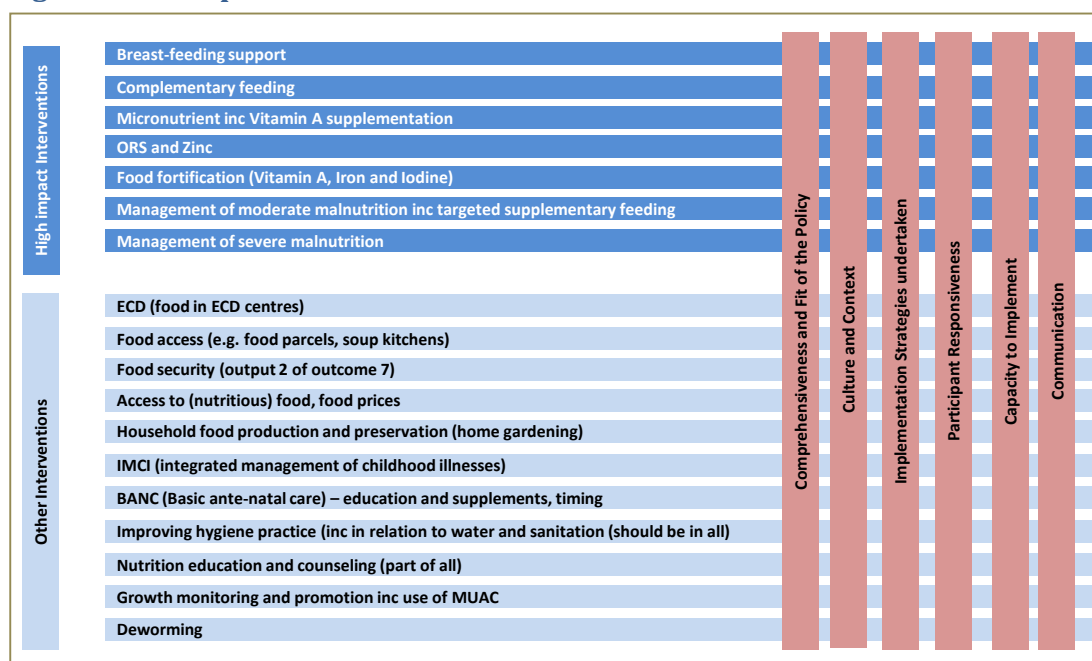
## 1.3 Approach / Methodology

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**

### 1.3.1 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, Columbia, 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, Columbia, 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.

### 1.3.2 FIELDWORK

Data collection then took place at national level and in four provinces (Western Cape, Eastern Cape, Free State, and KwaZulu-Natal). At national level, Key Informant Interviews were held with relevant national government managers as well as with representatives from international NGOs, donor organisations, and private food companies. In each province, Key Informant Interviews were held with relevant provincial managers in the Departments of Health, Agriculture, and Social Development, as well as with representatives from 3 NGOs and 1 ECD centre in each province.

Two districts were purposefully selected in each province and Key Informant Interviews were held with relevant district managers in the Departments of Health, Agriculture, and Social Development. Within each district, 4 health facilities were randomly selected for fieldwork and staff were interviewed. In addition, in each health facility, we also conducted focus group discussions (FGDs) with beneficiaries, rapid assessments of nurses' nutrition knowledge, and rapid assessments of the health facilities' equipment, supplies, and guidelines.

**Figure 2: Main Data Collection Components of the Evaluation**

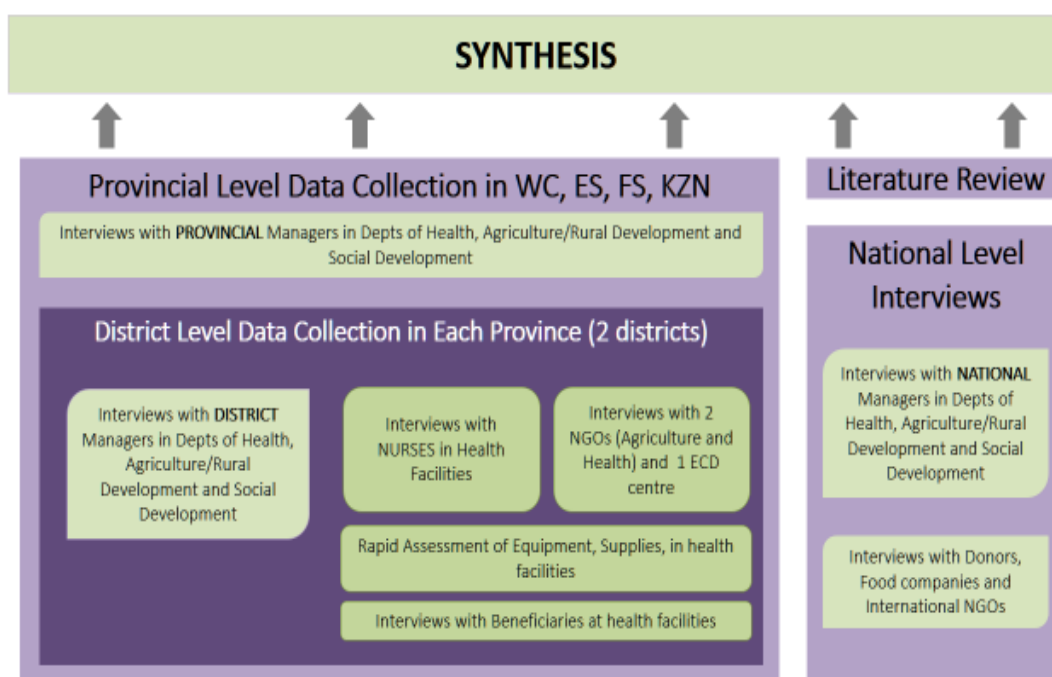
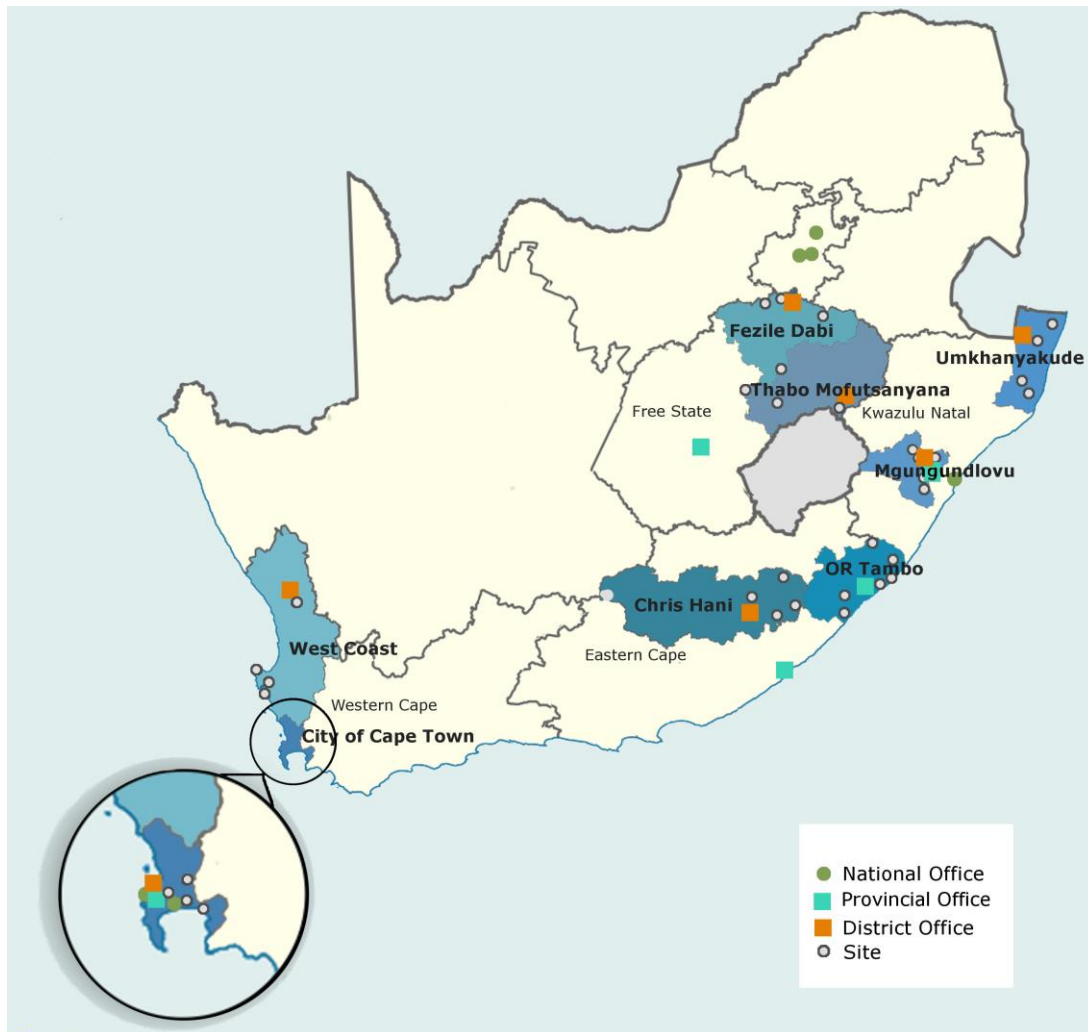


Table 2 presents a summary of planned and actual data collection, and Figure 3 presents a map of data collection sites.

**Table 2: Fieldwork Conducted**

Data Collection Method and Stakeholders Group	No. of Interviews / FGDs		
	Planned	Actual	Response Rate %
<b>Individual or Group Interviews</b>			
National Government Managers	4	5	125%
Representatives of International NGOs	4	4	100%
Donors	3	4	133%
Private Food Companies	4	4	100%
Provincial Government Managers	12	15	125%
District Government Managers	24	21	88%
Health Workers in Health Facilities	32	31	97%
Local NGO	8	8	100%
ECD Centre	4	5	125%
<b>Focus Group Discussions</b>			
Beneficiaries FGDs at health services and community projects	48	40	83%
<b>Other Assessments</b>			
Health Facilities Rapid Assessments	40	36	90%
Rapid Assessment of Nurses' Nutrition Knowledge	76	132	174%



**Figure 3: Fieldwork Locations**

Case Study reports were prepared for each of the four provinces where fieldwork took place, as well as each of the four priority interventions. In all, 11 reports were 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



## 1.4 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, particularly in the WC. Consequently, many respondents gave only cursory information around the issues that we sought to explore more deeply.

Because the INP's nutrition interventions for 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. As a result, 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 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.

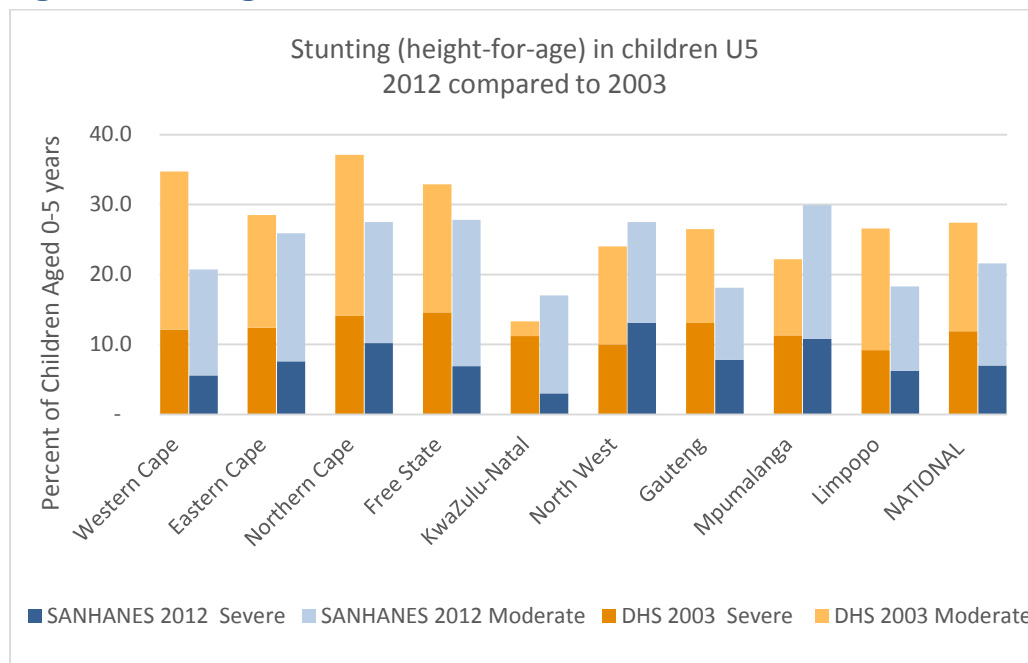
A detailed description of the methodology used in the evaluation is found in Appendix B to this report.

## 2 BACKGROUND

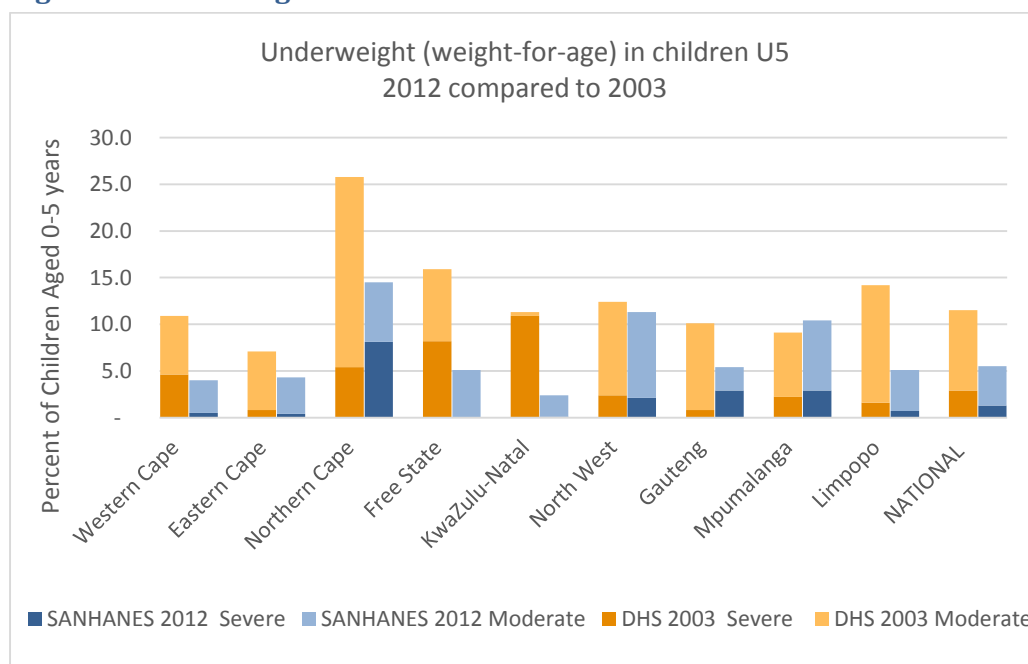
### 2.1 Nutritional Status of Young Children in South Africa

Presently, more than 20% of children under 5 years of age are stunted in South Africa, and 5% are underweight, although both rates have declined since 2003. Provincial differences are evident (Figure 4 and Figure 5) and in some provinces (KZN, NW, MP) the prevalence of stunting has actually increased since 2003.

**Figure 4: Stunting Prevalence in children U5 - 2003 and 2012**

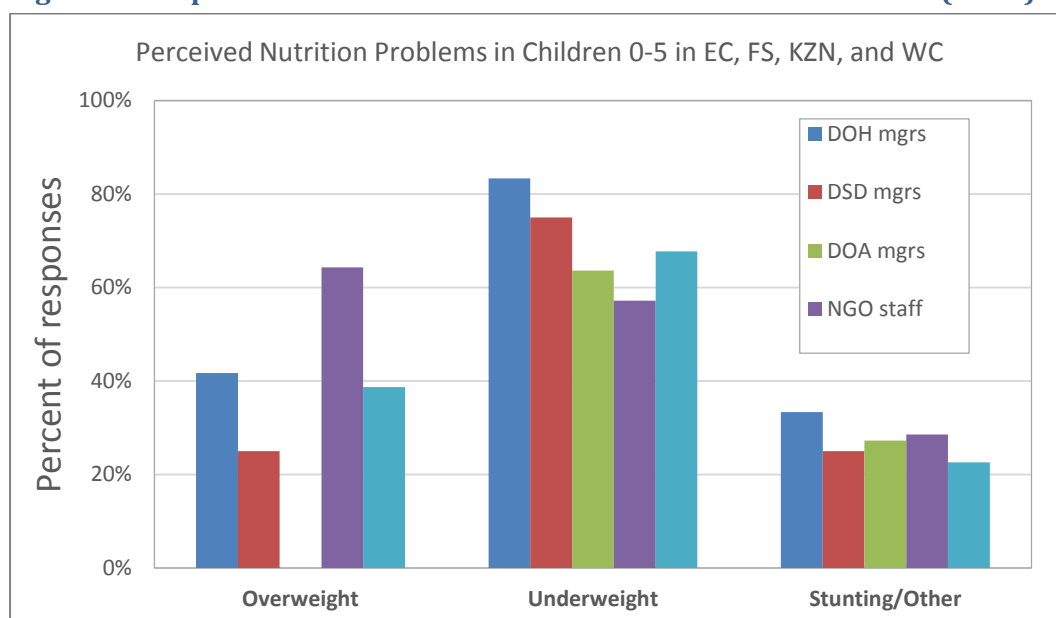


**Figure 5: Underweight Prevalence in children U5 - 2003 and 2012**



In contrast to the situation described above, most of the evaluation respondents perceive underweight to be the most common nutrition problem (Figure 6), with only a minority recognising stunting as a widespread nutrition problem, and few recognise overweight as an issue. The lack of awareness of stunting as a broad nutrition issue affects government programming and implementation of nutrition interventions.

**Figure 6: Respondents' Perceived Nutrition Problems in Children U5 (N=99)**



## 2.2 Food Access in South Africa

Food access can be defined as “the ability of a nation and its households to acquire sufficient food on a sustainable basis”<sup>3 4 5</sup>. Food access speaks to issues surrounding entitlement to food, purchasing power and consumption behaviour. It also plays to cultural issues, “where women usually are the last ones served”<sup>5</sup>, which are crucial in terms of nutrition interventions specifically targeting pregnant women.

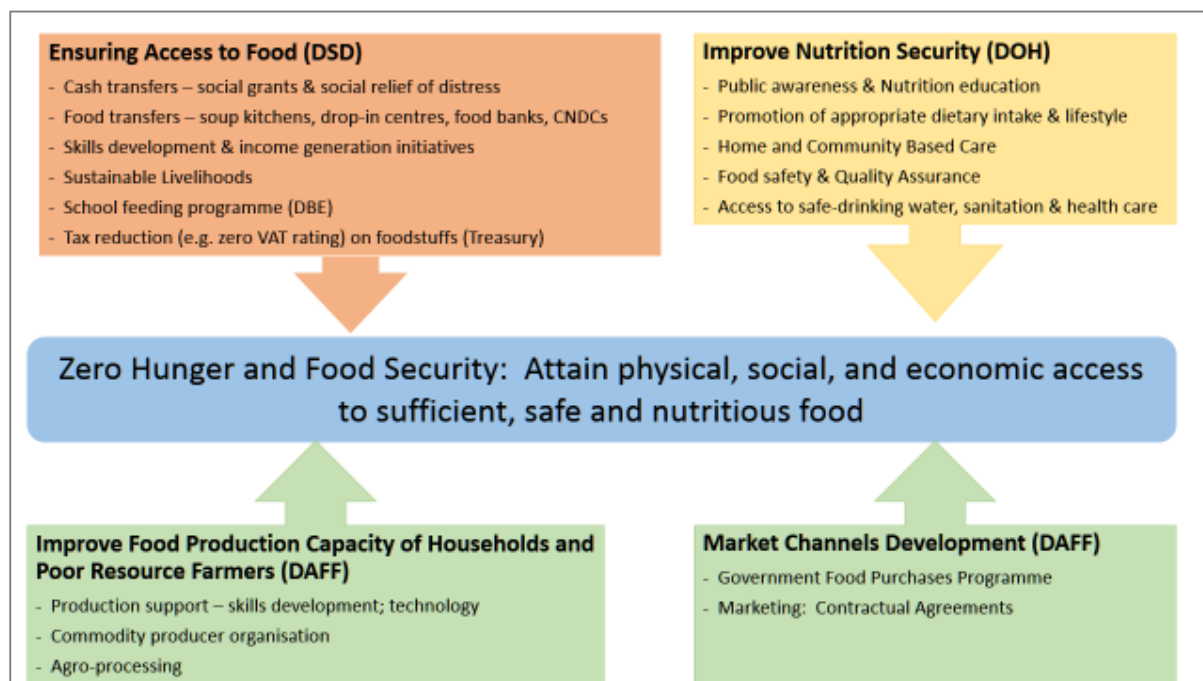
“Access to food” is fundamental to South Africa’s social safety net, and is one of the elements that contributes to South Africa’s Zero Hunger and Food Security Strategies (Figure 7).

DSD’s implementation of Food Access comprises three different interventions:

1. Cash transfers through various social grants and food vouchers;
2. Food support through supplemental feeding for at-risk groups (food parcels, soup kitchens) and support to ECD centres; and
3. Household/Community Gardens through its Sustainable Livelihoods programme.

In this report we focus on (2) Food Support with a special focus on children under the age of 5 and pregnant women.

Food access is fundamental to South Africa’s Framework for Comprehensive Social Protection that defines minimum acceptable living standards for all citizens, of which the “right to food” is part<sup>4</sup>. Moreover, South Africa is one of the few countries in the world that has this as part of its Constitution<sup>6</sup>.

**Figure 7: Logic Model for South Africa's Zero Hunger Strategy <sup>7</sup>**

Despite numerous poverty alleviation policies and programmes in South Africa since 1994, there are still high levels of hunger, poverty, reliance on social grants, unemployment and decrease in food production. The recent South African National Health and Examination Survey (SANHANES)<sup>8</sup> on hunger, food security, and nutrition found that overall, less than half the South African population is food secure (45.6%), while 28.3% were at risk of food insecurity and 26.0% were food insecure. The rate of hunger is lowest in Western Cape (16.4% of households) and Gauteng (19.2%), and highest in the Eastern Cape (more than 30%).

In 2009, the DSD introduced its “*Food for All*” initiative to acquire and distribute basic foods at affordable prices to poor households and communities as the department’s contribution to the country’s Zero Hunger Framework. The goal of *Food for All* is “to attain physical, social and economic access to sufficient, safe and nutritious food for food insecure South Africans at all times to meet their specific needs for an active and a healthy lifestyle”<sup>9</sup>. The *Food for All* campaign objectives include<sup>10</sup>:

- Ensuring access to food for the poor and vulnerable members of society
- Improving nutrition security of citizens
- Improving food production capacity of households
- Developing market channels through bulk government procurement of food, and
- Fostering partnerships with relevant stakeholders within the food supply chain

The *Food for All* campaign also aims to have an economic influence.

*“The aspect of capacity building was brought into the theme, as social welfare cycles needed to be evolutionary. The government could not provide families with social assistance for ever, but with empowerment and tools to develop self-sustainability the once vulnerable could build a new life for themselves. The cycle of supply and demand for food production in the country could stimulate the economy in itself.”<sup>10</sup>*

In pursuit of these goals and objectives, DSD delivers different forms of Food Access interventions – Food Parcels, Monetary Food Vouchers, Soup Kitchens, Sustainable Livelihoods Interventions<sup>11</sup>, and support to ECD Centres for meals – each of which are delivered independently from each other (i.e. not integrated).

In this evaluation, an overall scarcity of programme documentation regarding the DSD's Food Access interventions, particularly food parcels and soup kitchens, made it difficult to evaluate the sufficiency of implementation, although information on food support to ECD centres was more readily available.

### 3 FOOD ACCESS – THEORY OF CHANGE

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#### 3.1 What is to be Delivered and How?

##### 3.1.1 FOOD PARCELS

Food Parcels are a short-term response to provide immediate relief to households in conjunction with medium and long-term interventions that create conditions conducive to improving food and nutrition security. The South African Social Security Agency (SASSA) provides food parcels to people in distress for 3-6 months. These parcels are supposed to be comprised of basic staple foods that are high in nutritional content. Beneficiaries are identified through standardised eligibility criteria by DSD or other departments (e.g. DAFF and DOH staff), as well community leaders. Food parcels are then distributed monthly to the beneficiaries until alternate medium-term interventions are successfully introduced to render the beneficiaries self-sufficient, sustainable and not dependent on food relief.

##### 3.1.2 MONETARY FOOD VOUCHERS

As well as Food Parcels, the DSD/SASSA provides Food Vouchers for social relief. DSD prefers to give vouchers (rather than food parcels) in order to empower people to make their own choices and decisions, and to eliminate many of the logistical issues around food parcels (procurement, storage, distribution, security)<sup>12</sup>.

*“Food parcels require additional capacity, the food expires, management of the food cannot be controlled, and they are difficult to store. Human capacity is needed to sort the food, carry it, manage it, pack it, making it very intensive. Money is therefore the preferred choice to provide for people in need.”<sup>13</sup>*

Food vouchers are given either in actual monetary form, as "gift" cards for supermarkets, or as debit cards loaded with a total of ZAR3,400 for 3 months' worth of food, except in KZN where food vouchers are valued at ZAR3,000 for 3 months. The card is given with an ID and pin, and is thought to give people a sense of dignity by giving them the choice of what to buy and when, ensuring that food doesn't go to waste. Much like South Africa's social grants, the vouchers can be accessed through cashpoints, ATMs or Merchants. There is no specification as to how the voucher is used, although it is supposed to be for food.

In order to limit abuse of the vouchers, DSD has a list of accessible grocery stores where the food vouchers can be used, and they have developed a guide on nutritious and sustaining foods that can be purchased.

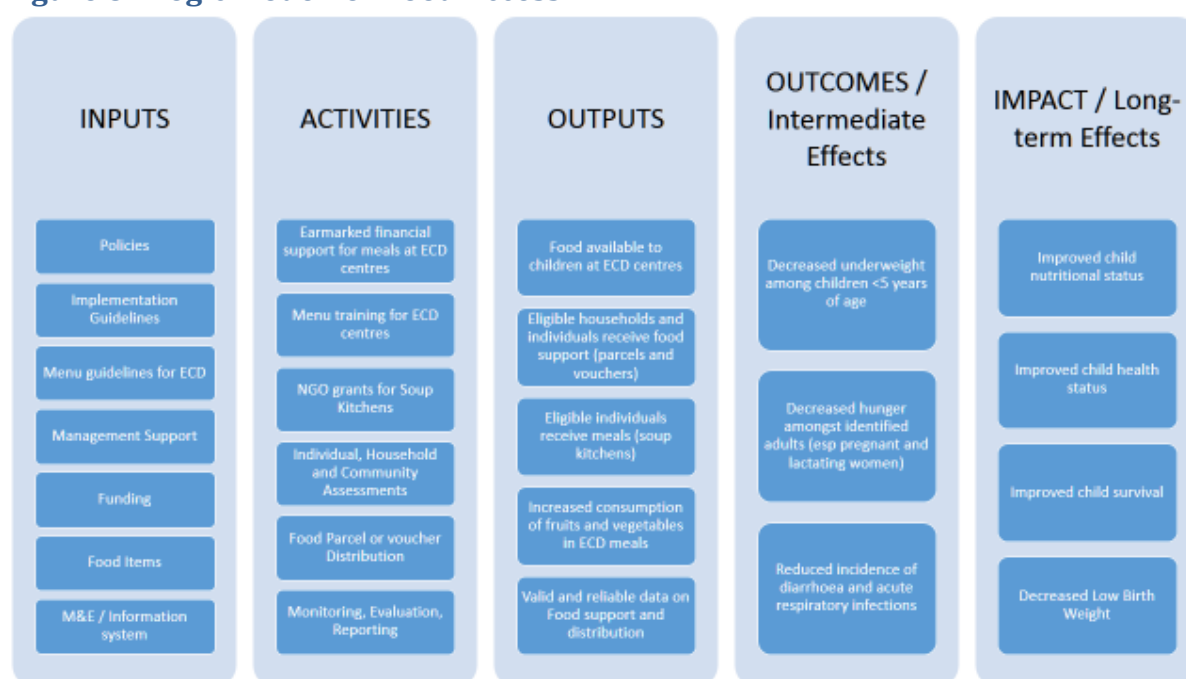
### 3.1.3 SOUP KITCHENS

Soup Kitchens are a third short-term intervention to address food insecurity. DSD partners with Home and Community based Care organisations (HCBCs) to establish soup kitchens for vulnerable children, youth, and adults who are malnourished and/or affected by HIV, AIDS, or TB. Ideally, a soup kitchen provides a nutritious meal that consists of meat, vegetables and salads.

### 3.1.4 ECD SUPPORT

In relation to children under 5 years of age, 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 also provides guidance on meal plans for ECD centres, and these are meant to guide the centres and DSD in assuring nutritious meals for children.

**Figure 8 - Logic Model for Food Access**



## 3.2 Intended Recipients

Except for the ECD programme support, the intended recipients for all food access programmes are all vulnerable members of society, i.e. the destitute, those living below the poverty line, or those who fall within the category of “hungry”. There are no nutrition-related targeting criteria for any of the Food Access programmes. Rather the criteria for identifying beneficiaries is poverty and “hunger” as shown in Table 3. Beneficiaries of food access interventions include children under 5 years of age, pregnant women, child headed households, and people living with HIV and AIDS and TB, elderly, and persons living with disabilities.

Recipients of Food Parcels and Soup Kitchens are also NGOs who then distribute the food to their beneficiaries. Examples of NGOs include orphanages, crèches, old age homes, shelters for abused women and children, soup kitchens and HIV and AIDS clinics. In the EC, Soup Kitchens are primarily for HIV and AIDS programmes, rather than malnourished mothers or children.

**Table 3: Illustrative Questions on Food Insecurity and Child Hunger in Household Profiling<sup>14</sup>**

<p><b>Household-level food insecurity</b></p> <ul style="list-style-type: none"> <li>– Does your household ever run out of money to buy food?</li> <li>– Do you ever rely on a limited number of foods to feed your children because you are running out of money to buy food for a meal?</li> <li>– Do you ever cut the size of meals or skip meals because there is not enough money for food?</li> </ul> <p><b>Individual-level food insecurity</b></p> <ul style="list-style-type: none"> <li>– Do you ever eat less than you should because there is not enough money for food?</li> </ul> <p><b>Child hunger</b></p> <ul style="list-style-type: none"> <li>– Do your children ever eat less than you feel they should because there is not enough money?</li> <li>– Do your children ever say they are hungry because there is not enough food in the house?</li> <li>– Do you ever cut the size of your children's meals or do they ever skip meals because there is not enough money to buy food?</li> <li>– Do any of your children ever go to bed because there is not enough money to buy food?</li> </ul>
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The primary recipients of ECD support are registered ECD centres who are meant to use a portion of the DSD subsidy to purchase healthy food for the young children (0-5 years of age) in their centres.

### 3.3 Intended Changes in Beneficiaries' Behaviour

*"Food availability and access by themselves (do) not translate into a well-nourished population; hence nutrition awareness and education coupled with socio-economic programmes are integral to the improved health status of the South African population. Awareness moves the individual from lack of interest and ignorance to an increased appreciation and finally to action."* <sup>6</sup>

The DSD's Food Access interventions are not designed to change nutrition or food-related behaviour; rather they aim to create changes in a person's wellbeing through the following outcomes:

- Increase food intake
- Decrease the number of individuals that are hungry due to the unavailability of adequate quantity of food

Food Vouchers are also intended to empower beneficiaries to utilise their money in the best possible way to receive nutritious foods, without placing restrictions on what food should be purchased or eaten. The vouchers are intended to also teach beneficiaries about the value and use of money, while also ensuring that they do not go hungry.

### 3.4 The Impact Sought

Overall the impact sought for all the Food Access interventions is to reduce hunger and malnutrition in the vulnerable populations in South Africa.

## 4 POLICY FIT FOR THE LOCAL CONTEXT

Various policies, strategies, guidelines were highlighted during fieldwork and during the review of literature as guiding the implementation of Food Access interventions:



**Table 4: Laws, Policies, and Strategies Relevant to Food Access**

Year	Responsible Department	Law, Policy, Strategy
<b>Legislation</b>		
2010	DSD	The Social Assistance Amendment Act (2010) <sup>15</sup>
2008	DSD	The Social Assistance Amendment Act (2008) <sup>16</sup>
2007	n/a	Children's Amendment Act <sup>17</sup>
2006	n/a	Older Person's Act <sup>18</sup>
2005	n/a	Children's Act <sup>19</sup>
2004	DSD	The Social Assistance Act <sup>20</sup>
1996	n/a	Section 27 of Chapter 2 (Bill of Rights of RSA Constitution of 1996:13)
<b>Policies</b>		
2013	DAFF / DSD	National Policy on Food and Nutrition (in process) <sup>21</sup>
2012	DSD	Social Service Professions Policy (in process)
<b>Strategies</b>		
2002	DAFF	Integrated Food Security Strategy (IFSS) <sup>22</sup>
<b>Guidelines</b>		
2010	DOH	Healthy eating for preschool children <sup>23</sup>
2006	DSD	Guidelines for ECD services (including nutrition and menu guidelines) <sup>24</sup>
No date	DSD/SASSA	The Social Relief Guidelines
<b>Special Programmes</b>		
2011	DSD	Food for All Campaign <sup>10</sup>
No date	Treasury/SARS	Tax exemption for food stuffs
No date	DAFF	Zero Hunger
No date	DSD	Sustainable Livelihoods programme

## 4.1 Institutional Context and Culture

DSD staff at district and local levels (mainly DSD Social Workers) are largely focused on diagnosing hunger and vulnerability and identifying potential recipients of Food Access interventions. The delivery of the Food Access interventions, however, is largely through NGOs, although in some communities DSD staff themselves deliver food parcels and other Food Access and social welfare support directly to households and communities. Some respondents in this evaluation noted that food parcels can also be given at soup kitchens.

Food Banks are used as a mechanism to support delivery of food to poor households, particularly in the processes of procurement, storage, and distribution. DSD has partnered with the Food Bank of South Africa (FBSA), the main coordinator of food banks in South Africa, to organize and establish food banks in communities with the highest concentration of food insecurity, with the aim of eliminating hunger and food insecurity specifically for:

- Child and Youth Development (pre-schools, foster care, shelters for orphans and vulnerable children and school feeding schemes);
- Adult Development (nutritional feeding centres and soup kitchens serving unemployed persons, HIV-infected persons and pregnant women); and
- Social Welfare (aged care, disabled care and care for the terminally ill)<sup>25</sup>.

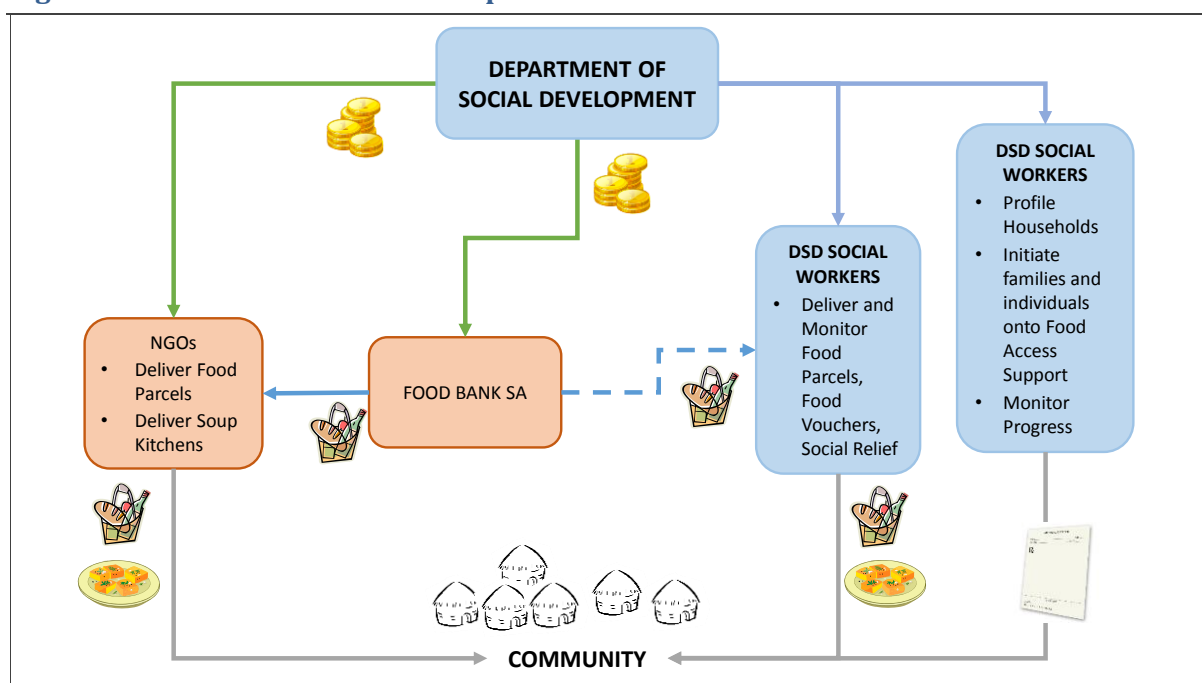
FBSA secures food and essential non-food groceries from producers, manufacturers, retailers, government agencies, individuals and other organisations. After removing branding from all donated products, FBSA stores them in warehouses and then dispatches them (daily) to its large



networks of NGOs based throughout South Africa. FBSA attains significant economies of scale, enabling it to source and distribute very high volumes of food at a significantly lower cost than other entities. DSD's Annual Report for 2011/2012 reports that ZAR 5 million was allocated to the Food Bank in March 2012<sup>26</sup>.

Community-based NGOs receive (or purchase) food products which they cook and serve to beneficiaries. Food products are received mostly from the DSD, other NGOs, FBSA and corporate donations. The amount of food products received varies, but on average soup kitchens provide 3 meals per beneficiary per week. In the WC, the Community Development Directorate finances community-based NPOs to distribute food parcels (as part of social relief) to the vulnerable and needy, and to operate community nutritional development centres (CNDs). This aims to provide nutritional support services to children (and their families) who are almost on the verge of being malnourished and/or facing growth faltering (i.e. falling outside the DOH's Nutritional Therapeutic Programme) as well as those do not qualify for Social Relief of Disaster support from SASSA.

**Figure 9: Process of Food Access Implementation**



In terms of leadership, across the four provinces, most DSD respondents considered leadership sufficient for Food Access interventions although each province noted something distinct. In EC, the DSD's Special Programmes (DSD-SP) was appointed as the champion and lead department for coordinating the province's Integrated Food Security and Nutrition Strategy. In both KZN and FS, DSD was said to have a clear vision and commitment to implementing nutrition/food access interventions. FS also indicated adequate leadership for addressing key nutrition and food challenges in the province, as evidenced by a directive from the premier's office to promote food gardens, improve household food security and establish ECDs.

Planning is inconsistent across the four provinces. In KZN, DSD has department-wide operational plans and directorate-specific plans that detail food access interventions as part of their service package. In FS, DSD's Annual Performance Plan (APP) contains little detail on Food Access budgets or targets. In WC, DSD's APP contains indicators and targets for ECD support (of which nutrition is

one component) and for targeted feeding schemes; however, there is no detailed financial information which unpacks this specifically for nutrition-related interventions.

## 4.2 Resource Allocation – Financial and HR

### 4.2.1 FINANCIAL RESOURCES

Most respondents across the four provinces considered financial resources to be generally adequate, except for financial resources for ECD. In EC, funding for ECD is only sufficient to reach a small portion of the eligible pre-school population. *“The children population in the province is estimated at around 600,000 and the department is only subsidising 57,000 children”*, said one EC respondent. Indeed, in 2012, the population of children aged 0-4 in South Africa was an estimated 10.9 million<sup>27</sup>, but the number of children attending registered ECD centres was less than 10% of this – only 789,000 (Table 5) excluding Grade R.

**Table 5: ECD enrolment** <sup>28</sup>

	EC	FS	KZN	WC
<b>No. of registered ECD centres in 2011</b>	2 911	2 979	3 167	1 417
<b>No. of children enrolled in registered ECD centres in 2011</b>	82 336	97 031	123 545	95 060
<b>No. and % of children enrolled who receive the ECD subsidy in 2011</b>	75 880	42 969	70 815	68 865
	<b>92%</b>	<b>44%</b>	<b>57%</b>	<b>72%</b>

The portion of the ECD subsidy allocated to food reportedly varies across provinces – in EC it is R6.00 per child per day, whereas in FS it is R7.00, and in KZN, R7.50. There is no monitoring on whether the money allocated for food is being used correctly (i.e. whether ECD Centres are spending the allowance for food on nutritious food).

During fieldwork, respondents provided different monetary values to the food parcels across the provinces. In KZN, the parcel's value was noted as ZAR 450, whereas in the EC, it was reportedly valued at ZAR1260 for adults and ZAR290 for children. However, these monetary values do not reflect the same time periods or numbers of people to be reached.

### 4.2.2 HUMAN RESOURCES

Respondents broadly cited human resources constraints as limiting implementation, particularly vacant positions and inadequate training of those currently delivering and monitoring Food Access interventions and ECD support. Indeed, South Africa is reportedly short of 77,000 Social Workers<sup>29</sup> at all levels.

KZN-DSD is troubled by a lack of permanent staff, specifically at head office and at district level where several managers are serving in acting capacities. At head office, one manager is temporarily seconded from the Ulundi Cluster Office, and still lives in temporary accommodation because of the tentative nature of her position, and this reportedly affects implementation. Also in KZN, there is a shortage of data capturers at ward level to capture all the relevant data which is currently collected by the Social Work Coordinators.

The FS provincial DSD also reports inadequate staff especially with skills and expertise on food and nutrition. Their current complement of 3 full-time social workers who are responsible for implementing the sustainable livelihoods, social relief, and the community development programmes have only undergone informal training on food and nutrition.



In EC, HR for Food Access interventions are reportedly inadequate for rural areas. For example, 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.

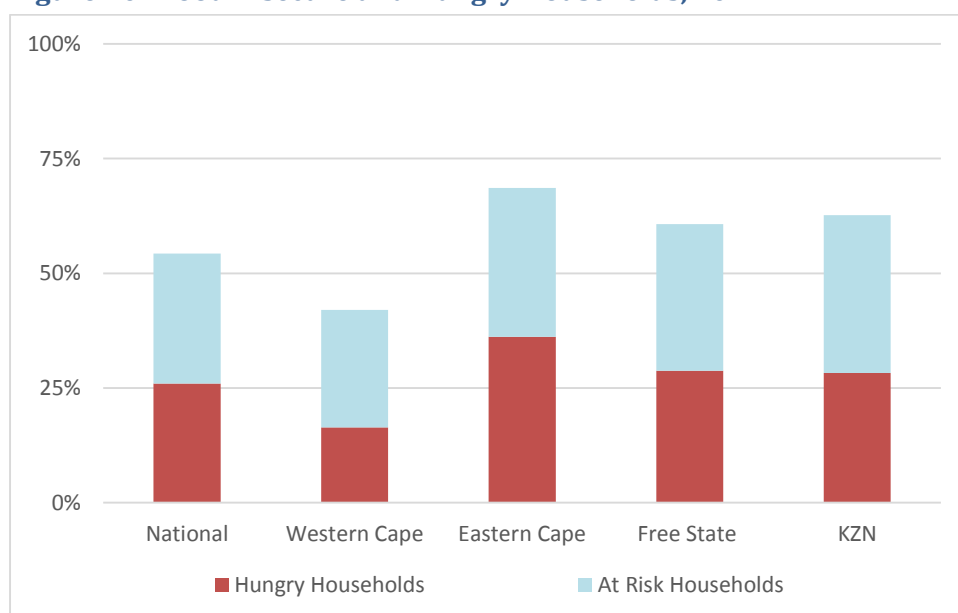
A shortage of Social Work Coordinators in WC spurred the province to engage NGOs for supporting ECD centres. Although this partially addresses the referral role of the social work coordinators, it doesn't completely fill the need (or the gap) for oversight and monitoring.

## 5 FINDINGS: IMPLEMENTATION MODEL / STRATEGY

### 5.1 Coverage of the Intervention

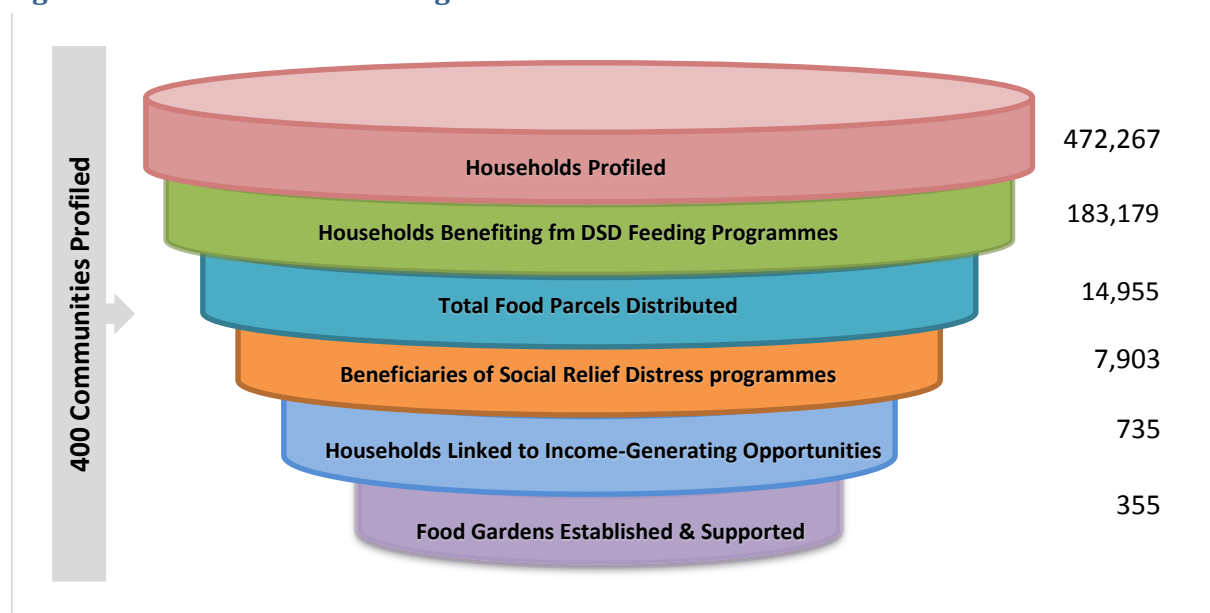
Recent data from the 2012 SANHANES<sup>8</sup> shows that more than 50% of households (or estimated 3.8 million households<sup>30</sup>) in South Africa are hungry or at risk of hunger (Figure 10). Food insecurity is highest in EC and lowest in WC among the four provinces involved in this evaluation.

**Figure 10: Food Insecure and Hungry Households, 2012 <sup>8</sup>**



Data from national DSD suggests that it is reaching only a fraction of these vulnerable households -- DSD has only profiled 12% of these households and has assisted 5% with Food Access and Sustainable Livelihoods services (Figure 11). But food access coverage rates vary across provinces. In the EC, SASSA's Ministerial Malnutrition Programme was said to have identified and provided 1,500 children with food parcels and supplements during 2012/2011 -- which if we consider each child represents a household represents assistance to only 0.25% of hungry households in EC. WC-DSD appears to perform slightly better than other provinces. According to the WC DSD more than 22,000 people were reached through awareness programmes on family support services in 2011/12<sup>14</sup> and this accounts for 8.3% of hungry households in that province.

Coverage of ECD is also low -- as less than 10% of the country's pre-schoolers attend registered ECD centres that receive the support.

**Figure 11: National DSD Coverage for Food Access Interventions in 2012<sup>26</sup>**

## 5.2 Standards / Norms / Guidelines / Protocols

The following guidelines, protocols and policies were mentioned by respondents in this evaluation, regarding Food Access Interventions:

- Children's Act 38 of 2005
- Western Cape Provincial Government Policy on the Funding of Non-Governmental Organisations for rendering Social Welfare Services
- Early Childhood Development Protocol
- DOH menu guidelines for ECD centres
- Food template for Social Relief of Distress
- Social Relief Guidelines
- Woolworth Trust SOPs

For food support to ECD centres, the ECD Guidelines<sup>24</sup> provide a sample menu and nutrition considerations for feeding all children, as well as special guidelines around breastfeeding, formula feeding, and complementary feeding for infants under two years of age.

For food parcels, no respondents were able to indicate any prescribed composition for parcels. However, from an NGO working with OVC in Gauteng, we learned that their monthly food parcels are packaged from donated food and consist of "5 kgs mielie meal, 2 kgs rice, and 8 tins of vegetables per family. Food lasts 10-15 days depending on size of family"<sup>31</sup>. While this parcel does contain key carbohydrates, it does not provide a completely balanced diet, as it lacks proteins and other nutrients.

Another example comes from a tender we found online from one city in Gauteng that had requested bids for the supply and distribution of 5 different food parcel options (Table 6). While encouragingly, each food parcel option does contain an item of protein and a carbohydrate, and sometimes a

vegetable, it is highly disturbing that every option contains a significant number of unhealthy processed foods that are high in fat, salt, sugar, caffeine, and additives (e.g. MSG). Few if any of the options provide foods that are rich in micro-nutrients. These are not nutritious food parcels, and they contain many items that are not appropriate for children (i.e. Monster Energy drink).

**Table 6: Contents of Food Parcels to be supplied and distributed for a City in Gauteng<sup>32</sup>**

Food Parcel Option	Contents of Food Parcel
<b>Option 1</b> Approximate quantities per annum: 18 000	1 x Corned Beef 300g Bull Brand or equal (No Pork) 1 x Sweet Corn Cream Style 215g Koo / All Gold or equal 1 x Potato Chips Assorted 30g/ 36g Simba / Willards or equal 1 x Two Minute Noodles 73g Maggi or equal 1 x Pvm Energy Bar 45g or equal 1 x Energy Drink Assorted 500ml Energade / Powerade or equal 1 x Plate Recyclable 155mm x 165mm 1 x Table Spoon Recyclable
<b>Option 2</b> Approximate quantities per annum: 12 000	1 x Hot Pilchards 425g Glenrich, Lucky Star or equal 1 x Beans 215g Koo /All Gold or equal 1 x Potato Chips Assorted 30g/ 36g Simba / Willards or equal 1 x Energy Sweets Super C or equal 1 x Energy Drink Monster 473ml 1 x Plate Recyclable 155mm x 165mm 1 x Table Spoon Recyclable
<b>Option 3</b> Approximate quantities per annum: 6 000	1 x Pilchards 425g Glenrich, Lucky Star or equal In Tomato Sauce 425g or equal 1 x Spaghetti In Tomato Sauce 225g Koo / All Gold or equal 1 x Peanuts Salted / Peanuts & Raisins 33g or equal 1 x Bioplus Energy 12 Chews or equal 1 x Energy Drink Assorted 500ml Energade / Powerade or equal 1 x Plate Recyclable 155mm x 165mm 1 x Table Spoon Recyclable
<b>Option 4</b> Approximate quantities per annum: 6 000	1 x Chicken Biryani 410g Koo / All Gold or equal 1 x Curried Mixed Veggies 420g Koo / All Gold or equal 1 x Potato Chips Assorted 30g/36g Simba / Willards or equal 1 x Chocolate Assorted Energy Bar 80g Beacon / Cadbury Nestle or equal 1 x Energy Drink Monster 473ml 1 x Plate Recyclable 155mm x 165mm 1 x Table Spoon Recyclable
<b>Option 5</b> Approximate quantities per annum: 7 200	1 x Corned Beef 300g Bull Brand or equal 1 x Baked Beans In Tomato Sauce 225g Koo / All Gold or equal 1 x Tuc Biscuits 100g or equal 1 x Energy Bar 60g Beacon / Cadbury or equal 1 x Energy Drink Assorted 500ml Energade / Powerade or equal 1 x Plate Recyclable 155mm x 165mm 1 x Table Spoon Recyclable

### 5.3 M & E Systems in Place

In terms of programme review processes, 75% of DSD respondents reported that there was an efficient management process for measuring the effectiveness of the delivery of Food Access interventions at service delivery point; however, we were unable to identify any standard indicators or data collections methods. All the M&E information we received suggested that each province tracks Food Access in its own unique way. Despite these processes, DSD does not appear to have any review processes that focus on nutrition issues or outcomes for its Food Access interventions.

In KZN, M&E systems reportedly function well with clear intervention-specific indicators, and few

data quality issues. KZN-DSD tracks the implementation of the Food Access interventions from data collected solely within the District Information system (DIS), using the following indicators:

- the number of organizations supported for ECD,
- the number of women- and child-headed households,
- the number of HIV/AIDS and TB beneficiaries reached;

In the EC, Home Based Care Workers and Social Workers collect various data on DSD services, but little data is reported to provincial or national level on the reach or nutritional effects of the food parcels, soup kitchens, or ECD interventions. The indicators identified in EC include:

- 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 investigates money spent on nutrition, environmental issues, and how food is being cooked at the ECD centres. One SASSA respondent in the EC also indicated that there was no internal management review process for the Social Relief of Distress activities, but SASSA does collect data on the intervention.

No information on the data elements being tracked for Food Access were obtained for WC or FS.

No M&E data is disaggregated to better track the number of children under 5, and pregnant mothers who have been reached with Food Access interventions. Moreover, the quality of existing data is uncertain; for example, there are lists of people who visit Soup Kitchens, but respondents reported that many more people visit these kitchens than are on the list.

## 5.4 Institutional Capacity for Implementation

As noted earlier, human resources are in short supply for DSD generally, but respondents also noted a lack of food and nutrition training for existing DSD staff. Particularly, in KZN, respondents from DSD, DAEA, as well as NGOs, noted limited training on food and nutrition and a lack of refresher trainings as limiting implementation.

In EC, inadequate financial resources for ECD support and inadequate material resources for Food Access interventions limits implementation effectiveness.

Limited resources for transport to conduct community outreach was also noted as a limiting factor all round.

## 5.5 Coordination, Referrals, Linkages, and Partnerships

The successful implementation of a comprehensive “package” of nutrition interventions to targeted populations hinges on 3 implementation principles:

- strong strategic coordination between government departments,
- strong referrals between government departments at implementation level, and
- strong linkages and partnerships with community-based organisations or other institutions to extend the reach directly to households.

Each of these are further explored below.



### 5.5.1 INTER-DEPARTMENTAL COORDINATION

DSD undertakes little strategic coordination with DOH or agriculture around nutrition at national level, but does work closely with SASSA in carrying out Food Access interventions. None of the DSD Food Access interventions are focused primarily on children or pregnant mothers. At provincial level, there is some evidence of coordination in KZN (through the Operations Sukuma Sukhe (OSS) initiative) and in WC, but not in other provinces.

### 5.5.2 REFERRALS

Referrals at local level are stronger, however. In WC, the referral system from ECD centres to other nutrition services is also reportedly effective, as DSD Social Work Coordinators refer cases of malnutrition directly to dietitians in nearby clinics and to social and agricultural services. However, some respondents noted that NGOs (rather than the DSD) often organise these referrals because of staff shortages and heavy workload for the Social Work Coordinators, and that rather than working through the DSD's Social Work Coordinators, ECD sites also refer directly to SASSA, local social workers, and DOH clinics without any involvement of DSD.

In KZN, Operations Sukuma Sakhe (OSS) war rooms facilitate linkages and referrals between the various departments for support to vulnerable households. DSD works closely with DOH in assisting severe malnutrition cases, and all DOH health facilities in KZN confirmed links with a DSD through a social worker. However, DSD-KZN noted occasional difficulty in tracing and finding severe malnutrition cases when DOH does not record all the necessary information, such as where individuals reside, or nearby locations.

In contrast to KZN, there was little evidence of referrals and linkages in the EC between DSD Food Access interventions and other government food/nutrition interventions. Although theoretically, when the DOH identifies cases of malnutrition, these should also be enrolled in the DSD / SASSA Social Relief of Distress programme and given food parcels, only one respondent reportedly worked closely with Social Workers when referring malnutrition cases for social assistance. This was confirmed by the DSD who noted generally that the linkages between its department and other government departments around nutrition are weak. ECD Centres in the EC, however, noted better integration with other government departments, as evidenced by the mechanisms ECD centres have to refer children to SASSA and the DOH, and the support given to ECD centres from SASSA (food parcels to poor families in distress identified at ECD centres), EC-DRDAR (assistance with vegetable gardens and other food security interventions), and DOH (vitamin A, weighing and education, and oral hygiene).

### 5.5.3 LINKAGES AND PARTNERSHIPS

Partnerships with NGOs do exist, but there is no programme documentation available on the number of agreements with NGOs, the level of funding, or the reach of NGOs working in Food Access.

Respondents also reported a few partnerships with the private sector including Foodbank SA (as described in section 4.1 above) and with Nestle, who in 2010 began support to the EC-DSD in strengthening ECD in the province. The partnership had 3 focus areas: (1) to beautify the ECDs, i.e. 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, Nestle supported a 2-day training workshop in nutrition in November 2010 for 30 Social Auxiliary Workers (SAW) who were 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 forks for gardening at ECD centres. Respondents from EC-DSD reported that the partnership with Nestle ended in 2012 at the urging of the DOH.

In addition, several large food companies are involved in food donations that parallel DSD's efforts. Tiger Brands, Pioneer Foods, Woolworths, and Pick n Pay provide significant food donations to FoodBank and/or other NGOs for onward distribution in food parcels or for soup kitchens. The Shoprite Group also runs a feeding program that distributes more than 300 000 cups of nutritional soup and bread per month to less privileged communities throughout South Africa through the deployment of 12 Shoprite mobile kitchen units<sup>33</sup>.

## 5.6 Beneficiary Engagement

In KZN, soup kitchens, food parcels, and food voucher programmes were not widely known by most beneficiaries interviewed in this evaluation, nor had they seen IEC materials or heard any radio advertisement about these programmes. In EC, on the other hand, most of the beneficiaries interviewed were aware of food in ECD centres, social grants, and food parcels, despite DSD's professed difficulty reaching people who live in remote rural areas because of the province's vast terrain and inaccessible roads.

In 2012, the DSD's Sustainable Livelihoods programme successfully organised a Taking the DSD to Communities campaign as well as a Social Development Outreach Month, where food parcels were distributed via soup kitchens and Food Banks to more than 1 million people<sup>26</sup>. The results suggested that DSD should invest more in promoting Food Access programmes to increase awareness among, and access for, potentially eligible beneficiaries.

## 5.7 Communication to the General Public and within Government

DSD uses several channels to raise awareness of its programmes among the general public, including road shows, awareness campaigns, radio advertisements, community referrals, and CHWs. Most DSD and other respondents felt that communication externally was adequate.

In contrast, internal communication was less positive. National level respondents from SASSA and DRDLR both expressed dissatisfaction with internal communication. In the FS, DSD also spoke of insufficient feedback about implementation from lower to higher levels.

# 6 RESULTS

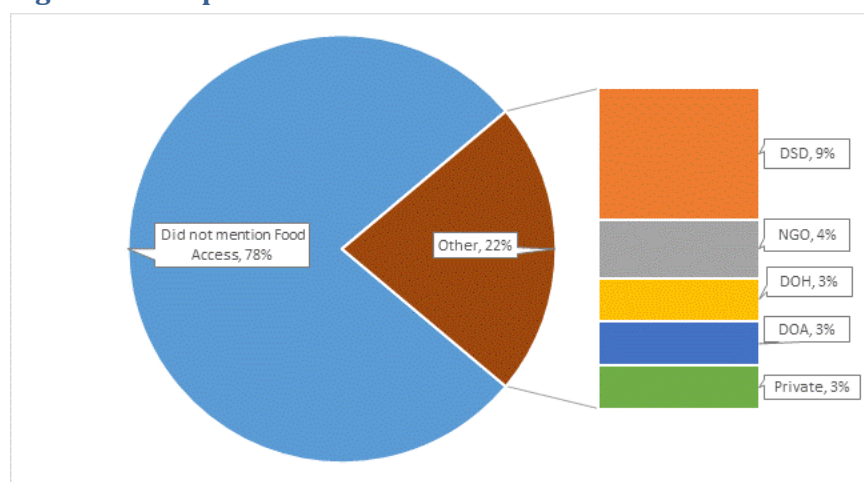
Given the evaluation's sampling framework, whereby health-sector-based interviews far outweighed interviews with DSD or DAFF, few individuals were able to speak knowledgeably about Food Access interventions (Figure 12), and those were mainly DSD and NGO respondents. This is consistent with findings elsewhere in this evaluation that showed most respondents are knowledgeable about the nutrition-related interventions implemented by their specific government department, but rarely the interventions of other government departments. This means that few health-sector or agriculture-sector respondents were able to comment on the adequacy of DSD's Food Access interventions, speaking to a lack of coordination and linkages between government departments around food and nutrition interventions. Even within DSD, it was apparent that respondents often did not have a "big picture" understanding of department's Food Access interventions, further suggesting the silo'd nature of such as food parcels, soup kitchens, ED support, and social grants.



However, nearly every DSD respondent mentioned support to ECD centres as a priority activity – a reflection perhaps of this evaluation’s focus on children under 5, but also of the fact that Food Access interventions (food parcels, soup kitchens) are not specifically or even generally targeted to young children but are rather targeted at adults.

This suggests that, along with a general absence of nutrition-specific objectives and goals, the overall scope of Food Access interventions is not sensitive to nutrition or to the needs of children under 5. Even ECD food support is not reaching infants and young children in the first 1000 days of life, as the vast majority of children enrolled in ECD centres are 3 years or older<sup>34</sup>.

**Figure 12: Respondents who mentioned Food Access Interventions without Prompting**



Food Access interventions are targeted to the poor, and there appears to be a good uptake of this intervention on the part of beneficiaries. However, the need appears to be greater than the supply, and the intervention is targeted towards any person who is destitute and in need of food.

Various factors limit implementation of Food Access interventions – namely, a gross shortage of human resources, limited inter-departmental linkages and coordination, no standardised protocols for implementation, no standardised delivery mechanisms, and no standardised M&E system.

The shortage of human resources has forced some provincial DSD’s to scale back activities, while others have engaged NGOs to support delivery, but monitoring and oversight of these NGOs isn’t apparent and the lack thereof could lead to inappropriate delivery and implementation. Few, if any, DSD staff have training in food and nutrition.

Limited inter-departmental coordination leads to fragmentation of, and poor return on, government’s investments in food and nutrition. Access to food must be coupled with good health and other nutrition-related interventions in the agriculture sector to ensure an effective response from each and every intervention. Strategic coordination at provincial level only appears to effectively exist in KZN. Referrals and linkages at local level need strengthening everywhere. As one DOH respondent lamented, *“Severely malnourished children are discharged from hospitals without food support, and then they end up being re-admitted”*.

The poor composition of food parcels as discussed in section 5.2 above, demonstrates an urgent need for more intensive guidance on optimising the nutritional value and quality of the food parcels.

Finally, despite a relatively-sound policy base, the absence of standardised delivery or M&E protocols leads to ad hoc implementation that makes it difficult to manage or improve for maximum nutritional effect. Moreover, there is little programme documentation about the various Food Access interventions, how they are delivered, their reach, and their effects.

## 7 CONCLUSIONS

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Secure Food Access is related, but different, to Nutrition Security. Availability of – and access to – food are necessary but not sufficient conditions for nutrition security. The latter is achieved when secure access to nutritious and healthy food is coupled with a sanitary environment, adequate health services, and knowledgeable nutrition care<sup>35</sup>. Although the *Food for All* campaign provides a strategy for improving nutrition for pregnant women and children under age 5<sup>10</sup>, this evaluation suggests that it is still an idea that has not yet been implemented or integrated into existing interventions. Each DSD intervention is implemented in a silo, with little integration internally or externally with the work of other government departments. Moreover, there is no targeting of pregnant women and young children, particularly for the first 1000 days of life, to prevent malnutrition (i.e. stunting or underweight).

There is need to establish effective monitoring systems around the delivery of Food Access interventions and their effects. While not examined as part of this evaluation, there may be an opportunity to consolidate nutrition and Food Access data using the new SASSA biometric cards (introduced in March 2012 for grant disbursements) for SASSA beneficiaries specifically.

Disappointingly, aside from food support given to ECD centres, there is a lack of focus on the adequacy of food provided or consumed – i.e. nutritional diversity, nutritional balance, and overall health quality of food items (i.e. free from pesticide residues) – that are either provided in parcels or meals, or that are purchased with grants and vouchers. Although separate legislation and standards regulate some of these concerns (such as pesticide residues), DSD's focus in Food Access and Sustainable Livelihoods is on making available a greater quantity of food and not quality of food. This is a shortcoming that urgently needs more attention.

## 8 RECOMMENDATIONS

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1. Formalise protocols for the delivery of each Food Access intervention with a focus on nutrition goals and objectives. Require all implementation bodies (DSD staff, NGOs, etc.) to adhere to these protocols.
2. Clarify implementation roles and responsibilities between DSD's Sustainable Livelihoods programme and DAFF's Household Food Production and Preservation programmes with respect to Food Access.
3. Create strategic coordination mechanisms at national and provincial levels that have the authority to hold different departments accountable, and ensuring that pregnant women and young children can access a full range of food and nutrition services from multiple service points in as integrated a way as possible.
4. Fill vacancies and train staff on food and nutrition needs and requirements of pregnant women and young children.
5. Improve supervision and monitoring of the delivery of all Food Access interventions, including tracking the length of time individuals and households are enrolled in the intervention, and their



change in nutritional status as a result of participation, and their relapse rate.

6. Develop more accurate, reliable, and comprehensive data on Food Access interventions, disaggregated to local level to assist planning and targeting. Improve M&E systems by including additional data points on the delivery of food and nutrition interventions to pregnant women and children under 5 and to include outcome level data that indicates the effects of these interventions.
7. Clearly indicate performance targets for delivery of Food Access interventions to pregnant women and children under 5 in Strategic Plans and APPs.
8. Explore the possibility of consolidating nutrition and food access data on the SASSA biometric cards.

## APPENDIX A TERMS OF REFERENCE

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### 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;

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- 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.



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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?<sup>1</sup> 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?<sup>2</sup>
- 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 dietitians 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?

<sup>1</sup> A list will be provided

<sup>2</sup> Note some work has been happening in terms of food control agencies

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- 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	<ul style="list-style-type: none"> <li>• What do we need to do to ensure that our children are well nourished and able to use their full potential?</li> <li>• What institutional arrangements and M&amp;E is needed across departments and agencies (government, private sector, community actors) to improve the effectiveness of nutrition interventions for children?</li> </ul>	<ul style="list-style-type: none"> <li>• Reprioritise resources</li> <li>• To strengthen intergovernmental cooperation (and with civil society) around child nutrition and development?</li> </ul>
All departments and provinces	<ul style="list-style-type: none"> <li>• What interventions are being implemented effectively, what aren't and where are the gaps?</li> <li>• Why are some interventions not being implemented effectively and efficiently and how can we strengthen, upscale and sustain them?</li> <li>• How does each department's role need to be strengthened to address this?</li> </ul>	<ul style="list-style-type: none"> <li>• Overcoming blockages and improving implementation</li> <li>• Reprioritise resources</li> <li>• Collaborate more effectively with other agencies</li> </ul>
Development partners and NGOs	<p>As above plus:</p> <ul style="list-style-type: none"> <li>• Where are the key gaps where our support can make a difference?</li> </ul>	<ul style="list-style-type: none"> <li>• Prioritise funding and support to programmes</li> </ul>
Staff at facility or community level	<ul style="list-style-type: none"> <li>• What skills and support do we need to ensure we can deliver services appropriately</li> </ul>	<ul style="list-style-type: none"> <li>• Recognising their shortcomings</li> <li>• Motivate for the support they need Allocating their time differently</li> <li>• Motivating and mobilising the community more appropriately</li> </ul>
Industry	<ul style="list-style-type: none"> <li>• How can industry's products and services be more appropriate in addressing child</li> </ul>	<ul style="list-style-type: none"> <li>• Refocusing products and services</li> </ul>



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User	Key question	How they may use the evaluation results
	nutrition <ul style="list-style-type: none"> <li>What type of partnership with government is appropriate to promote child nutrition?</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate partnerships established</li> </ul>

### 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 Women pregnant/caring for children under 5	Exclude children >5 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 3s 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

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- 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
<b>KwaZulu-Natal</b>	Its emphasis on community nutrition
<b>Western Cape</b>	The general perception that nutrition and health programmes are well implemented in the Western Cape
<b>Free State</b>	The general perception that nutrition and health programmes are well implemented in the Free State
<b>Eastern Cape</b>	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.

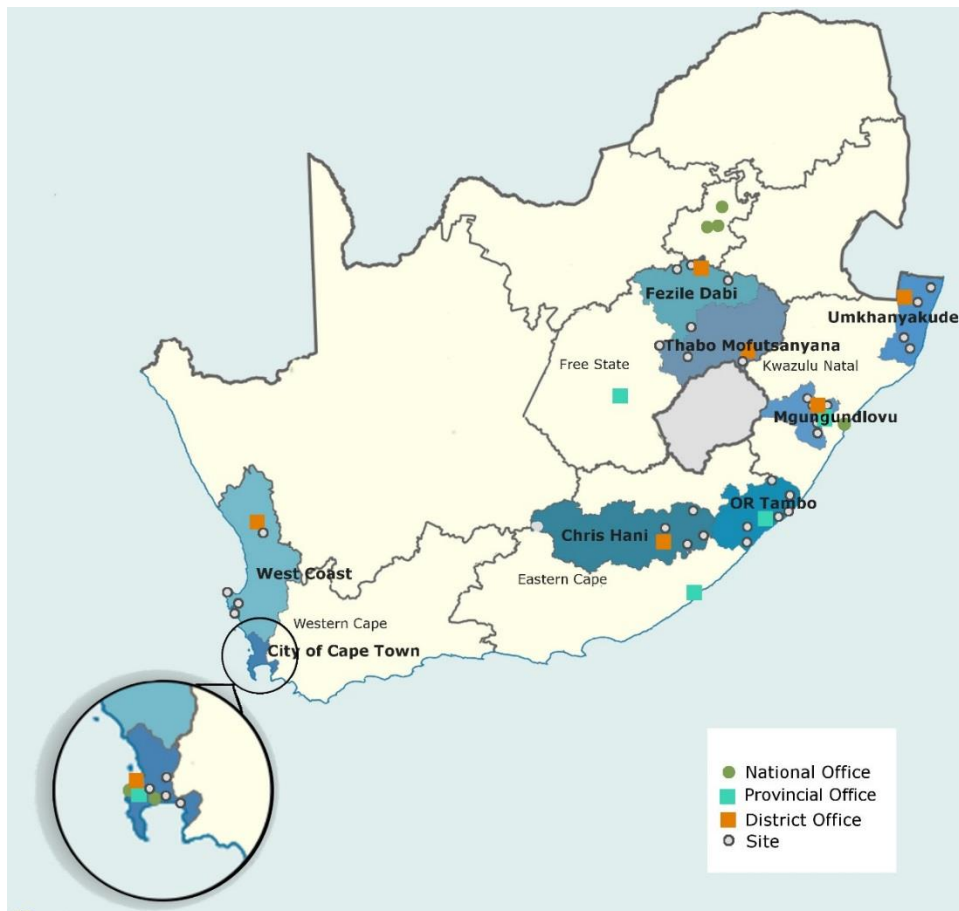
#### DISTRICTS INCLUDED IN THE SAMPLE

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

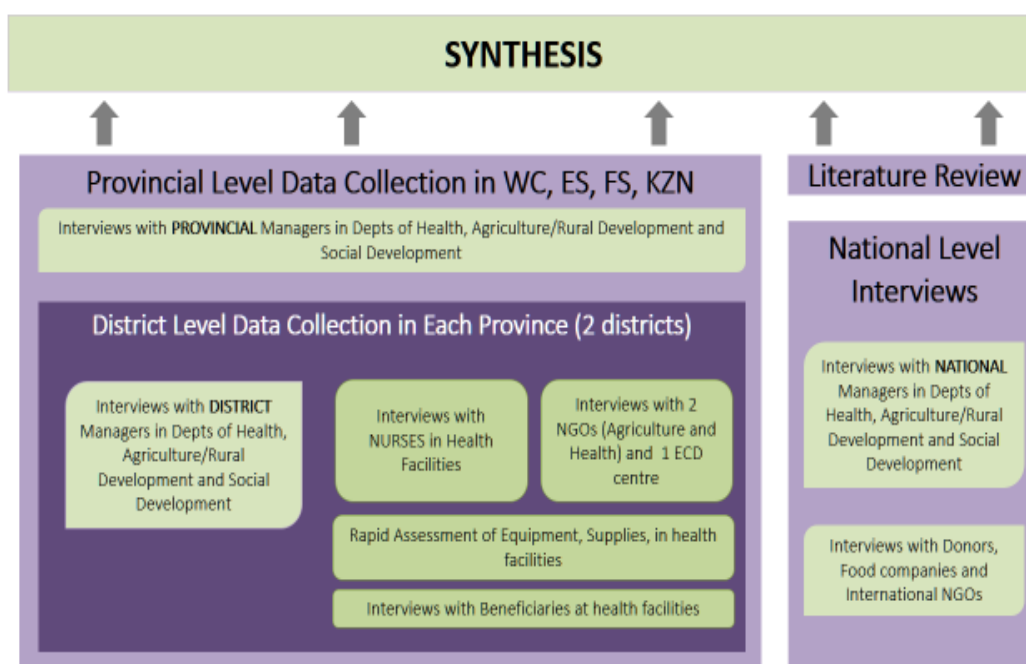
## DATA COLLECTION METHODS

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
<b>Key informant interviews</b>	Relevant Government managers at national, provincial, and district levels	<ul style="list-style-type: none"> <li>• Perceptions on current needs and practice around nutrition</li> <li>• Moderating factors (i.e. policy content and fit, organisational context and culture, commitment, capacity, facilitation processes that affect participant responsiveness, and communication)</li> <li>• Institutional arrangements</li> <li>• M&amp;E for food/nutrition</li> <li>• Funding levels</li> </ul>
	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)	
<b>Focus Group Discussions</b>	Beneficiaries	<ul style="list-style-type: none"> <li>• Experiences with food and nutrition programmes and services</li> <li>• Satisfaction with services</li> <li>• Need for food/nutrition support</li> </ul>
<b>Rapid Performance Assessment</b>	Health Facilities	Review of relevant infrastructure, equipment, and supplies for delivering nutrition interventions

Method	Target Respondents	Content explored
<b>Assessment of Health worker Knowledge</b>	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 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	%	
<b>Individual or Group Interviews</b>				
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
<b>Focus Group Discussions</b>				
Beneficiaries FGDs at health services and community projects	48	40	83%	267
<b>TOTAL</b>	<b>143</b>	<b>140</b>	<b>98%</b>	<b>445</b>
<b>Other Assessments</b>	<b>Planned</b>	<b>Actual</b>	<b>%</b>	<b>No. Persons Reached</b>
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 the table below.

#### ACTUAL NO. INTERVIEWS AND FGDs CONDUCTED BY PROVINCE

	Western Cape		Free State		KwaZulu 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
<b>TOTAL</b>	<b>21</b>	<b>38</b>	<b>33</b>	<b>99</b>	<b>32</b>	<b>170</b>	<b>34</b>	<b>110</b>	<b>19</b>	<b>28</b>	<b>139</b>	<b>445</b>

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 FGDs 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.

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