ANNEXURE A: MANAGEMENT RESPONSE

NUTRITION EVALUATION – CONSOLIDATED RECOMMENDATIONS

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
IMPROVEMENT OBJECTIVE 1 Develop an integrated nutrition plan with sensitive nutrition indicators which also delivers implementation of the mtsf priorities		
R1 Nutrition of under 5s should be elevated to the level of an output of Outcome 2 on Health, and so included in the Medium-Term Strategic Framework and the Delivery Agreement.	**Agree with the recommendation as it is in line with government Priorities. Nutrition for under fives is already reflected in a government outcome documents:** National Development Plan 2030 (chapter 11) points to the need to for household food and nutrition security. The Medium Term Strategic Framework 2014-2019 covers nutrition and food security in Outcome 13 (Social Protection), with a target for reducing stunting of children from 21% to 10%. Outcome 2 (Health) has targets for reducing severe acute malnutrition case fatality rate from 9% in 2012 to 5% in 2019. Outcome 7 (Rural Development), has a target to reduce the percentage of households vulnerable to hunger from 11,4% in 2011 to below 9,5% in 2019.	
R2 Develop a well-defined Nutrition Plan for nutrition outputs targeting children under-five across all sectors This plan should: • Include common, measurable goals • Re-configure or consolidate service-specific policies, strategies, and guidelines along life cycle stages, rather than basing them by the	**Agree with the recommendation** Addressing all forms of malnutrition including over and under requires a multisectoral approach. The well defined plan should address all actions that impact on nutrition both direct and indirect., this will	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
intervention (Figure 14). • DoH, DSD, and DAFF should work together to plan and then provide a comprehensive package of services • Communicate effectively about the Nutrition Plan across sectors and levels of government (national, provincial, municipal, district, facility, community). • National Treasury is doing an expenditure review of nutrition and this should be done quickly to inform this planning process and to revise budgets for nutrition.	enable key players to have a common vision and goal. The plan will not be implemented in isolation but will be linked to other initiatives within government. Implementation and monitoring of the plan could be linked to the Food and Nutrition Security implementation plan, which is being prepared by the Inter-Governmental Working Group led by DAFF.	
R 3 As part of the Nutrition Plan create common indicators for tracking Food and Nutrition across all sectors with a common and consolidated M&E framework for tracking both the delivery and the effects of nutrition interventions prioritised under the Plan. This should include: • Creating Sensitive Indicators. • Indicators need to be able to be tracked for priority groups including pregnant women and children under 5.	**Agree with the Recommendation** **Same response as in recommendation 2**	
Improvement objective 2 Establish a supra departmental structure for coordination of nutrition activities supported by higher level posts to champion nutrition in different departments, with coordinated delivery focusing on clients with particular problems.		
R4 Elevating nutrition to an output should be accompanied by placing nutrition to at least a cluster manager in national DoH and to a directorate level at provincial DoH. Districts also need a nutrition-trained person. Other national and provincial departments need a nutrition-trained focal person to manage their contributions. Vacant posts must be filled. National DoH should track this.	**The Department acknowledges the need to elevate nutrition, and identify the need to strengthen nutrition leadership at all levels. The provincial differences with levels and structures will need to discussed further as part of the DOH's Human resource plan.**	
R5 Stronger coordination is needed of the implementation of nutrition interventions by the individual line ministries responsible for the nutrition response, and ensuring that the nutrition programme plan is being followed. The **national DoH is the natural champion** as most interventions are within its domain. Support is needed from the Presidency to elevate the political profile of nutrition. An integrated programme plan is needed to facilitate cross-sectoral collaboration, and facilitates more effective	**Recommendation need to be viewed in keeping with other proposed structures both within health and other government Departments**	Whilst there may be a need for a supra departmental structure, it is the view of the Department of Health that this function should be included as a sub-structure in existing or proposed structures

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
consolidated planning, budgeting and oversight of each ministry's performance in achieving nutrition goals. DPME needs to look at lessons which can strengthen programme coordination mechanisms.		such as the Health Commission. Another possible structure that could be used include statutory Food and Nutrition Security Advisory Committee based in the Presidency as proposed in the Food and Nutrition Security Policy. existing structures should be explored to ensure that there is no duplication of functions and structures.
R6 Establish a National Nutrition Council as a coordinating council, like SANAC for HIV/AIDS, which has broad representation from key government sectors and programmes, civil society, suitable involvement of the private sector, to mobilise all sectors around nutrition. The DoH will provide the secretariat for this. As has been done for maternal mortality and morbidity (COMMiC), this Council should be served by a committee of experts – a Committee on Nutrition (COMMoN). Other committees addressing infant and child health should also have a nutrition focal point.	**See comments under recommendation 4**	
R7 At Provincial level, DSD to establish with the War on Poverty unit in DRDLR a case management approach, based on household vulnerability and determinants of malnutrition. This would allow for better targeting of vulnerable households and a more comprehensive and harmonised delivery of the various nutrition interventions. This approach is being used in KZN and it seems to be working at a provincial and ward level in DoH, but less so at district level and with the provincial department of agriculture. Such an approach could also facilitate the monitoring of household uptake and behaviour, in contrast to the current monitoring system which only monitors the supply of services and not utilisation. A particular target would be pregnant and breastfeeding women and children U5. • Evaluate the KZN experience to identify lessons; if proven to work	**DSD TO RESPOND**	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
well, adopt the model. • There is duplication of households and communities profiling between DSD, DRDLR, DAFF, and DoH. A standard approach should be used and captured in a common database. Doing so will eliminate multiple profiles and better integrate services. Ensure referrals are tracked and followed and successfully addressed. SASSA cards provide the opportunity to track vulnerable children and resources provided; • There should also be tracking of severely malnourished children leaving hospital to ensure that the family are linked to food and nutrition support.		
IMPROVEMENT OBJECTIVE 3 Focus on behaviour change and communication		
R8 Change focus of services and communication across relevant sectors to focus more on promotion and prevention, exclusive breastfeeding, complementary feeding, dietary diversity, hygiene education and to help create an enabling environment: • DoH to use real **change management efforts** to change behaviours (e.g. to ensure exclusive breastfeeding for 6 months). Do not expect only counselling of mothers to effect practices; their support network (grannies, husbands, community leaders) must understand and support the new practice. Examples for achieving this include the use of TV and radio as platforms to educate about sound nutrition. Make use of civil society and CHWs/CCGs to provide relevant nutrition counselling and to help change behaviours and attitudes at community and household level. This should be a key focus of the Nutrition Plan. • DoH to create a specific, well-defined, dedicated **health promotion and communication strategy on nutrition for under 5s**, as happened for HIV/AIDS. At the moment, nutrition education (forming part of other strategies) is not reported on as an individual outcome and therefore not prioritized. Develop relevant multi-media IEC interventions (e.g. radio in EC) and materials to address incorrect or negative perceptions about nutrition interventions e.g. perceived stigma	**Agree with the Recommendation** Efforts are under way to improve behaviour change and communication. The areas listed in the recommendation have been included in the communication plan of the Department of Health. The Obesity Strategy and the Hand washing campaign are examples of this initiative.	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
around the use of targeted supplementary feeding (TSF), and counter messages to food advertising. Use the public broadcaster (both TV and radio) to educate pregnant women and children under 5 about the importance of sound nutrition, use celebrities to elevate the status of breastfeeding, and encourage good nutrition practices targeting all members of the family. • DoH to address the growing problem of **overweight and obesity** among children under 5 years of age (18.9% overweight/4.9% obesity in girls and 17.5% overweight/4.4% obesity in boys aged 2 to 5 years), and promote exclusive breastfeeding and appropriate infant and young child feeding. • Incorporate private providers, NGOs and other civil society actors in behaviour change efforts, and in the proposed National Nutrition Council. • DoH to analyse the SANHANES data to see if there is a particular problem for teenage and working mothers in breastfeeding, which may need targeted responses.		
IMPROVEMENT OBJECTIVE 4 Effective community-level services provided at community and facility level in a PHC context		
R9 DoH to use the PHC reengineering process to ensure clinics and CHWs provide growth monitoring and provision of nutrition advice and targeted supplementary feeding and provide appropriate space for counselling: 1. Ensure there is a nutrition-trained person in the PHC teams, ideally nutritionists or dieticians. Training of these specialists has been scaled back because there has been no market for these staff even though the need is great. 2. Ensure pregnant women and children under 5 receive regular health services, either from clinics or CHWs/CCGs etc. i. Develop **"a one-stop" approach** for delivering routine	**Agree with the Recommendation** Nutrition is incorporated in the training and package of services offered by community health workers.	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
health/nutrition interventions at community level to provide mothers/care givers a full range of services during one visit. Such an approach complements the *eventual* scale-up of PHC re-engineering. ii. Use **Community Level Assistants** (CHWs/CCGs) as in KZN to identify, refer, and follow-up underweight, stunted and overweight children and pregnant and lactating mothers and give talks to communities on nutrition and advice to mothers on food preparation and appropriate feeding practices. Training needs to be improved to ensure that quality growth monitoring is being done. This model is equally relevant to other sectors such as community food gardening advisors, community animal health workers. DPME should evaluate the optimal use of community-based workers in different sectors and identify lessons for widespread scale-up of such models. iii. Similarly, to make this work, there will need to be **an expansion of NGO involvement**. In the health sector such partnerships are more common with PMTCT services, but there are some nutrition-focused NGOs such as Philani working with health facilities in EC and WC. DPME should conduct an evaluation of the experiences of NGO delivery of services for government and how these can be scaled-up effectively, for nutrition but potentially for other sectors. 3. As access to supply systems expands, DoH to engage Treasury and DSD to consider the possibility of conditionality such as adherence to basic health monitoring (i.e. BANC, vaccination schedule, and growth monitoring) to social grants.		
R10 Improve Knowledge, Skills and Attitudes: Improve pre- and in-service nutrition **training** of health, agriculture and social development employees (including ECD Managers) to expand knowledge and skills (e.g. diagnosing malnutrition; nutrition education, and	**Agree with the Recommendation**	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
teaching communities to plant and care for gardens).		
R11 Reduce frequent stockouts for food supplements, ORS, Zinc, as well as equipment such as breast pumps and posters. The budget needs to be ring-fenced as a non-negotiable.	**Agree with the Recommendation**	
• Levels of awareness of nurses of key nutrition messages only averaged 50% in the 3 provinces apart from KZN, and means to ensure regular training is needed. Nutrition should be included in pre-service training and regular updating of health professionals including doctors and nurses through strong partnerships with academic institutions. Academic institutions should be involved as with the example of the UKZN working closely with the DoH in KZN, and University of WC students giving talks at ECD centres. • Create Standard Operating Procedures (SOPs) for all nutrition programmes specifying the steps to be taken and referrals/follow-up. These SOPs should be published in wall charts for easy reference. This is particular important around behaviour change interventions e.g. breastfeeding counselling and support, hygiene education. • Expanding the use of CHEs/CCGs and support groups can take off some of the load from nurses and provide them with more time for counselling, and additional support. KZN has allocated dedicated nutrition advisors in every clinic, as well as CHWs trained in nutrition.	**Agree with the Recommendation**	
R12 Promote use of healthy and diverse food: • DSD to consider options to **restrict use of vouchers to prescribed food options**, e.g.by linking voucher use/parcels only to fortified staple foods and VAT zero-rated food. • DoH to develop guidance on food quality and diversity for DSD interventions such as soup kitchens/ECD and for DSD/departments of agriculture for good gardens. • Departments of agriculture should change strategies to focus on **diversified diets** by emphasising the production of special crops with high nutritional value (e.g. Orange-fleshed Sweet Potato, morogo) and promotion of local food production and preservation of food, as	**DSD and DAFF to consider the recommendations** Discussions are being held with DAFF to address their role in promoting diversified diets.	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
well as goat's milk. • Establish and enforce regulations to **reduce children's access to unhealthy foods**, • DoH to review the micronutrient programme to (i) use CHWs/CCGs to distribute Vitamin A twice per year, (ii) optimise the levels of bioavailable micronutrients in fortified foods and explore alternative delivery mechanisms, e.g. multiple micronutrient powders; (iii) DSD to use DoH-approved fortified products, (iv) explore more effective mechanisms for engaging small millers to fortify grain, or by promoting household fortification.		
R13 Improve focus on food security: • Food security should be a sub-output of the main nutrition plan with some standard indicators. There is a challenge of who is the right champion for this. DAFF's food security strategy has focused on commercialisation and does not cover nutrition in a substantive way. However even supporting household subsistence production requires technical skills. The key champion for food production for subsistence needs to be clarified and if it is to be DSD then significant technical expertise needs to be provided. • A review of the experience of NGOs supporting food gardens in SA should be undertaken and a major new programme designed, using NGOs and community-extension mechanisms. There is extensive experience internationally in doing this at scale (e.g. PRADAN in India) which should be brought in to assist in the planning. • Support for food production should include nutritious indigenous foods (e.g. morogo, orange sweet potato), as well as small livestock. DSD food parcels should contain only nutritious foods including fresh produce procured locally e.g. through cooperatives. • DSD should increase registered ECD sites and learners subsidised, thus improving their access to food. The menu guidelines must be followed and implementation monitored. • There is a need to standardise measurement of food security to incorporate nutrition indicators at national, provincial and district	**DAFF AND DSD TO RESPOND**	

RECOMMENDATION FROM THE NUTRITION EVALUATION REPORT	RECORD OF AGREEMENT OR DISAGREEMENT	REASONS FOR DISAGREEMENT
levels, including for impact indicators such as level of stunting. DAFF should work with DoH to do this.		