Khulisa Management Services (Pty) Ltd
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FREE STATE PROVINCE CASE STUDY REPORT

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

South Africa Department of Performance Monitoring and Evaluation (DPME)

Nutrition SLA 12/0287

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Antiretroviral Treatment
ARV	Anti-retroviral
AWA	Active Women Association
BANC	Basic Antenatal Care
BFHI	Baby Friendly Hospital Initiative
CBO	Community Based Organisation
CCGs	Community Care Givers
CHCs	Community Health Centres
CoGTA	Cooperative Governance and Traditional Affairs
CSIR	Council for Scientific and Industrial Research
CWP	Community Work Programme
DAFF	Department of Agriculture, Fisheries and Forestry
DARD	Department of Agriculture and Rural Development
DHIS	District Health Information System
DOH	Department of Health
DSD	Department of Social Development
EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
EPI	Expanded Programme on Immunisation
FHI	Family Health International
FY	Financial Year
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
HOD	Head Of Department
IEC	Information, Education and Communication
IFSS	Integrated Food Security Strategy of SA
IMCI	Integrated Management of Childhood Illnesses
INP	Integrated Nutrition Programme
INS	Integrated Nutrition Strategy
IYFC	Infant and Young Child Feeding
M&E	Monitoring & Evaluation
M2M	Mothers2Mothers
MBFI	Mother-Baby Friendly Initiative

MCH	Maternal and Child Health
MCWH	Maternal, Child and Women's Health
MEC	Member of the Executive Council
MUAC	Mid-Upper Arm Circumference
NGO	Non-government organisation
NVP	Nevirapine
OM	Operational Manager
ORS	Oral Rehydration Salts
OVC	Orphans and Vulnerable Children
PEM	Protein Energy Malnutrition
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHCs	Primary Health Clinics
PMTCT	Prevention of Mother to Child Transmission
R	Rand
RtHB	Road to Health Booklet
SANHANES	South African National Health and Nutrition Examination Study
SASA	South African Sugar Association
SASSA	South African Social Security Agency
TB	Tuberculosis
U5	Under 5 (years of age)
UNICEF	United nation Children's Fund
URTI	Upper Respiratory Tract Infection
WHO	World Health Organisation

GLOSSARY

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

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

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

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

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

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

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

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

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

1 INTRODUCTION

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

1.1 Background to the Nutrition Evaluation

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

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

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

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

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

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

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

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

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

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

Table 1: 18 Nutrition Interventions Explored in this Evaluation

Nutrition Intervention *(NB: the first four interventions (bolded) are the main focus of the evaluation)*	**Responsible Department**
1. Breastfeeding support*	Health
2. Management of moderate malnutrition including Targeted Supplementary Feeding*	Health
3. Household food production and preservation (home gardening)	DAFF
4. Food access (e.g. food parcels, soup kitchens)	DSD
5. Early Childhood Development (ECD) (food in ECD centres)	DSD
6. Complementary feeding*	Health
7. Food fortification (Vitamin A, Iron and Iodine)*	Health
8. Micronutrient including Vitamin A supplementation*	Health
9. Oral Rehydration Salts (ORS) and Zinc*	Health
10. Management of severe malnutrition*	Health
11. Deworming	Health
12. Growth monitoring and promotion including the use of Mid-Upper Arm Circumference (MUAC) measurements	Health
13. Nutrition education and counseling (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:

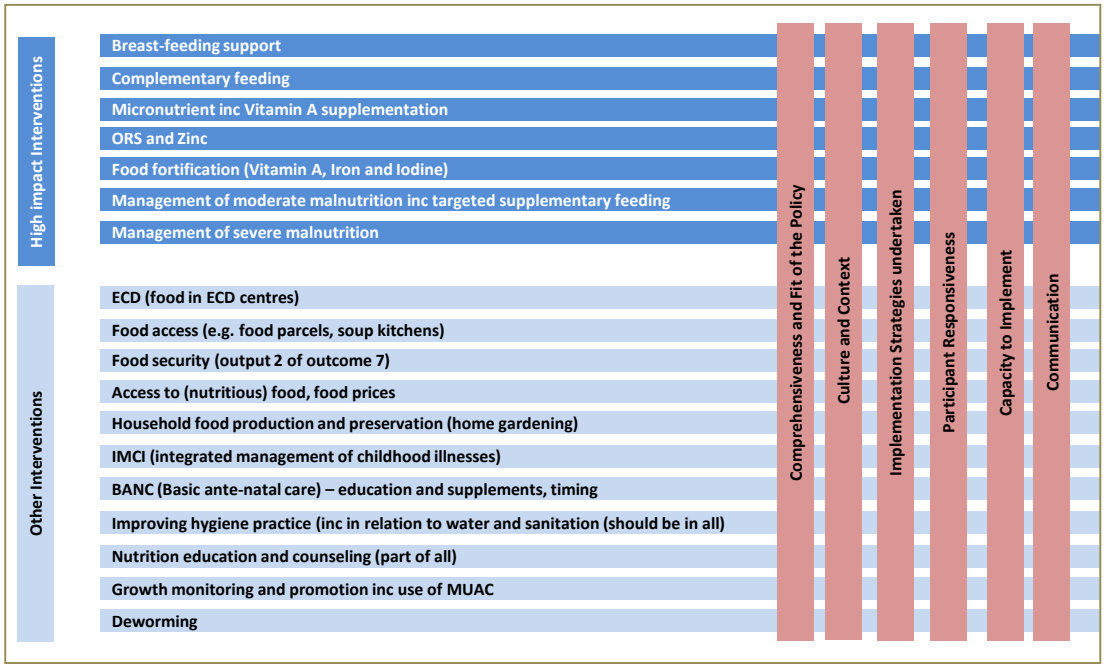
1) the policy's content and fit for the local environment,
2) the institutional context and culture, including readiness to change and the extent of commitment at all levels through which the policy passes,
3) the various implementation strategies (i.e. models) devised for carrying out the policy,
4)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

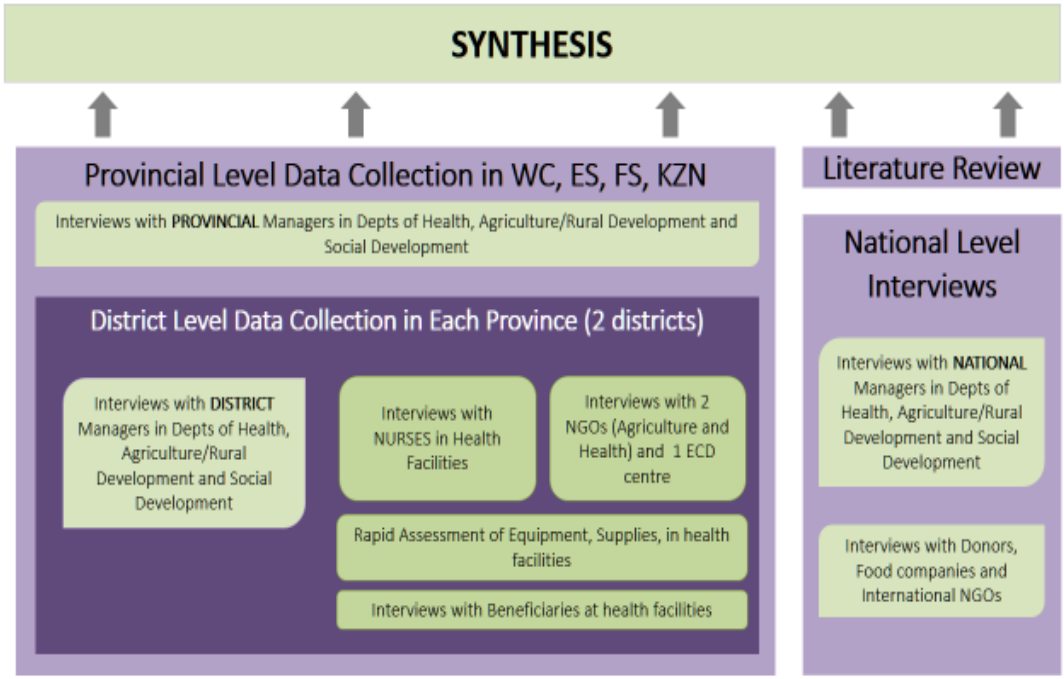


Table 2 presents a summary of planned and actual data collection, and Figure 3 presents a map of data collection sites.

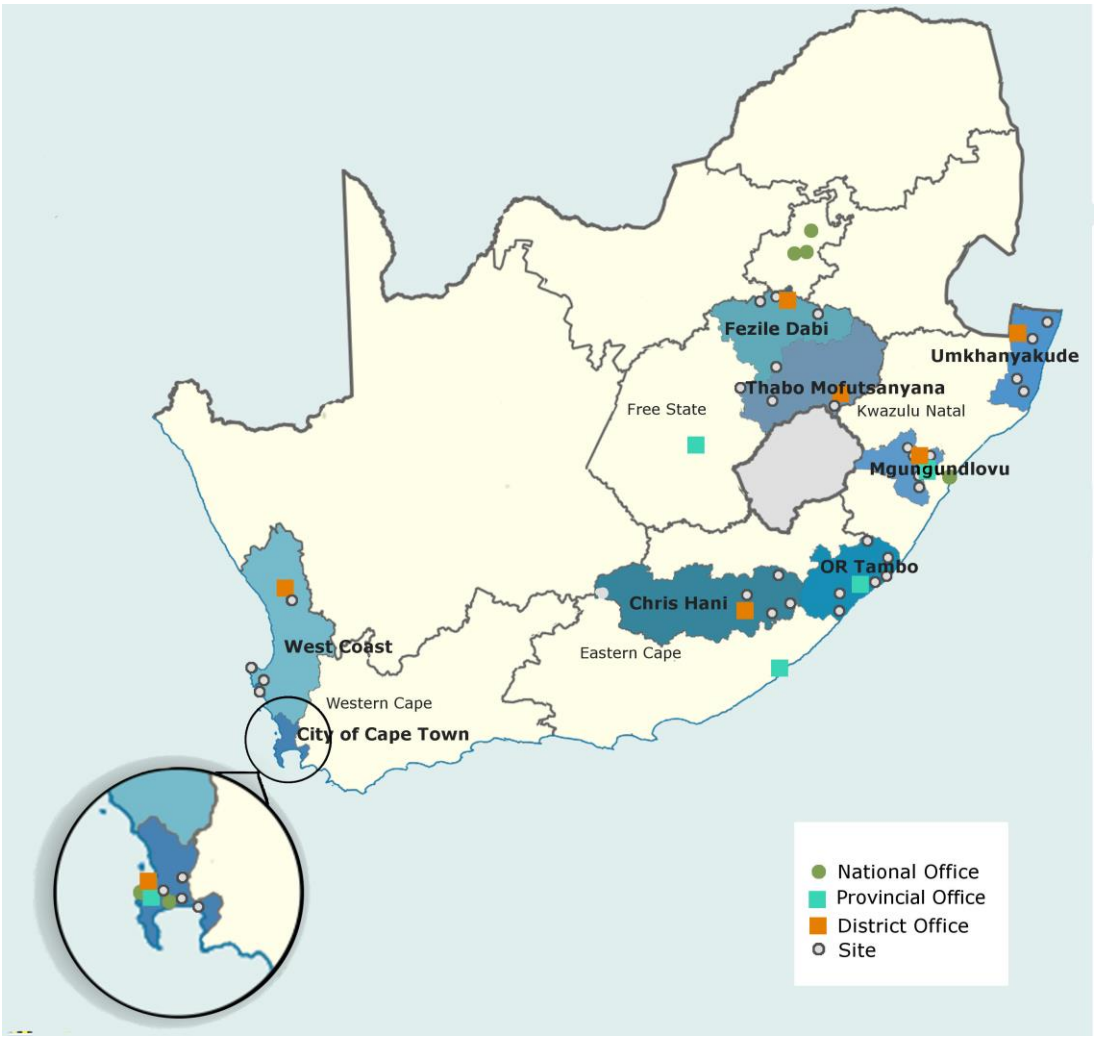
Table 2: Fieldwork Conducted

Data Collection Method and Stakeholders Group	No. of Interviews / FGDs		
	Planned	Actual	Response Rate %
Individual or Group Interviews			
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%

Data Collection Method and Stakeholders Group	No. of Interviews / FGDs		
	Planned	Actual	Response Rate %
Local NGO	8	8	100%
ECD Centre	4	5	125%
Focus Group Discussions			
Beneficiaries FGDs at health services and community projects	48	40	83%

Other Assessments	Planned	Actual	Response Rate %
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 for 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.

1.5 Free State Sample

In the Free State province, data was collected at 20 (twenty) sites as presented in Table 3 below. In each site, various key informants were interviewed about the nutrition needs in their area, the types and quality of nutrition interventions that are implemented, the resources (financial and human) available for nutrition interventions, and enabling and constraining factors related to implementation.

Table 3: Actual Data Collection sites in the Free State

Provincial Offices Interviewed		
Provincial Department of Health –Bloemfontein Provincial Department of Social Development – Bloemfontein Provincial Department of Agriculture and Rural Development – Glen		
District Offices Interviewed		
Fezile Dabi District	District Department of Health – Kroonstad and Sasolburg District Department of Agriculture – Sasolburg District Department of Social Development – Kroonstad and Sasolburg	
Thabo Mofutsanyane District	District Department of Health – Qwa Qwa District Department of Agriculture – Kestel District Department of Social Development – Qwa Qwa	
Health Facilities Interviewed	**Urban**	**Rural**
Fezile Dabi District	Harry Gwala PHC - Zamdela, Sasolburg Thusanang PHC - Sasolburg	Qalabotjha PHC - Villiers
Thabo Mofutsanyane District	Ladybrand Clinic - Ladybrand Kokelong PHC - Marquard	Eva Mota PHC - Tseseng Village, Qwa Qwa Rearabetswe PHC - Petrus Steyn
NGOs Interviewed		
ECD site: Lethabong Crèche – Qwa Qwa Agriculture/home gardening: Mphohadi Vegetable Garden - Cornelia PEPFAR-funded health project: CARE South Africa - Bethlehem Non-PEPFAR funded health project: Lebone Village – Bloemspruit		

Table 4: No. Interviews/FGDs and Respondents in Free State Province

	No. Interviews / FGDs	No. respondents
Provincial and District DOH managers	4	5
Provincial and District DSD managers	4	6
Provincial and District DOA managers	3	5
NGO staff	4	7
Health facility staff	7	7
Beneficiaries	11	98
TOTAL	**33**	**128**

1.6 Data Collection Challenges

Several fieldwork challenges were experienced including (a) issues related to the scheduling and timing of the evaluation, (b) communication about the evaluation to the provinces and districts, (c) respondent substitutions, and (d) collecting data at health clinics. These challenges are described in more detail in Appendix C.

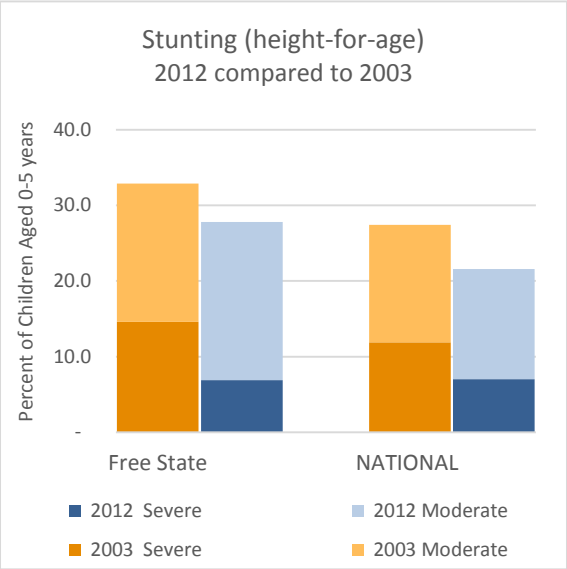
2 FINDINGS: NUTRITION CONTEXT

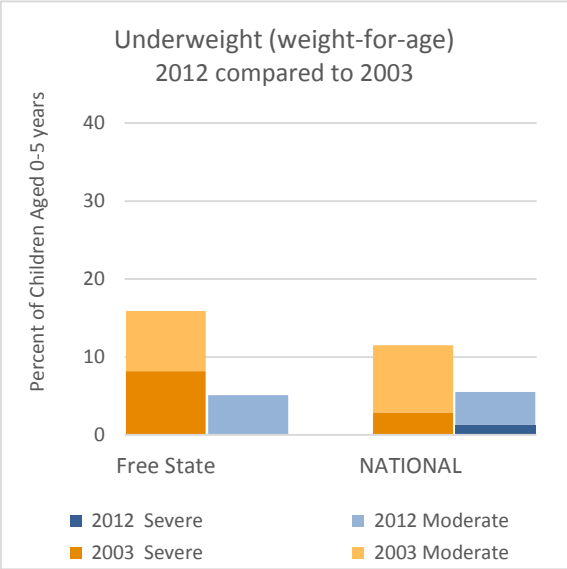
2.1 Nutrition Status of Young Children in Free State Province

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

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

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





2.2 Perceived Nutrition Needs in Free State

In contrast to the situation described above, most respondents in this evaluation perceive underweight to be the most common nutrition problem in the province (Figure 5), although some identified stunting and obesity as a nutrition problem for young children.

Most believe the main underlying reasons for poor nutrition are unavailability of food/poor food security, lack of knowledge, and general behavioural factors. However, there are noticeable differences in reasons given between the types of respondents (Figure 6).

- Health managers and staff and NGOs are more likely to recognize health and illness factors as an underlying reason for malnutrition.
- Health managers were also the only respondents who recognized poor or no breastfeeding as a contributing factor to poor nutrition.

Figure 5: Perceived Nutrition Problems in Children under 5 in FS

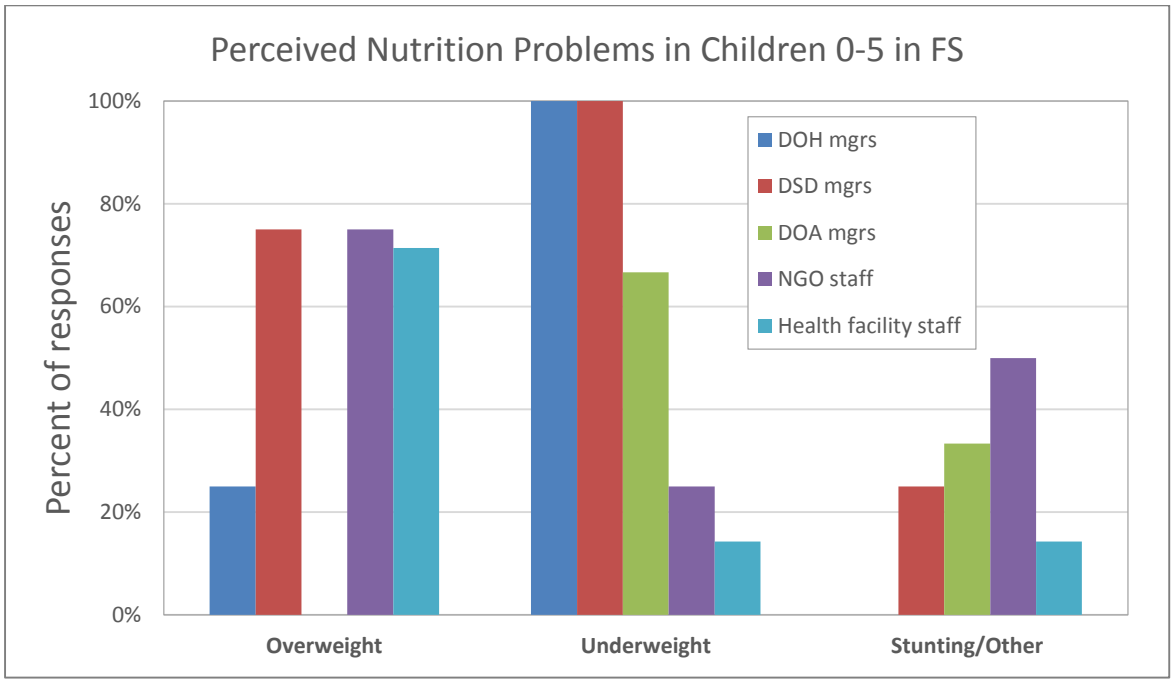
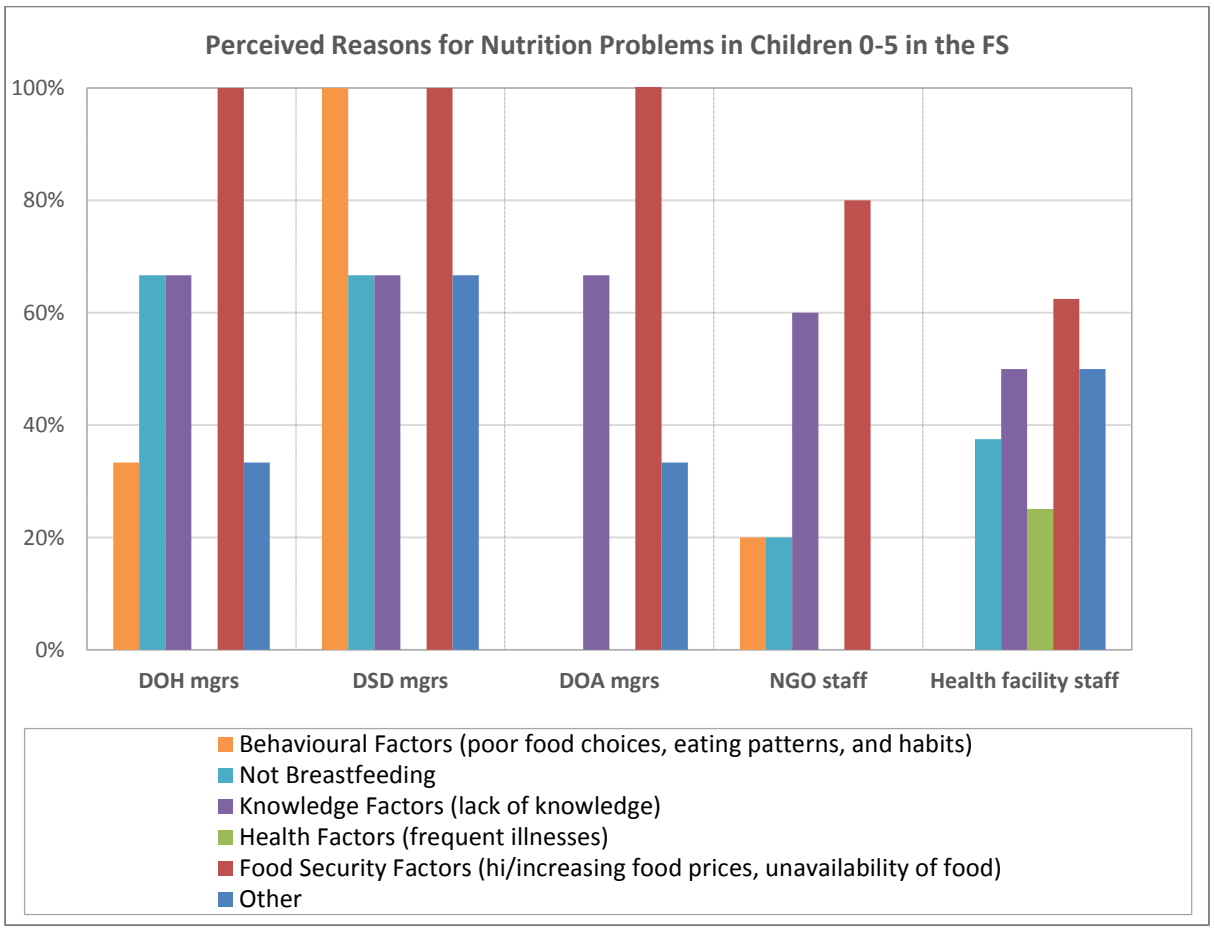


Figure 6: Perceived Underlying Reasons for Maternal-Child Nutrition Problems in FS



Teenage pregnancies, child headed families, and lack of adequate care by caregivers are reportedly some of the underlying causes of food and nutrition problems amongst under-fives in the province. Young mothers delay seeking medical advice due to lack of knowledge and ignorance. Although the Department of Rural Development is one of the key implementers of the INP and the Integrated Food Security Strategy (IFSS), lack of access to rural based community food security programmes contributes to the high incidence of malnutrition challenges in the Free State.

The number of overweight children is also on the increase, especially amongst babies older than six (6) months. This problem is caused by lack of education on when to introduce solids, what type of food to feed these babies, frequency of feeds and the portions. Cow's milk will even be introduced in the first few months after birth because mothers and grandparents believe that the baby is not satisfied. There is a belief that "anything that is not poison, is food". Poverty and ignorance are contributing factors. This may also be due to inadequate education and information given to mothers on correct feeding practices as well as due to household food security issues. Most of the time, the staple diet in these households is mealie meal pap, potatoes or soft porridge.

Maternal deaths leave babies, especially those under 6 months of age, vulnerable to malnutrition. The problem is further complicated by incorrect interpretation of policies, most notably the Tshwane Declaration. A decision was taken by the provincial DOH in December 2012 to stop the supply of formula milk in the province as a means to advocate for EBF. However, the way the policy guideline is interpreted and applied, has left a gap in the provision of feeding supplements for babies less than six (6) months in cases where the mothers have passed away. Despite the issuance of a policy circular, there is still a lot of confusion about what the intention of the Tshwane Declaration was, even leading to expired stock of the formula in some of the districts, according to the Provincial PMTCT Coordinator

Failure to pay attention to growth monitoring by Healthcare Workers (HCWs) at facilities appears to also be an issue. For example, babies coming to health facilities are either not weighed or, if weighing does happen, the results are not interpreted correctly and as a result no intervention kicks in. This seems to be a major problem, especially in Thabo Mofutsanyane District. Amongst numerous observations where there was no intervention provided to children with nutrition and development problems, the case of a two year old boy seen at Rearabetswe Clinic, born HIV negative to an HIV positive mother bears reference. The mother was attending the clinic as part of the Expanded Programme of Immunisation (EPI) Campaign for Polio and Measles. She was recruited to participate in the Beneficiaries Focused Group Discussion. At the end of the discussion, the researcher requested to have a look at the Road to Health (RtH) Booklet/Card of the children. The child was not thriving, looked ill and was under weight. Reviewing the child's RtH card revealed that at every clinic visit, the child's weight was recorded, charted and the graph plotted. According the guidelines on the RtH card, there was a clear indication that the child needed an intervention as he remained below the median line and was losing weight with subsequent visits. In spite of this, during one of the visits, the attending nurse indicated in her clinical notes that the child had normal milestone development and provided no intervention towards addressing the nutritional status of the child. It was only after bringing this issue to the attention of the nurse that the child was issued with a supplement.

2.3 Nutrition Actors in the Free State

Three departments in the Free State Province play a significant role in implementing the Integrated Nutrition Programme (INP) and its strategies and interventions. The role of the Department of Health is to implement interventions to prevent and treat malnutrition in children under five and pregnant women. The Department of Social Development contributes to the programme through provision of food security services by ensuring food access to food insecure households, in that way directly or indirectly benefiting children under five and pregnant women. The department's mandate is carried out by its implementing agency, the South African Social Security Agency (SASSA) which provides social grants and food parcels to profiled food insecure households. This intervention is meant to provide short term relief for three (3) months.

The Department of Agriculture and Rural Development's role in INP is mainly to implement Food Security programmes indirectly benefiting pregnant women and children under 5. Rural Development focuses on household profiling to identify food insecure households and Agriculture provides support (in the form of seeds and implements) and training to household backyard and community farming or gardening projects. There seems to be some degree of duplication of effort as DSD's social auxiliary workers also carry out community profiling activities. This may be due to haphazard planning by government departments which results in overlapping programme implementation. To some degree, this can be attributed to lack of (most notably in Fezile Dabi District) or weak programme coordination mechanisms at the district level. In contrast, patient inter-departmental referral systems are quite strong despite weak programme coordinating mechanisms and absent coordination forums between the stakeholder departments.

2.3.1 Free State Department of Health (DOH)

The Nutrition and Child Health Programme within the Provincial DOH is a Sub-directorate within the Strategic Health Programmes Directorate. The programme is managed by a professional nurse, with the support of a Principal Dietician. Thabo Mofutsanyane District's nutrition programme has only 1 (one) registered dietician in the position of District Nutrition Manager and other non-nutrition related activities make up almost 20% of her responsibilities. There appear to be inadequate nutrition activities and support to health facilities due to the shortage of dieticians and nutritionists in the district. Support to Primary Health Care facilities (PHCs) is provided by dieticians during their Community Service year assignment at district hospitals. As these dieticians also have responsibilities and duties they have to fulfil at the district hospital they're based at, support and consultation visits to PHCs ends up being inadequate to meet all the needs of the facility and its patients. As a result of the infrequent support visits, the visiting dietician tends to only see the same facility-based clients/patients during their visit - hence the wider community is not reached.

In contrast to the situation at the provincial level and in Thabo Mofutsanyane District, the district of Fezile Dabi is adequately resourced with 4 qualified dieticians and a nutritionist at district level who provide nutrition services to PHCs in the district. The Assistant Manager – Nutrition has no other non-nutrition responsibilities thus making it possible for her to dedicate 100% of her time to the programme. This ensures the availability of the dietician's services to the PHCs is more regular for patients who require specialised interventions.

At health facility level, INP is integrated within the PHC Basic Care Package and is offered as part of IMCI and BANC for under-5's and pregnant women respectively.

2.3.2 Free State Department of Social Development (DSD)

The Food and Nutrition Programme within the Department of Social Development is managed under the Community Development Programme at both provincial and district levels. Food security is the main focus of the programme through provision of short term relief services in the form of food parcels. The department is assisted by the South African Social Security Agency (SASSA) to implement its mandate. SASSA is responsible for the distribution of food parcels and administration of the social security grant.

There are currently 1,600 Early Childhood Development Centres (ECDs) registered and subsidised by the department. The ECD Programme of the Department subsidises the Food Programme within ECDs with R14.00. It is compulsory for all ECDs to spend 50% of their R14.00 subsidy on food. The challenge currently experienced within the Programme is the issue of fraudulent activities by the management of some ECD centres. Unfortunately, monitoring is not carried out adequately due to staff shortages. The DOH developed a menu with input from the Provincial ECD Coordinating mechanism which was approved but is currently awaiting printing and distribution to all ECDs. The DOH does not have funds at present to print the manual.

Social workers, with the assistance of social auxiliary officers and community development officers, carry out household profiling activities to identify food insecure households and refer them to SASSA for assistance in accessing short term relief services and long term support services. In addition, they collaborate with the Department of Home Affairs to ensure that families without identity documents are assisted to apply for and obtain these in order to qualify for a social grant.

2.3.3 Free State Department of Agriculture and Rural Development (DARD)

The Department of Agriculture and Rural Development's role in INP is mainly to implement food security programmes. Annual Performance Plans direct focus on poverty alleviation programmes that need to be prioritised for implementation during each fiscal year. Their role is to ensure adequate production of produce to contribute to food security programmes, such as the proposed Food Banks in the provinces.

The department also provides agricultural starter packs (seeds and home gardening tools) to households that were red-flagged during profiling for them to start their own backyard gardens to ensure a more sustainable food supply. This however, seems to be the only intervention towards Food Security. The same resources – seeds and gardening implements are provided year in year out, hence these projects do not grow to become self-sufficient, productive and sustainable. This inadequacy is a clear indication that there's a general lack of understanding at executive level, of what Food Security as a programme entails, hence it being relegated to providing seeds for home gardens.

2.3.4 Non-Governmental Organisations (NGOs)

The PEPFAR funded programme, PATH, will provide technical support to the province through its programme, Nutrition Assessment and Counselling Support (NACS). This process still has to be formalised through signing a Memorandum of Agreement (MOA). The rate limiting step in getting the MOA concluded and signed was the review process by the Office of the Premier – Legal Department. The MOA was eventually signed in May 2013.

The PEPFAR funded programme, CARE SA provides indirect support for nutrition and food interventions in the province through funding CBOs. The organisation only provides support to CBOs in Thabo Mofutsanyane District. These CBOs appoint Community Care Givers (CCGs) or Home Based

Carers (HBCs) who provide community outreach activities and support, mostly to PLWHAs. Under-fives may also benefit from these interventions. CARE SA also provides CBOs with training and organizational capacity building on HIV/TB screening, their flagship programme, Integrated Access to Care and Treatment (iACT) and support for HCT campaigns. IACT advocates for PLWHA to start support groups which would establish home gardens and community based gardens to supplement the food parcels they receive. Funding provided to CBOs also caters for food supplements (e.g. Philani enriched instant porridge for adults and children) for PLWHAs, amongst them, under-fives and pregnant or lactating mothers.

Lebone Village, a non-PEPFAR funded NGO, focuses on supporting OVCs by providing a safe home environment that will positively contribute to the children's upbringing. The NGO's nutrition and food programmes include vegetable garden tunnels, a chicken farm and food parcels issued through the local health facility. A supplement in the form of formula milk is procured at a discounted price for babies under-12 months old who cannot be breastfed. Their partnership with KFC's CSIR initiative, 'Add Hope' enables the NGO to purchase the formula milk distributed to beneficiaries.

Mphohadi Vegetable Project was established with a mandate to provide vegetable parcels to 50 food insecure households in the community of Cornelia. Other Non-Governmental Organisations in the districts are mostly involved in provision of food parcels, soup kitchens and community based support to CBOs for OVCs and PLWHAs.

3 FINDINGS: PROVINCIAL STRUCTURE

3.1 Nutrition leadership and management arrangements in the Free State Province

There is inadequate leadership commitment and skills capacity at Provincial DOH level, to effectively inform and support policy implementation at lower levels. The lack of commitment by principals is demonstrated by the total staff complement of the Nutrition Programme in the province. Nutrition is a sub-directorate under the Child Health Directorate thus reducing its stature among other health interventions. The Maternal Health programme receives the attention it deserves as qualified midwives are hired to ensure the success of the programme. The Nutrition Programme, on the other hand, is not getting enough appropriately skilled and qualified professionals, thus diluting the importance of the programme. Qualified Nutrition professionals are few and their significance is down played.

The nutrition programme is not integrated into mainstream health services and is still implemented in silo. Respondents believe that the focus within the health sector is only on the value and importance of doctors and nurses at the expense of other health professionals critical to the Nutrition Programme. Furthermore, the programme lacks a platform where nutrition related issues and concerns are raised and addressed at a provincial level with each district contributing to the platform. Such a platform would also provide a coordination mechanism within the DOH to strengthen the programme and an opportunity to review progress towards INP implementation.

Within DSD, there is adequate leadership commitment to address key nutrition and food challenges in the province. There's a directive from provincial leadership at the level of the premier to promote food gardens, improve household food security and establish ECDs. There are systems and strategies to implement the policy but the challenge is implementation of these policies at lower levels

According to the respondents, DARD's leadership and management lack vision to support the Food Security programme implementation at district level. Lack of interest is seen with emphasis on numbers (number of home gardens started) and not quality measured in terms of sustainable and self–sufficient home and community gardens established and supported. There is also no adequate allocation of resources to enable staff to implement food security programmes.

3.2 Plans for implementation of nutrition interventions in the Free State Province

Annual Performance Plans (APPs) in the province across the three (3) departments seem to only be applicable to and inform planning and resource allocation at provincial level. There also appears to be a pattern in decreased allocation vs. budgeted as seen with the FS DOH and DARD.

Provincial DSD APP specific for ECDs does not have a budget specific for nutrition related activities except for the R14.00 per child subsidy that the ECDs receive. R7.00 of which is supposed to be spent on the procurement of nutritious food for the children (e.g. meals for breakfast and/or lunch). The budget for ECDs is actually R15.00 per child, however, R1.00 is retained by the Department for building ECDS - Lethabong Creche is one of the ECDs built under this initiative.

Stakeholder departments are expected to include ECD related activities in their APPs and present these to the ECD Provincial Coordinating mechanism. Activities are planned, but due to budget cuts and inadequate allocations, departments are unable to fulfil their mandates and provide meaningful contribution to the programme.

District DSD also prepares and submits APPs but these are not adequately resourced.

The Food Security Programme within DARD is aimed at reducing household food insecurity and meeting the demands of previously disadvantaged people seeking assistance to develop small enterprises. Two of the 5 (five) strategic objectives of the sub-programme are i) Improve support to homestead food security projects and ii) Promote agricultural activities in rural schools and community institutions which may include formally registered ECDs.

At DARD's district level, however, District Annual Performance Plans are developed and submitted but when allocations are made, there appears to be no relation to the plans submitted. The impression at district level is that it is a fruitless exercise to plan activities as the provincial office does not consider these when allocations are made. As a result, for example, there's no progress and growth in terms of support for Backyard Farming Initiatives implemented at district and community level. The same resources – seeds and gardening implements - are provided year in and year out, inhibiting the projects' ability to grow and become self-sufficient, productive and sustainable.

3.3 Resource Allocation – Human and Financial

3.3.1 FS Department of Health

The Provincial DOH's Child Health and Nutrition Programme is a Sub-directorate within the Directorate – Strategic Health Programmes. The programme is managed by a professional nurse, with the support of a Principal Dietician. The Maternal Health programme of the DOH receives the attention it deserves as qualified midwives are hired to ensure the success of the programme. The Nutrition Programme, on the other hand, does not have enough appropriately skilled and qualified professionals in leadership positions. Qualified Nutrition professionals are few and their significance is down played.

There are not enough posts created for nutrition professionals at the various levels of care and the focus for those available at the health facility level is mainly on the HIV and AIDS Programme. The nutrition programme is not integrated into mainstream health services and is still implemented in silo. Respondents believe that the focus within the health sector is only on the value and importance of doctors and nurses at the expense of other health professionals critical to the Nutrition Programme. Furthermore, respondents stated that task shifting nutrition programme responsibilities on to nurses at the health facility level has contributed to the current nutrition related challenges experienced in the province. On the whole, the programme lacks a platform where nutrition related issues and concerns are raised and addressed at a provincial level with each district contributing to the platform. Such a platform would also provide a coordination mechanism within the DOH to strengthen the programme and an opportunity to review progress towards INP implementation. In addition, of the 91 posts established in the province, 33 (or 36%) are vacant according to the 2012-2013 Annual Performance Plan[7].

Thabo Mofutsanyane district's nutrition programme has only 1 (one) qualified dietician in the position of District Nutrition Manager. Other non-nutrition related activities make up almost 20% of her responsibilities. As a result, there are inadequate nutrition activities and support to health facilities due to the shortage of dieticians and nutritionists in the district. Support to Primary Health Care facilities (PHCs) is provided by dieticians in their Community Service year allocated to district hospitals. As these dieticians also have responsibility and duties towards their facility, support and consultation visits to PHCs is inadequate to meet the needs of the facility and its patients. As a result of the infrequent support visits, the visiting dieticians tend to see the same patients during their visit hence the wider community population is not reached.

In contrast to the situation at provincial level and in Thabo Mofutsanyane, the district of Fezile Dabi is adequately resourced with 4 qualified dieticians and a nutritionist at district level who provide nutrition services to PHCs in the district (Table 5). The Assistant Manager – Nutrition has no other non-nutrition responsibilities which make it possible for her to dedicate 100% of her time to the programme. This ensures the dietician's services are regularly available to the PHCs and for patients who require specialised interventions.

Table 5: DOH Human Resources for Nutrition in the Free State (April - May 2013)

Level	Posts Approved	Posts Filled	Posts Vacant
Provincial Nutrition and Child Health Sub-Directorate (Nutrition Programme)	2	2	0
District (Thabo Mofutsanyane)	1	1	0
District (Fezile Dabi)	5	4	1
Hospital/CHC	No data collection at this level	No data collection at this level	No data collection at this level
CHC / PHC	0	0	0
TOTAL	**8**	**7**	**1**

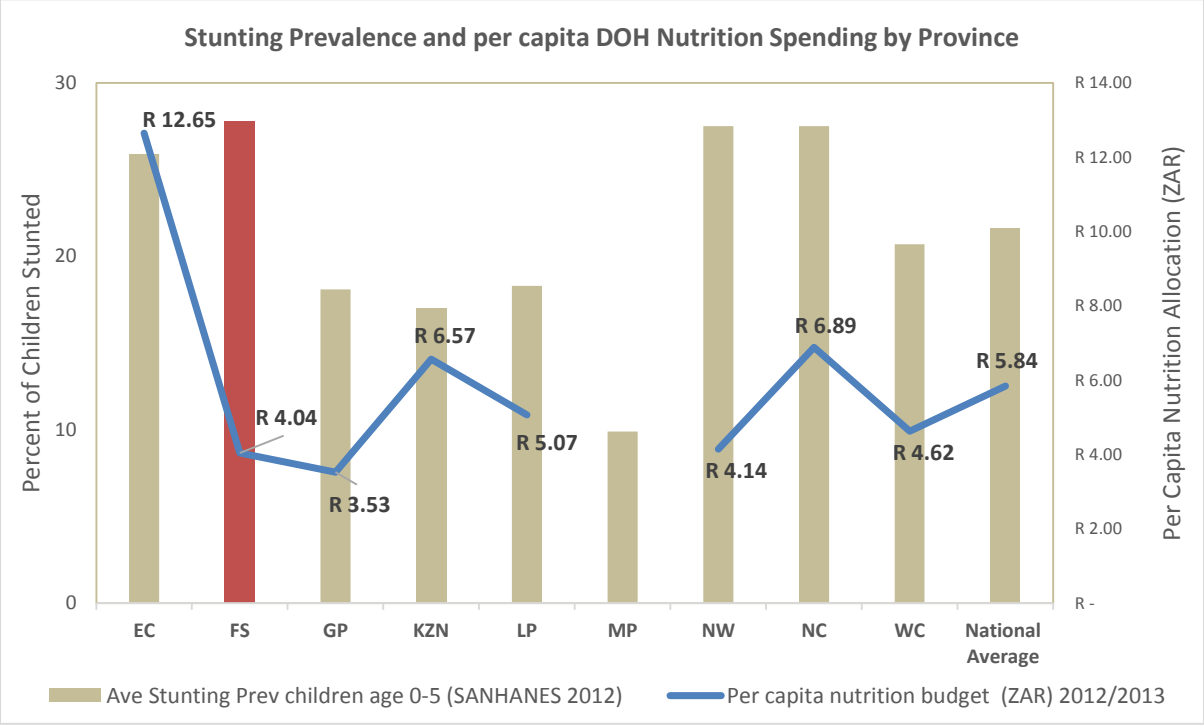
The Operational Manager at PHC level has the responsibility for ensuring the implementation of the Nutrition programme. In some facilities, the Operational Managers have delegated the programme to other staff members based on the passion the individuals have for the programme.

[7] Free State Department of Health, *Annual Performance Plan 2012-2013*.

Across the board, the Provincial financial situation is dire. There is lack of adequate funding to ensure the successful implementation of the INP at provincial, district and health facility levels. This may be due to the fact that the programme at provincial level is not a stand-alone programme, but is integrated with Child Health, and therefore it is difficult determine how much budget is dedicated to the INP as the budget currently allocated is not exclusively for INP. The sub-directorate was not allocated any budget for FY11/12 and only received some funding in Q3 of FY11/12. For 2012/13, the planned share of the District Health Services budget that is dedicated to nutrition is the lowest in the country – only 0.39% compared to an average of 0.57% in this other provinces.

Figure 7 presents a comparison between the Free State and other provinces in terms of U5 stunting prevalence and per capita budget allocations for nutrition in the 2012/13 APPs. Although the Free State has one of the highest rates of U5 stunting in the country, it has one of the lowest per capita nutrition allocations in the country. This represents a serious financial constraint for meeting the goals of the INP in the province, affecting such areas as staffing, training, provincial programme coordination, availability of IEC material and other essential support activities for the districts. For example, the current goal to have one (1) accredited MBFI assessor per delivering facility as per the National Strategy on MBFI cannot be achieved due to financial constraints. As a result, the province has the lowest number of accredited facilities in the country.

Figure 7: U5 Stunting Prevalence and Per Capita DOH Nutrition Allocation (2012)[6, 7]



At district level, programmes do not have dedicated budgets. Clinical programmes fall under the clinical support programmes and all share from the same pot. The District Nutrition Programme procures nutrition related products for both district hospitals and PHCs. Actual expenditure in FY11/12 under the Nutrition Programme was R3.5 million but the current trend in decreasing allocation (FY10/11 – R800k; FY11/2012- R750k and the current FY13/14 allocation of R238k) is not reflective of the actual expenditure. The decrease in funding could be attributed to the change in policy regarding the promotion of EBF under the Tshwane Declaration. With the implementation of

the Tshwane declaration, there appears to be a misconception about the policy on exclusive breast feeding i.e. that there is no place for formula milk (breast milk substitutes). This misconception has led to a lack of adequate financial resources which in turn has resulted in stock shortages of nutrition supplements in both districts.

The current FY13/14 budgets for Nutrition Supplements for both districts visited were cut by as much as 30% compared to the FY12/13 allocation. At present, the two districts are using the PMTCT grant to procure supplements especially for the under-fives.

3.3.2 FS Department of Social Development

Provincial DSD does not have adequate numbers of people with skills and expertise on food and nutrition. The current complement of three (3) full time social workers is responsible for the sustainable livelihoods programme, social relief and the community development cluster. They have all undergone informal in-service training on food and nutrition. Food Bank SA provided information sessions in preparation for the implementation of two planned Food Banks in the province. According to the respondents, the successful implementation of the food security programme will require the appointment of suitably qualified food security candidates and the up-skilling of those already in the programme.

The Provincial ECD Programme has only 5 posts on its organisational structure. Three (3) of these are in leadership positions - the Executive Manager – Partial Care and ECD, 2 Assistant Managers for ECD and Partial care – while the other two (2) are administration posts.

The current financial constraints in the province restrict the creation and filling of much needed posts. Furthermore, the current organizational structure appears to lack the necessary skilled implementers – especially in the middle management - to support policy implementation. For FY12/13, the ECD Programme had to subsidise salaries and benefits with R11 million from its own budget. The Community Development Unit budgeted R28 million for FY13/14 to support Nutritional Development centres in the districts.

3.3.3 FS Department of Agriculture and Rural Development

DARD is adequately staffed at provincial level, with a Director for Farmer Support and Food Security, Manager for Food Security and four (4) agricultural extension officers who support Food Security programmes at district level. Each district, with a line function supervisory role, has at least one (1) Food Security Officer to support implementation of Food Security programmes at district level. The district level officers receive indirect support from additional extension officers appointed at district level. There is usually lack of support amongst these cadres which may further be affected by the dual line function reporting systems in place.

Financial allocation at provincial level to support district level programme implementation of Food Security has shown a declining trend in resource allocation. For FY08/09 Food Security received about R6.5 million compared to the FY11/12 allocation of R1.3 million; FY12/13 is R1 million and MTEF for FY 13/14 is R1.2 million.

3.4 Coordination between Government Departments

Intergovernmental Coordination mechanisms for food and nutrition that exist at Provincial level are focused on Food Security through the Integrated Food Security and Nutrition Strategy (17 July 2002), led by DARD and the National Plan for Early Childhood Development in SA 2005 – 2010, led by DSD.

The Provincial Food Security and Nutrition Task Team Forum is meant to hold its meetings quarterly

where DSD, DARD, District DOH, Food Bank SA, COGHTA, Mangaung Metro Municipality, University of the Free State (UFS) and Central University of Technology are participants. The last meeting was held November, 2012 and the meeting scheduled for March 2012 did not make the quorum.

This coordination forum also exists in Thabo Mofutsanyane and the driving force behind the success of coordination is the fact that the district receives a lot of attention – it is a Pilot District for NHI; it is one of 18 Priority Districts in the country; etc. No formalised coordination mechanism exists in Fezile Dabi, as far as the respondents were concerned. However, interdepartmental referral systems are quite effective in making sure that people who need services provided by other departments are able to access them through these referrals. These informal ad-hoc linkages and networks created and facilitated by individuals is a demonstration of a high degree of their commitment to address nutrition challenges that exist in the district.

The barrier to coordination of Food and Nutrition programmes in the district of Fezile Dabi could be attributed to the challenge in getting other departments to participate. There is need for a more senior representative from DARD as lead department, to lead the formation and facilitate decision making & commitments. Participation in coordination forums at district level is also not included in individual APPs.

3.5 Coordination between Government and Private Sector

At the provincial level, interaction between DOH and the private sector is not as extensive as its interaction with the non-profit sector. A recent interaction took place towards the end of 2012 at a meeting held at the University of Free State where private sector nurses working in maternity and casualty wards of private hospitals were present. The meeting shared the Tshwane Declaration and its implementation strategy. While this was viewed as an important interaction, respondents mentioned that sustaining this dialogue will require engagement at higher levels. Within Districts, the interaction between the Nutrition Programmes and the private sector is mainly around sharing the contents of policies and strategies.

In Thabo Mofutsanyane, Pick n Pay, Spur and Checkers provide the youth (teenage mothers) with economic opportunities. This partnership is facilitated by the Community Development Unit within DSD. The district DTEA provides assistance in identifying and fostering the linkages with the private sector.

4 FINDINGS: FOCUS INTERVENTIONS

4.1 Breastfeeding Support

This intervention is delivered through health talks and education in ANC, PMTCT and post natal well baby clinics where healthy baby competitions are also run to promote exclusive breastfeeding. There are also community health group talks and campaigns to increase the public's awareness and utilization of the services. The IMCI points also serve as a means of promoting exclusive breastfeeding for the first six months and encouraging mothers to continue breastfeeding beyond six months.

Guidelines, protocols and policies used to guide the implementation of the exclusive breastfeeding initiative include BFHI policy, PMTCT guidelines, IMCI guidelines, mother and child health nutrition booklets and the road to health booklets. IMCI guidelines are found to be informative, clear and easy to follow; however, in some facilities, staff find it difficult to make time to read and acquaint

themselves with the guidelines as they are short staffed. In most facilities, there is only one focal person managing various health programmes and nutrition interventions end up not being prioritized.

Staff implementing nutrition interventions do as much as possible to render quality services under limited human, material and financial resources. These resources appear to be adequately allocated in provincial and district levels. Shortages are seen in local implementing levels; clinics and NGOs and CBOs. Most clinics have indicated the need to have regular access (weekly or even daily) to the services of the dietician. The more common monthly (or even fortnightly) visits by dieticians to facilities is regarded as not being sufficient. This sentiment was expressed even by facilities which are able to refer patients to dieticians based at district hospitals. One facility noted the need to have someone dedicated for the nutrition programs particularly to support mothers exclusively breastfeed. In addition to staff required to effectively implement nutrition intervention at community level, nutritionist, nutrition advisors and community breastfeeding support groups are recommend by these facilities. One clinic mentioned that it use clinic staff to assist mothers with breastfeeding with the support of professional nurses if required. In addition, implementing facilities noted the need for supplies such as nipple shields, breast pumps, videos and pamphlets, and registers.

There appears to be good uptake of this intervention which is mostly encouraged by health talks and IEC materials. Respondents feel that it is not difficult to promote this intervention because it links well with cultural practises of infant feeding although there is still some pressure from families for mothers to mix feed. The main challenge expressed by respondents appears to be the issue surrounding formula feeding in cases where the mother is dead or has breast with sores. There are also gaps with regards to working mothers because breast pumps are not readily available to distribute to mothers who are working or attending school.

4.2 Targeted Supplementary Feeding

Targeted Supplementary Feeding is a nutritional intervention for all age groups who are moderately or severely malnourished. Delivery channels for this intervention are TB clinics, HIV/AIDS clinics, ART clinics, ANC Clinics, tracer teams, childcare forums, home based care, and IMCI stations. This intervention is mostly managed by dieticians who initiate and register patients on the malnutrition register. Nurses then assist with continuous management and schedule appointments with the dieticians. Generally, facilities have noted few cases in need for Targeted Supplementary Feeding; however staff have also confirmed not promoting this intervention. Malnutrition policy/guidelines, nutrition supplementation guidelines, IMCI, PMTCT guidelines, etc. are all used to implement this intervention.

The major concerns expressed regarding this intervention were as follows: 1) this intervention caters only for the patient diagnosed at the facility and not for the entire family and no proper follow up is made to visit the family of the patient for family profiling, 2) Poverty and laziness to feed babies properly are major contributors to the observed malnutrition, and 3) there are frequent stock outs. Facilities identified the need for better stock management to ensure dependable stock availability.

There is still some stigma attached to patients receiving Targeted Supplementary Feeding due to its association with HIV/TB patients. Being a recipient of this intervention is regarded as an indirect disclosure of one's HIV/TB status. Nurses in some facilities indicated giving away the supplements to poor patients even in the absence of a clinical diagnosis as a way of making sure that stock is used up and does not expire and get wasted at the clinics. NGOs have indicated a need to assist especially

with the distribution of stock at community level as they have the capacity and infrastructure to do so. This intervention has been noted to link up strongly with SASSA.

4.3 Food Access

This intervention is implemented by DSD in partnership with SASSA and food security programmes and referrals from health facilities. Social workers give informational sessions on the services they render and there is no resistance to uptake – there's always a need and it exceeds supply. The intervention is implemented through NGOs/CBOs who distribute food parcels and run soup kitchens. Soup kitchens provide for one meal per day but provide a nutritious meal with meat, vegetables and salads where volunteers help out to prepare meals. SASSA also helps out with temporary relief. This intervention is reported to be adequate because children are healthier and perform better at schools. The key partners in this intervention are SASOL, Phela O Phedise and other community based organizations. One meal per day is seen as not adequate and also some facilities are unhappy with the contents of the food parcels distributed.

4.4 Household Food Production and Preservation (Home Gardening)

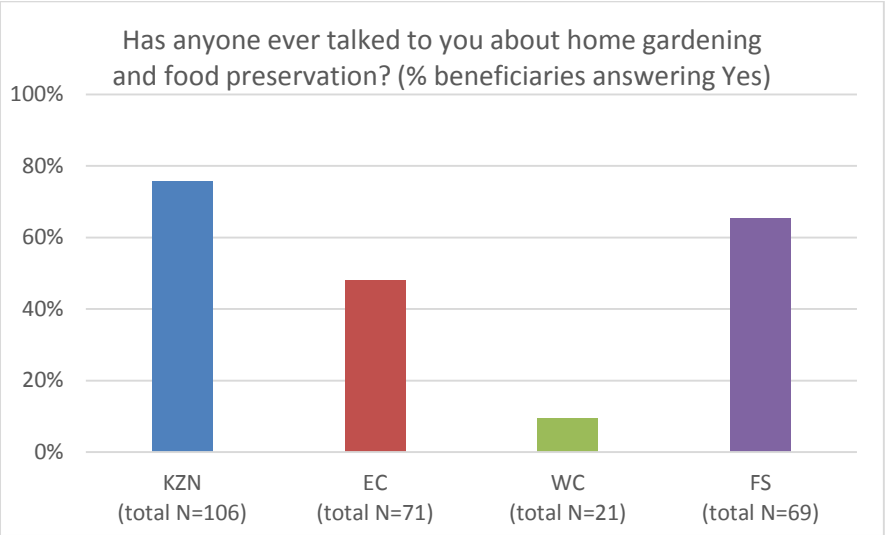
This intervention is implemented by DARD through extension officers and food security officers. Beneficiaries are identified through community and household profiling. The intervention is targeted at food insecure households and, while the questionnaire does capture the ages of children in a household, there is no provision to prioritise households with children under 5. Nearly 60% of FS beneficiaries reached during this evaluation reported that they have been given information about home gardens (Figure 8).

Home gardens are seen as a way to establish a sustainable food supply rather than waiting for hand-outs. Coordination mechanisms include Agriculture providing seeds, CBOs providing soup kitchens (e.g. St Gezzito, Child Care Forum), Catholic church, ward councillors, community volunteers, Sasol and district municipality that also distribute seeds. War rooms have been identified as a key food security forum in coordinating this intervention.

The Integrated Food Security Strategy of SA (July 2002) and Food Security strategy are both the guiding documents that inform Food Security plans and interventions in DARD. The vision of the strategy is to attain universal physical, social and economic access to sufficient, safe and nutritious food by all South Africans at all times. The challenge within DARD however, is that the Food security Policy and guidelines are subject to different interpretations which directly affect budget allocation and subsequent spending. There is non-adherence to policy directives as far as allocation and expenditure for Food Security programmes and activities are concerned.

Ideally DARD is to provide seeds, training and equipment through various packages to facilitate the implementation of this intervention, but some facilities and households sometimes run out of seeds to plant. There is also a general need for hosepipes, gardening tools, sprays/ insecticides, and fertilizers. The delivery channels for this intervention are mainly stakeholder meetings, extension officers, food security officers, and community information sessions. Communities are given land to start gardens. This intervention is in line with local knowledge and beliefs as it is a culturally accepted practice - although no longer a widely practised one. Respondents commented on how people are lazy and are too dependent on hand outs such as social grants. In some facilities there are no gardens because there are no volunteers to provide attention to the garden.

Figure 8: % of Beneficiaries who have been Given Information about Home Gardening



5 FINDINGS: OTHER FOOD/NUTRITION INTERVENTIONS

5.1 Principal Nutrition Interventions in the province – Frequency of mentions

Without being prompted, respondents were asked to list the main nutrition interventions being implemented in the province. Figure 9 presents the frequency with which nutrition interventions were mentioned.

Figure 9: Principal Nutrition Interventions in the province – Frequency of mentions

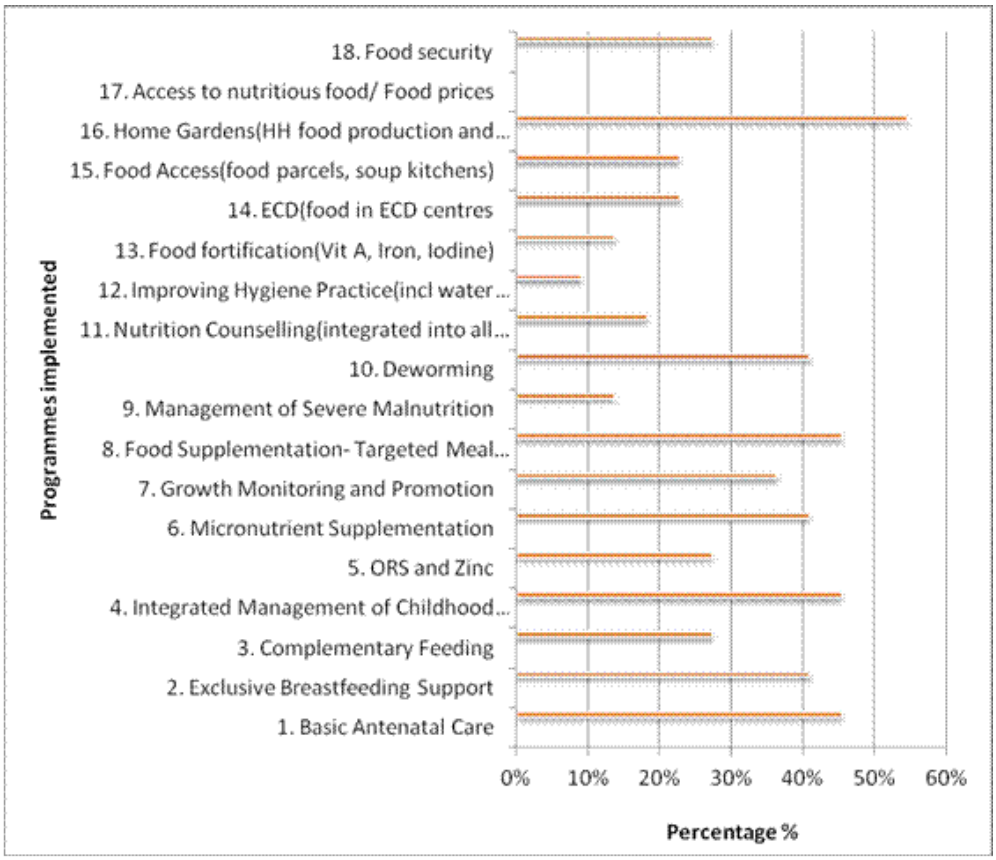


Figure 9 indicates that less than 50% of the respondents across the different departments were familiar with principal nutrition interventions, with the exception of household food production interventions, where more than 50% of the respondents mentioned this intervention without probing. None of the respondents mentioned Access to Nutritious Food / Food Prices as a key Nutrition intervention. These results could be attributed to the fact that the INP is not widely and comprehensively distributed within the stakeholder departments to staff expected to implement, despite most of the respondents' view that the policy is shared and implemented. For example, the INP Poster was only seen twice throughout the data collection process – at the District Health Offices of the Nutrition Managers in the DOH.

5.2 Findings of the Health Facility Rapid Performance Assessment

Table 6 presents the status of materials and infrastructure related to the delivery of nutrition interventions in the health facilities assessed. Although the sample is small, it is clear that nutrition IEC materials and key micronutrients were in short supply. More than 50% of facilities reported stock outs of some nutrition products in the 6 months prior to data collection, although no expired stock was found on the shelves at facilities during fieldwork. In addition, counselling space is inadequate in nearly half the clinics visited – thereby making it difficult for health workers to provide recommended nutrition counseling.

Table 6: Status of Materials and Infrastructure in FS Health Facilities

Element	% of FS health facilities (N=7)
Infrastructure	
sufficient no. consultation rooms	72%
sufficient space for counseling	69%
sufficient no. counseling rooms	56%
IEC Materials (Posters or Pamphlets available in the health facility)	
Promotion of EBF	71%
Handwashing Posters at basins	43%
Management of Severe Malnutrition	29%
Complementary Feeding	29%
Healthy Eating/Dietary Guidelines	29%
Handwashing Posters at toilets	29%
Nutrition During Pregnancy	14%
Vitamin A	14%
Breastfeeding in the context of HIV	14%
Feeding of the Sick Child	0%
Policies, Protocols, Guidelines (available in the health facility)	
Vitamin A Supplementation	100%
Management of Severe Malnutrition	100%
Nutrition Supplementation Guidelines	100%
HIV and Infant Feeding	86%
Malnutrition Supplementation Register	86%
IYCF Policy	57%
PHC Tick Register	57%
Equipment, Drugs, Supplies (available in the health facility)	
functioning baby weighing scale	100%
Vitamin A Capsules 100,000	100%
Vitamin A Capsules 200,000	100%
Iron	100%

Element	% of FS health facilities (N=7)
TSF Porridge	100%
functioning adult weighing scale	86%
Length measuring boards	86%
Folic Acid	86%
Road to Health Cards - Boys	71%
Road to Health Cards - Girls	71%
Oral Rehydration Salts	71%
Vitamin A Capsules 50,000	57%
Zinc	57%
MUAC Tape	43%
Iron-Folic Acid (combined)	14%

5.3 Findings of the Health Worker Knowledge Snapshot

The nutrition knowledge of FS nurses is average in comparison to that of other provinces (Figure 10), but knowledge could be improved. There is inadequate counselling of mothers for breastfeeding difficulties and for managing growth problems (Figure 11 to Figure 13). This could be attributed to high work load, staff shortages and a general lack of knowledge amongst health care workers at facility level. As a result, little, if any, follow up of children is undertaken to properly monitor growth following supplementation interventions.

Figure 14 illustrates a serious lack of adequate knowledge among health workers in both districts of the effects and benefits of micronutrient supplementation of both Vitamin A for under-fives and pregnant women, and folic acid for pregnant women. This is represented by the unacceptably low percentages in terms of knowledge of the overall benefits and effects of micronutrients. This may explain the inappropriate substitution of folic acid with vitamin C or calcium when folic acid was out of stock. Interestingly, more than 80% of the respondents knew <u>when</u> folic acid should be given.

On average, knowledge levels were significantly higher in urban areas (53%) than rural areas (34%), but there was no noticeable difference between two districts.

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

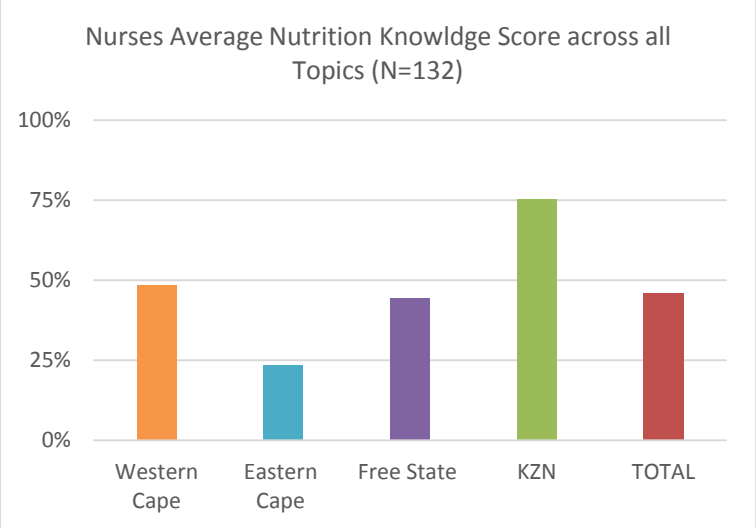


Figure 11: FS Nurses' Knowledge around Diagnosing Breastfeeding Difficulties

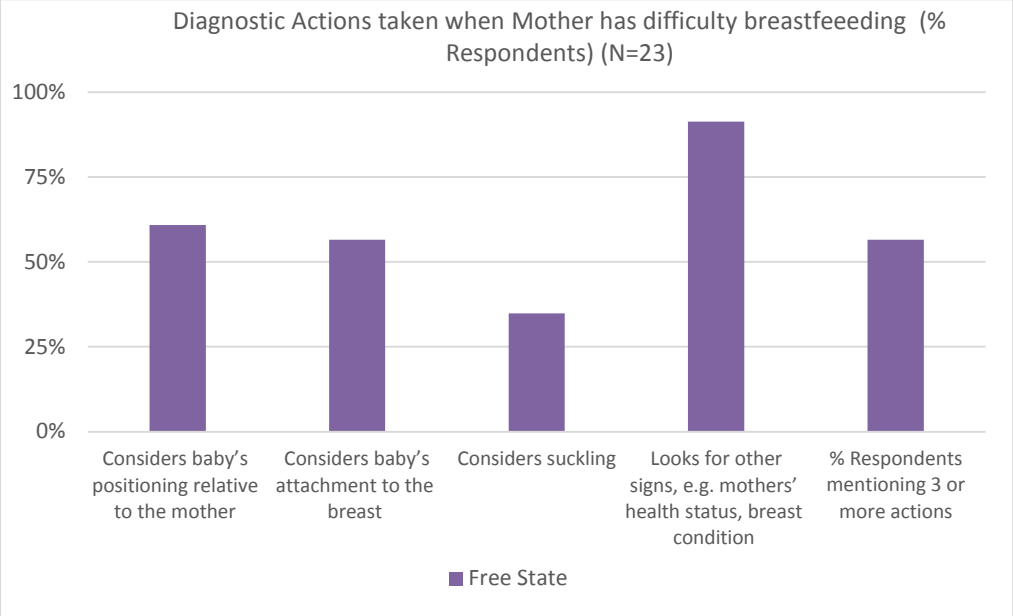


Figure 12: FS Nurses' Knowledge around Counselling Mothers with Breastfeeding Difficulties

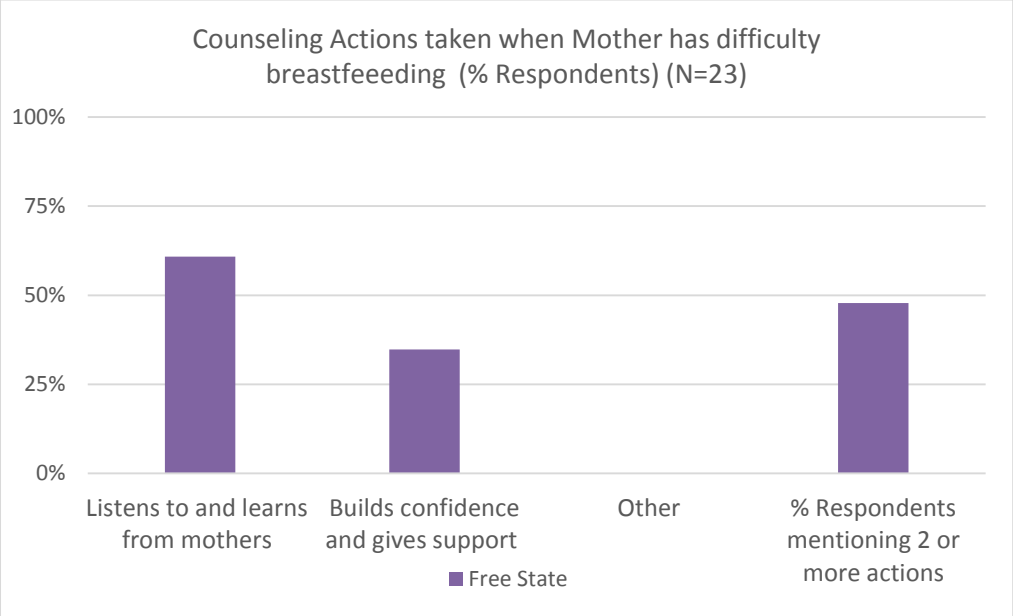


Figure 13: FS Nurses' Knowledge around Counselling Mothers when Children aren't growing well

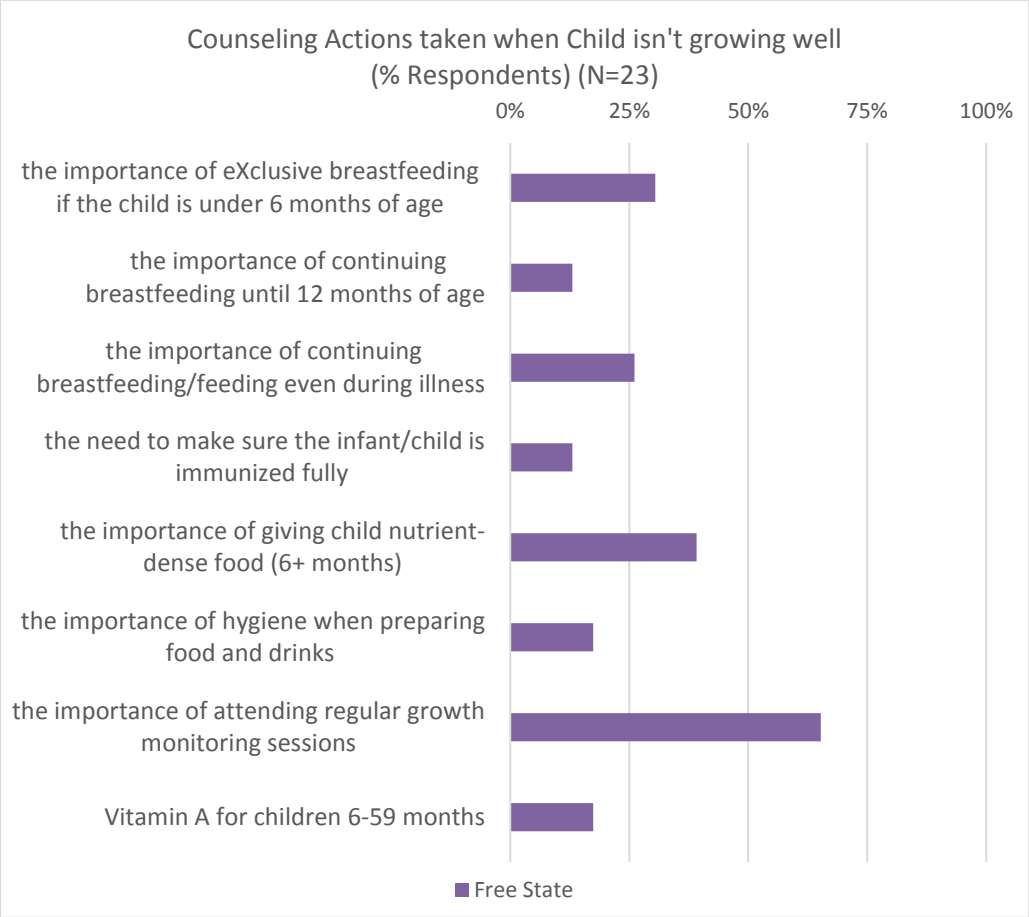
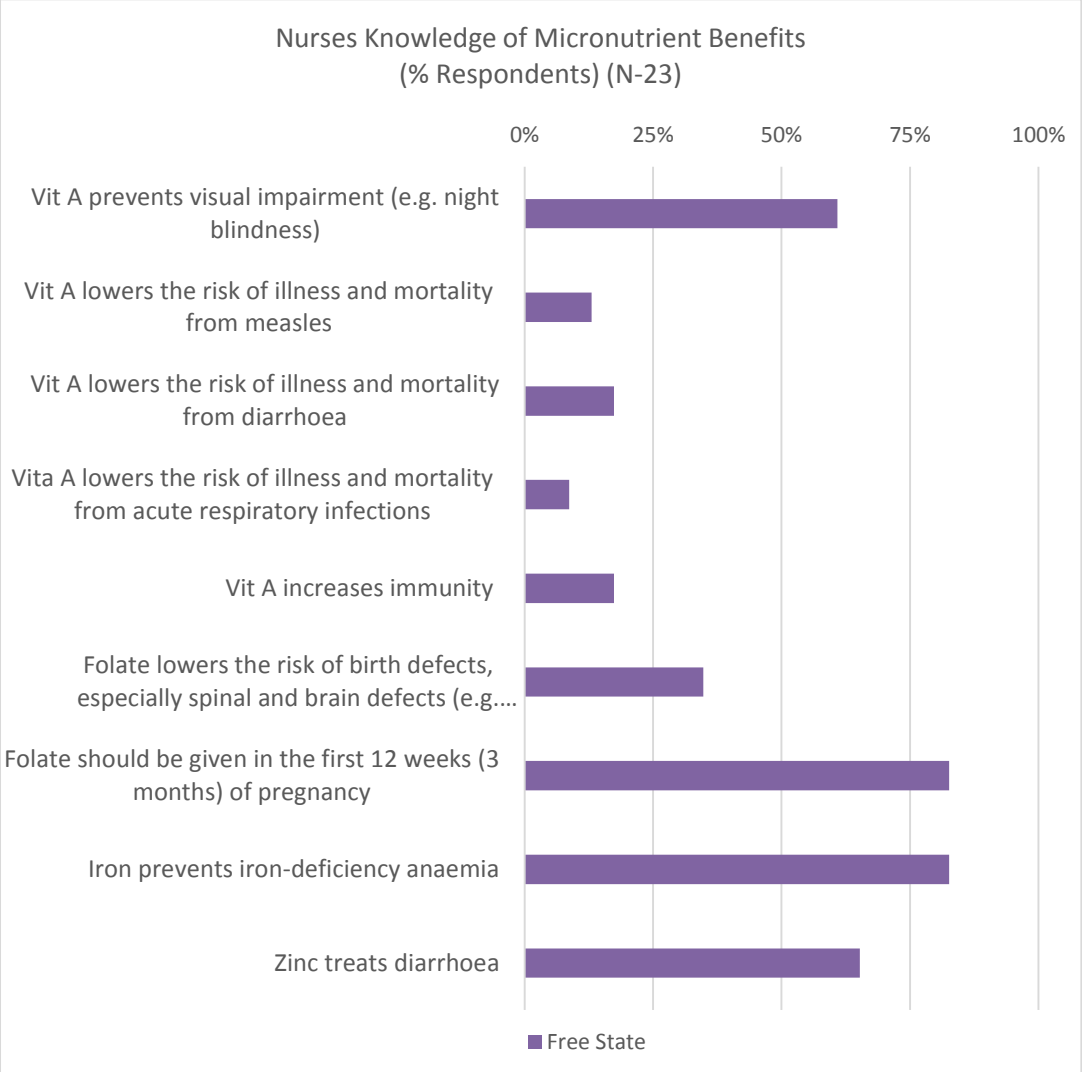


Figure 14: FS Nurses' Knowledge of the Benefits of Micronutrient Supplementation



Some respondents reported a challenge with loss to follow up which may be due to the movement of mothers and their children between towns as well as a failure to present RtHBs or cards during clinic visits. The availability of the new RtHB in the Free State was reported as a problem across both districts. In some hospitals, this has led to the issuance of a 2 page photo copy of the RtHB to mothers post-delivery instead of the full booklet. This has, in turn, prevented proper growth monitoring of babies at the 2 week visit as well as during subsequent well baby visits. Furthermore, there is a general lack of knowledge amongst health care workers providing health services with special regards to the IMCI Programme.

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Table 7: Respondents' Views on Implementation of Other Nutrition services

Nutrition-Related Service	Reported Main Delivery Channel	Reported Guidance / Protocols	Respondent's General Perceptions on effectiveness of the service in addressing Nutrition
Basic Antenatal Care	• ANC • Family Planning • PMTCT • Health talks/Group talks • Campaigns based on Health calendar	• Mother Child health and nutrition (2012). • Integrated school Health policy. • IMCI guidelines, Nutrition support guidelines and policies • Nutrition Supplementation Programme Policy • SA Guidelines for people living with HIV/AIDS and TB and other chronic diseases	Respondents find the guidelines helpful. Education is provided to mothers during family planning sessions as well as during ANC and Child health visits. However, various challenges still affect the effective implementation of this intervention. • Late presentations are still a big issue. • In one facility, respondents indicated that no supplements were given to pregnant women. • There is also an issue with the availability of IEC materials and, where these available, illiteracy at times is a barrier.
Complementary Feeding	• ANC • Post natal clinics • IMCI • Health talks • Well baby clinics	• BFHI guidelines	Slightly more than half of the health facilities visited in the Free State mentioned Complementary Feeding as one of the interventions they implement. Of these, even fewer (2 facilities out of the 7 visited) could comment on how well it was being implemented. Respondents at one facility indicated that formula is always available for those who need it while at another facility, respondents stressed the need to have formula available at facilities as a backup for mothers who run out of it. At the district level, respondents indicated that there is some education at the facility level but not in a structured or formalised way. Some district respondents see baby food advertisements as affecting the effective implementation of this intervention with one respondent saying that the "Code of marketing" will also reduce the use of solids before 6 months."

Nutrition-Related Service	Reported Main Delivery Channel	Reported Guidance / Protocols	Respondent's General Perceptions on effectiveness of the service in addressing Nutrition
IMCI	• Well baby clinics • IMIC focal nurses	• IMCI Guidelines	There are clear guidelines for this intervention and respondents generally consider this as an effective intervention for preventing malnutrition, child morbidity and mortality. However, respondents noted that shortage of skilled staff is a barrier to effective implementation of this intervention and that the guidelines are not always followed strictly. Implementation is also affected by stock outs of key supplies.
ORS/Zinc	• Well baby clinics • Health talks	• IMCI Guidelines • PMTCT Guidelines	Of the facilities which mentioned this intervention without being prompted, almost all regarded it as being implemented effectively. However, some notable implementation challenges include: • Loss of cases to follow-up. • Lack of education and engagement of mothers (or care givers). Respondents indicated that, although the intervention is initiated at facilities, it should ideally start at the home level. One facility reported that mothers are generally in a hurry and do not stay long enough to be shown how to prepare ORS. • Stock out of supplies - particularly zinc..
Micronutrients Supplements Including Vitamin A	• Mothers given at hospital postpartum and also • EPI • IMCI focal nurses • Well baby clinics	• IMCI Guidelines • Essential Drug List	• This intervention is administered as part of EPI and given when children come for screening. However, the coverage for this intervention is poor among children 24 -59 months of age. One district reported making use of ECDs to reach this age group.

Nutrition-Related Service	Reported Main Delivery Channel	Reported Guidance / Protocols	Respondent's General Perceptions on effectiveness of the service in addressing Nutrition
Growth Monitoring And Promotion	• Health education to mothers • IMCI focal nurses • Community education through CHWs	• IMCI Guidelines • Road to Health Booklet • ANC Policy • Maternal care guidelines	Growth Monitoring and Promotion is part of the regular services available at the majority of health facilities visited. Respondents noted that, ideally, children under 24 months of age are supposed to be weighed monthly. Various health care providers are involved with the implementation of this intervention including nurses and assistant nurses. In one facility, even cleaners reportedly render assistance with growth monitoring. Some of the challenges faced in the implementation of this intervention include: • Lack of equipment e.g. scales. • Incorrect plotting of weights. • Loss to follow up in children 24 months and above, and • Incomplete data capturing.
Management Of Severe Malnutrition	• IMCI nurses • Well baby Clinic • PMTCT • ANC	• Management of Severe malnutrition guidelines	None of the facilities visited reported providing this service. Management of Severe Malnutrition is generally provided at either the District or Regional Hospital. District respondents noted that training is provided to doctors and specialists but that there were insufficient training/ reference materials.
Deworming	• School health teams • ECDs	• EPI • IMCI • Essential Drug List	In the facilities visited, there was a general lack of knowledge amongst staff and communities that deworming should be administered every six (6)monthly for the first twenty four (24) months The implementation issues reported by the facilities included: • Loss of Road to Health Cards • No cards for children from Lesotho. • Loss to follow up. • Occasional stock shortages.

Nutrition-Related Service	Reported Main Delivery Channel	Reported Guidance / Protocols	Respondent's General Perceptions on effectiveness of the service in addressing Nutrition
Nutritional Counselling	• Monthly facility visits by dieticians where individual counselling takes place may also do group counselling' also attend to referrals by Dr/Professional Nurse • Individual counselling sessions with HCT counsellors • School health teams also making referrals from schools	• ANC Policy Guidelines • IMCI • RtH Key Messages	• Only one out of seven facilities visited mentioned delivering nutrition counselling and indicated that it is delivered as part of the ANC service. • The intervention was mentioned unprompted by all district respondents but not by the provincial respondents. • Individual counselling considered to be implemented more effectively than group counselling/education as participants in the latter do not listen as attentively. • Insufficient time for nutrition counselling was noted as a constraint
Improving Hygiene Practice	• Health education in schools, ECDs and health facilities • Community Based Care Workers	• None- left to CBOs/facilities to develop their own	• This intervention is delivered at the household/community level. Posters are used to demonstrate correct hand washing practices and messages on infection control is given to households.
Food Fortification	• During training with nurses	• No guidelines	Respondents knew very little about this intervention and did not feel able to comment on it.

6 FINDINGS: THE FOOD INDUSTRY IN THE PROVINCE

The Food Industry plays a supportive role with regards to government food and nutrition programmes in Free State Province. In the Department of Agriculture and Rural Development, Nestle is the major sponsor for the department's Annual Competition for Women Farmer Entrepreneurs in the 5 districts. They provide cash prizes for the winner which is meant to be invested back in the business. The South African Poultry Association is also active in the province through DARD. They provide technical assistance and training to farmers in such areas as "Bulk Purchasing" and "Formation of Cooperatives" among others. Staff at provincial and district levels within DARD initiate the engagements and request for training and IEC materials.

Tiger Brands organised to provide wholesaling in a form of a Private Public Partnership (PPP) to support the ECD Nutrition Programme. The Monitoring and Evaluation of the programme was a barrier to the success of the programme. Staff at provincial DSD level interact with the private food industry through workshops.

The International Code of Marketing of Breast milk Substitutes is only applicable to the DOH, where it is enforced. However, there is inadequate monitoring for the enforcement of the policy at health facility level except during supervisory visits. At health facility level there is no indication of the Food Industry involvement as far as marketing of their products is concerned. There was no evidence of sponsorships from formula manufacturing companies or any other companies involved in the food industry.

There is no expenditure on formula at provincial and district level within the DSD and the DOH Sub-directorate - Child Health and Nutrition DOH. Expenditure on formula is incurred under the PMTCT Programme which procures on behalf of districts. The expenditure on formula for both District Health Services lies only within the PMTC sub-programme. The DSD subsidises the food programme for ECDs with R7.00 per learner per day and ECD centres decide what food they spend it on. It was reported that the department discourages admission of children under-2 years to ECDs due to health related issues (e.g. childhood illnesses).

7 RESULTS

Table 8 below summarises the principal strengths and weaknesses of the implementation of nutrition programmes in the Free State.

Table 8: Strengths and Weaknesses in the Free State

Implementation Factor	Implementation Strengths / Enabling Factors	Implementation Weaknesses / Inhibiting Factors
Institutional Culture and Context Includes readiness to change and the extent of commitment at all levels through which the policy passes	• Exclusive breastfeeding is able to build on the fact that breastfeeding is an acceptable practice across all cultures. • There is a clear policy on exclusive breastfeeding implementation • Operational plans appear to have budgets for nutrition activities • Communities are used to planting their own produce which makes it easy for the implementation of the Household gardens intervention	• Culture also promotes mix feeding and mothers get a lot of pressure from their spouses, mothers and in-laws to mix feed. In general, there appears to be very little external support for exclusive breastfeeding such as health/ community staff dedicated to support mothers, materials such as breast pumps, nipple shields, etc. With the policy change towards exclusive breastfeeding, there is also very weak support for those babies and mothers who are forced to formula feed, in cases where breastfeeding is not possible. • Staff attitude towards exclusive breastfeeding: – Although they have been trained, they have not taken full ownership of this intervention and see it as a separate nutrition activity There is a hesitance to change with changing policies • Some DOH Operational plans do not include NGOs if there is no direct funding relationship with them. • It is difficult to get senior staff to attend collaboration forums and this delays decision-making and solution implementation. • Seeds and equipment to ensure effective implementation of Household food gardens are not always available. Clinic gardens are not thriving because very few volunteers are available to maintain them. There is also less attention given to food preservation. • Poor leadership and management of the nutrition programme at provincial and district level Negligence and mismanagement of children with growth and nutrition challenges is a major problem, especially in Thabo Mofutsanyane. Amongst numerous observations where there was no intervention provided in a child with nutrition and development problems, the case of a two year old boy seen at Rearabetswe clinic, born HIV negative to an HIV positive mother bears reference. The mother was attending the clinic as part of the EPI Campaign for Polio and Measles. She was recruited to participate in the Beneficiaries Focused Group Discussion. At the end of the discussion, I requested to have a look at the RtH book or cards of the children. The child

Implementation Factor	Implementation Strengths / Enabling Factors	Implementation Weaknesses / Inhibiting Factors
		was not thriving, looked ill and was under weight. At every clinic visit, the weight was recorded, charted and the graph plotted. There was a clear indication according the guidelines on the RtH booklet, that the child needed an intervention as he remained below the dark green line and was losing weight. In spite of this, during one of the visits, the attending nurse indicated in her clinical notes that the child had normal milestone development and provided no intervention towards addressing the nutritional status of the child. Lack of financial and human resources at provincial, district and facility levels is a barrier to the successful implementation of the INP, especially as far as the DOH as lead department is concerned. Province-wide budget constraints are affecting not only staffing but also the availability of supplies as well as transport for outreach work. Furthermore, lack or disregard for policy funding guidelines has also compromised the successful implementation of the INP, most notably as far as Food Security and Supplementation interventions are concerned. Changes in policies have resulted in confusion due to misinterpretation of these policies and guidelines.
Implementation Strategies Used the various implementation strategies (i.e. models) devised for carrying out the policy	• War rooms provide a way of creating strong inter-department linkages around the nutrition interventions • There is a strong involvement of private sector such as Nestle, Sasol, Tiger Brands, etc.	• War room meetings are not regularly attended. • Misdirected spending – spending on non-key Food Security activities, is quite prevalent in the Department of Agriculture and Rural Development. There seems to be no oversight on what the department's commitment should be towards resolving Food Security challenges in the province. This situation directly impacts negatively on food security activities at district level. District Annual Performance Plans are developed and submitted but when allocations are made, these bear very little resemblance to the plans submitted. The impression at district level is that it is a fruitless exercise to plan activities as the provincial office does not consider these when allocations are made. As a result, for example, there's no progress and growth in terms of support for Backyard Farming Initiatives implemented at district and community level. The same resources – seeds and gardening implements are provided year in year out, hence these projects do not

Implementation Factor	Implementation Strengths / Enabling Factors	Implementation Weaknesses / Inhibiting Factors
		grow to become self-sufficient, productive and sustainable. • The Mphohadi Agricultural Project in Cornelia cannot grow to reach the expected outcomes and be in a position to provide support to 50 households as per the original plan at the commencement of the project. The 2 (two) beneficiaries and owners who work on the project have experienced challenges in getting the project to be self- sufficient. The income they make from the sale of the limited produce they get form the garden, is spent on procurement of seeds, transport to workshops. The land donated by the Municipality is not conducive to planting because of the poor quality of the soil. A number of efforts and interventions were provided by DARD Extension officers to improve the soil quality without much success. • Currently, the only support received from the provincial office is in the form of seeds, which sometimes are out of season to be planted. In Thabo Mofutsanyane, there are no seeds available to distribute to the communities. In both districts, cost containment measures have been put in place as there are no funds available for travelling to provide support and oversight to active community projects. Telephones in the Fezile Dabi district office are out of order and there are no resources to support food security activities at this level. Seeds were available in Fezile Dabi, but due to cost containment measures, the officers cannot distribute to the communities as they are either not allowed to travel or the allowed amount of travel is too limited to reach the communities in need. • The Comprehensive Agricultural Support Programme (CASP) conditional grant policy requires that 10% of the grant be spent on Food Security interventions. However, this is not always adhered to. In FY12/13, the provincial budget allocation for CASP was R100 million but instead of the R10 million that was expected, only R3.9 Million was allocated for Food Security interventions.
Participant Responsiveness facilitation processes and interactions that influence	• In general there appears to be good uptake of nutritional interventions being implemented through the various actors. The level of awareness amongst communities of the interventions available	• It appears as if some interventions are preferred over others. Gardening appears to be least preferred by communities due the amount of work involved.

Implementation Factor	Implementation Strengths / Enabling Factors	Implementation Weaknesses / Inhibiting Factors
participant responsiveness	makes the implementation easier.	• Communities are dependent on government social grants and less keen to produce their own foods • There is still some level of stigma that is faintly visible to those enrolled on the Targeted Supplementary Feeding intervention. This intervention tends to be associated with HIV and TB or the elderly.
Capacity to Implement Adequacy of financial, material, and human resources to implement the policy	• Staff members implementing the nutritional interventions are motivated and even though short staffed, they try their best to render quality services. •	• Many facilities have indicated the need for: additional space to keep all the supplements; extra enrolled nurses and nutrition advisors; and increased funding for nutrition components implemented by the CBOs'. • It appears that there are regular stock outs of seeds which makes it difficult for Household food gardens to be implemented effectively.
Communication	• There are systems in place to communicate nutrition interventions internally (staff meetings, training and workshops) and externally through collaborative meetings, community forums and campaigns.	• Some IEC materials are not in local languages. • There is no strong communication between facilities and those rendering nutrition services at community levels. Sometimes there is no feedback from Health facilities as to whether or not the patient received nutritional support. Thus delaying any needed follow up.

8 CONCLUSIONS

Food and nutrition interventions implemented by the DOH and the DSD tend to reach pregnant women and children better than DOA interventions. Among the four focus interventions targeted in this evaluation, home gardening appears to be the least sensitive to the intended target group.

Exclusive Breastfeeding is a priority intervention in the Free State at all levels. Breastfeeding is generally well accepted and there appears to be good uptake. The main source of resistance to exclusive breastfeeding appears to come from the older generation who believe that breast milk alone is not adequate for the growth of the child and leads to a restless child. This leads to mixed feeding in infants under 6 months old. There is a concern among implementers that the total shift to exclusive breastfeeding has left a gap in addressing cases of children who cannot be breastfed for reasons ranging from children whose mothers work in other provinces to those whose mothers are deceased. The issue of working mothers and students and the need to support mothers with expressing and storing breast milk is also a gap that has not been fully met.

Targeted Supplementary Feeding is a facility-based intervention that is intended for moderately malnourished individuals from all age groups. Entry into / exit from this intervention is determined following an assessment by a dietician. In the Free State, the successful implementation of this intervention appears to be significantly hampered by the limited availability of dietician services at the facility level. When available, dieticians generally tend to visit facilities only once a month. Poor stock management appears to be an issue across both districts visited. While some facilities experience frequent stock outs, others have too much stock which they end up giving away to poor individuals who do not necessarily qualify for the intervention in order to avoid “wasting” the stock. There also appears to be a stigma attached to this intervention as the supplements are associated with HIV/TB patients. Lack of follow up of beneficiaries of this intervention at the community and household levels limits the reach of this intervention.

Food Access interventions such as food parcels, soup kitchens, social grants are targeted to the poor and, in the case of social grants, the number of children in the family is taken into consideration in calculating the amount of the grant. There is good uptake of this intervention on the part of beneficiaries and the need appears to be greater than the supply. However, there is strong belief amongst the respondents that the social grant has created a dependent society that is totally reliant on the grant. This has prevented communities, especially mothers of under-fives receiving the grant, from working in community gardens established in ECDs’; clinics and schools. In most cases, the grant is not used to buy nutritious food for the children but is often misused. The case of under-fives under the care of their grandmothers, living on farms on the border of South Africa and Lesotho in the Thabo Mofutsanyane district requires a high level intervention as that is a node for high rates of malnutrition amongst under-fives in the district. The high incidence of teenage pregnancies seems to be the source of the problem. Mothers then leave the farms to seek employment in the neighbouring towns, in the care of the grandmother without providing for the children with the grant they receive on their behalf. The grandmothers are left to fend for the children with the meagre income they make. This is further aggravated by the lack of access to nutritious foods on the farms as a result to the labour policy on minimum wages that took away rations which farmers used to apportion their farm workers. Alcohol abuse and general neglect add to these challenges.

Household Food Production and Preservation was the most frequently mentioned intervention among all respondents. As implemented in the Free State, the intervention does not specifically target pregnant women and children less than 5 years of age. The profiling questionnaire used to

identify food insecure households does ask about children under 5 years but not about pregnant women. However, there is no evidence that food insecure households with children under 5 are necessarily prioritized. Although there is a realization amongst implementers that this intervention is not necessarily adequate to address the nutritional challenges of pregnant women and children under 5, it is felt that it better than nothing. To a great extent, lack of access to nutritious food and lack of interest by communities to engage in household or backyard farming interventions results in children being given food without any consideration to its nutritious value.

Overall, there is inadequate leadership, management, expertise and capacity to fully address and support the nutrition programme's needs both at provincial management level and at facility and community implementation level. This negatively impacts on the performance of the programme at district and facility level within the province.

Changes in infant feeding policies have resulted in some confusion due to a certain level of misinterpretation of the policies and guidelines. For example, The Tshwane Declaration is interpreted as saying that there should not be formula milk in the facilities. This has left a gap as there is no alternative supplement for those infants whose mothers have died as well as infants of mothers who cannot breastfeed either due to severe illness or other conditions precluding them from breast feeding.

In Thabo Mofutsanyane, the procurement processes for supplements by health facilities are not clearly defined and communicated, leading to confusion and misinformation regarding stock availability.

APPs are developed at provincial and district levels. However, allocations tend to not reflect the submitted APPs /budgets. At the district level, the sentiment appears to be that there is no point in preparing budgets and APPs as they are simply disregarded. Furthermore, there appears to be a trend of declining allocations from year to year and this in turn affects the funds available for food and nutrition related interventions. There is no dedicated budget for food and nutrition interventions at DOH but is incorporated into the general Child Health and Nutrition budget instead.

There are generally not enough personnel to support and focus on nutrition interventions. There is a shortage of dieticians to provide regular nutrition services at the implementation level. There is also a shortage of staff to follow up with families of malnourished children. Furthermore, there are knowledge gaps that exist at facility level amongst health workers expected to implement the nutrition interventions – particularly in rural areas, and particularly around counseling topics.

Irregular and unreliable supply chain management processes in place to support the Nutrition Programme to ensure availability of related products, IEC material, stock (formula and supplements) is a barrier to a successful implementation of the programme. The same challenge is experienced within DARD with the availability of seeds and agricultural implements to support community based household gardening to ensure Food Security. This is to a greater extent experienced by Thabo Mofutsanyane than Fezile Dabi.

There are strong interdepartmental coordination mechanisms at the provincial level but not at the district level. There appears to be a need for clearer role definition, senior level representation, and joint planning at district level in order to significantly improve coordination between departments and avoid duplication of efforts.

There is a huge untapped potential for improved nutritional outcomes for under-fives and pregnant women if government can leverage the contribution to the Food and Nutrition programme by NGOs, CBOs and the private sector. This is particularly the case with regards to interventions that require

the active involvement of households and communities for effective implementation.

There is no evidence of undue marketing practices by Food Companies and Formula Milk Company and the policy on Code of Marketing of Breast milk substitute is adequately enforced

Across all three departments and all levels, some data is collected relevant to food and nutrition. All departments have issues with timeliness of data as well as accuracy. However, not all departments consistently conduct data verification. The data that is collected data is used to improve the implementation of the interventions.

9 RECOMMENDATIONS

- Re-emphasise INP as a priority programme to receive a more concerted effort in the implementation of the Policy. A similar approach to that of the PMTCT/HCT/ Programme.
- Review budget allocations and strengthen district planning processes – a form of Nutrition Programme Conditional Grant – ring fenced budget. Most urgent would be for DOH provincial and district budgets, more so because Thabo Mofutsanyane is an NHI Pilot District.
- Clarify roles and responsibilities of each stakeholder department to minimise duplication of effort – all departments had spent some of their budgets on procurement and distribution of seeds. House hold profiling of food insecure households also seems to be duplicated to a large extent.
- Capacitate and strengthen the DOH Provincial and District Nutrition Programmes – review the organizational structure – Thabo Mofutsanyane as a Health Priority district.
- Address the shortage of dietician services at the facility level.
- Strengthen general nutrition training, especially among staff based in rural areas. Counseling skills need particularly strengthening among all health staff.
- Strengthen intergovernmental coordination mechanisms at district level through assigning a lead department and a more senior official (director level) to facilitate coordination and decision making at this level.
- Increased and more concerted effort to advocate for INP Policy within the stakeholder departments through targeted Nutrition Training interventions more so at executive management level and at implementation level (district and facility levels – to address knowledge gaps).
- More visible advocacy for EBF and Household gardening projects through print and visual media to reach communities and address the current stigma attached to the interventions – similar to HCT/HIV Prevention Campaigns. These interventions should carry messages – to reach teenage mothers and the old – to reach mothers, grandmothers and in-laws.
- Review the Child Grant – investigate alternative delivery or funding models – in most cases, it does not directly benefit the intended beneficiaries.
- Develop strong linkages with NGOs, CBOs and FBOs to better follow up on pregnant mothers and children under 5.
- Develop and implement, in partnership with communities and other stakeholders (CBOs, NGOs,

and FBOs), community development programmes that are relevant and responsive to the needs of the communities to address the prevailing dependency syndrome.

- Undertake a more in-depth analysis of Food Banks as service delivery channels for Food Security as there are no clear guidelines to guide and inform the implementation of these service delivery models.
- Review the data management system and put measures in place to address data quality issues.

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APPENDIX A TERMS OF REFERENCE

DEPARTMENT OF PERFORMANCE MONITORING AND EVALUATION

THE PRESIDENCY

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

RFP / Bid number: 12/0287

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

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

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

1 Background information and rationale

1.1 Background to the intervention being evaluated

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2 Purpose of the evaluation

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

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

2 The focus of the evaluation

2.1 Evaluation questions

The key evaluation questions that this evaluation will address include:

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

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

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

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

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

2.2 Intended users and stakeholders of the evaluation

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

Table 2: Users and their use of the evaluation results

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

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

2.3 Scope of the evaluation

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

Table 3: Scope of the nutrition evaluation

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

3 Evaluation design

The key elements of the design include:

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

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

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

APPENDIX B METHODOLOGY

LITERATURE REVIEW

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

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

SAMPLING

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

Stage 1: Selection of Provinces

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

JUSTIFICATION FOR THE PROVINCES SAMPLED

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

Stage 2: Selection of Districts

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

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

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

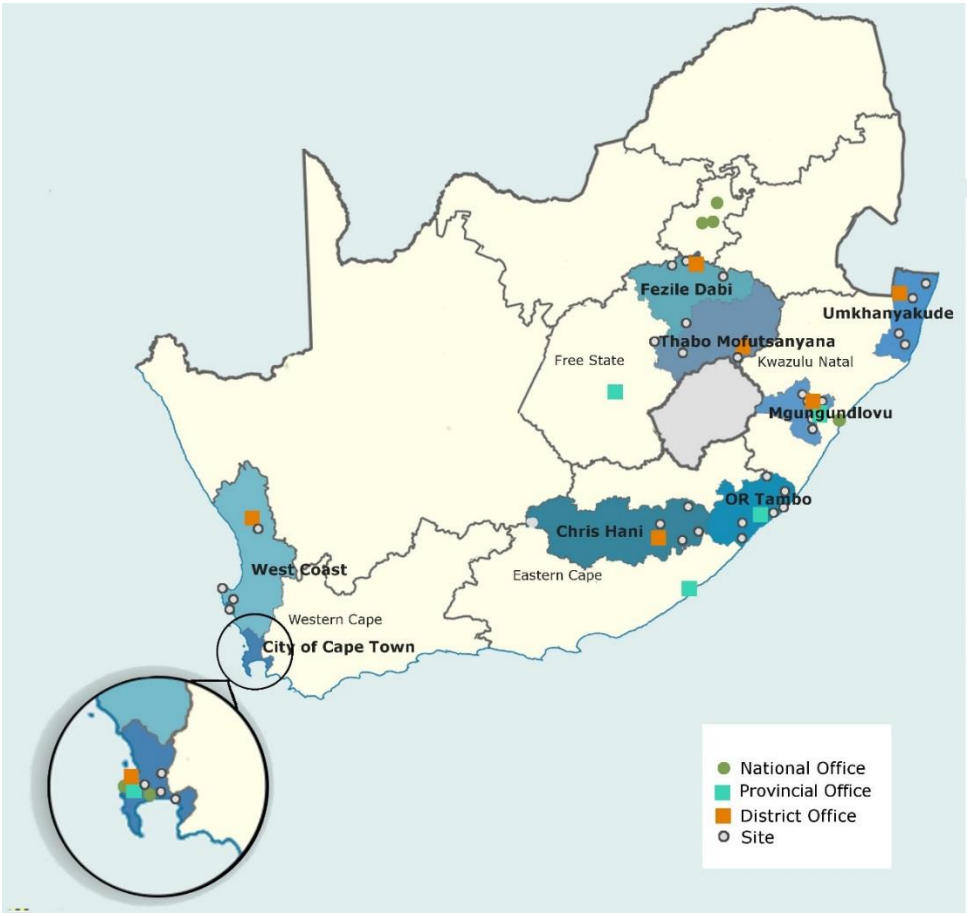
DISTRICTS INCLUDED IN THE SAMPLE

PROVINCE	HIGH PERFORMING DISTRICTS		POOR PERFORMING DISTRICTS	
	District Name	Justification	District Name	Justification
Eastern Cape	Chris Hani	Recommendation from the EC nutrition focal person.	OR Tambo (Umtata)	NHI pilot site Poor Child Health indicator score Poor Rural Development indicator Score
KZN	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
Free State	Thabo Mofutsanyane	Recommendation from FS nutrition focal person	Fezile Dabi	Recommendation from Nutrition Manager in FS province
Western Cape	West Coast	Recommendation from WC nutrition focal person.	City of Cape Town	Recommendation from Nutrition Manager in WC province

Stage 3: Selection of Facilities/Organisations

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

FIELDWORK LOCATIONS



Stage 4: Selection of Individual Respondents

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

Proposed Respondents (and method of data collection)

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

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

3) **District Level Respondents** *(in-depth interviews or focus group discussions)*
   - District DOH nutrition managers
   - District DSD nutrition managers
   - District Rural Development food/nutrition managers
   - District Agriculture food security managers
4) **Health Facility Respondents** *(in-depth interviews or focus group discussions)*
   - MCH nurse or nursing assistant
   - Counsellors for pregnant women and/or mothers of young children
   - Community health workers attached to health facilities
5) **NGO Respondents** *(in-depth interviews or focus group discussions)*
   - Programme or Site Manager
   - Community workers
6) **Beneficiary Respondents** *(focus group discussions)*
   - Pregnant women and mothers of children under 5 years present at health facilities
   - Beneficiary participants in NGO programmes

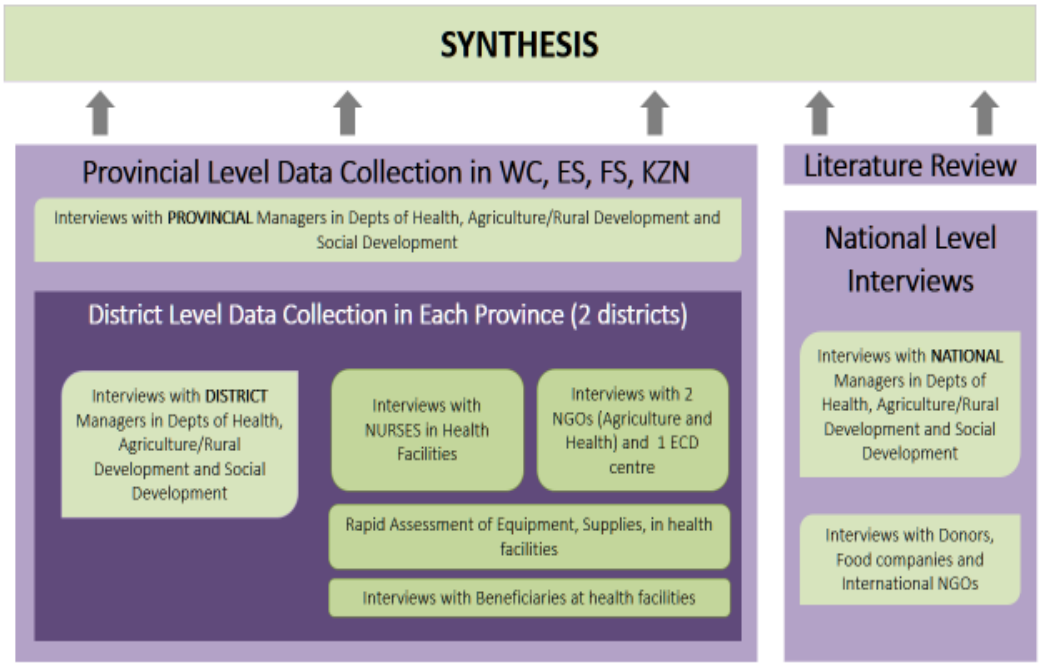
DATA COLLECTION METHODS

Data collection methods used in the evaluation are as follows:

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

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

Summary of Data Collection Components of the Evaluation



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

Data Collection Methods and Target Respondents by Content

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

PLANNED VS. ACTUAL DATA COLLECTION

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

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

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

FIELDWORK PLANNED AND ACTUAL

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

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

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

ACTUAL NO. INTERVIEWS AND FGDS CONDUCTED BY PROVINCE

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

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

DATA RECORDING AND CAPTURING

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

DATA ANALYSIS

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

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

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

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

REPORTS PRODUCED

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

evaluation as listed below:

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

LIMITATIONS OF THE EVALUATION

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

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

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

APPENDIX C FIELDWORK CHALLENGES

Scheduling and Timing: Some of the district level respondents confirmed appointments but had to attend to other priorities on the day of the interview or indicated that they were not the relevant person to interview and referred to colleagues who were hesitant to do the interview.

Communication about the evaluation to the provinces and districts: The evaluation was not clearly communicated by the DDG's office to the relevant Departments. FS Department of Health respondents wanted a letter from their Acting HOD, giving permission for data to be collected in Health Facilities and District Offices. This was facilitated because of the relationships built previously with staff in the HOD's Office.

Respondent substitutions: During the interview with the Chief Director – ECD at DSD, it was recommended that an interview be scheduled with the Chief Director of Community Development, the section directly responsible for Food Security Programmes, in order to get a more comprehensive picture of Food or Nutrition services within the department. Respondent substitutions happened at the Thabo Mofutsanyane District – DSD. The initial respondents were not available on the day confirmed for the interview and also cited that they were not the relevant people to interview. This resulted in the researcher having to set up additional appointments with related time and logistical issues.

Collecting data at health clinics: One (1) facility, Villiers Clinic was left out due to a scheduling misunderstanding between the researcher and the logistics coordinator. Data collection at health facilities was a challenge due to staff shortages as the EPI Campaign was also running at the same time as the data collection, the time taken to conduct the interviews as the tools were quite lengthy and respondents became restless, impatient and complained about the time taken, and the distances between the facilities. During Focus Group Discussions with Beneficiaries, one would start the discussion with a group of 10 to 12 mothers, but most would leave in the middle of the session due to various reasons – fear they would miss their place in the queue, lack of interest in the topic discussed or they were in a hurry to leave the facility as they had prior engagements to attend to. At times those present would not respond to questions and would keep quiet. This happened in spite of attempts to break the ice to develop a rapport by discussing issues other than food or nutrition. Upon further investigation with health workers, one learned that mothers do not like to be asked about food or nutrition related issues concerning their children.

APPENDIX D LIST OF PEOPLE INTERVIEWED BY LOCATION

Provincial Respondents:
Department of Health
Department of Health
Department of Social Development
Department of Agriculture and Rural Development (Glen)
Department of Agriculture and Rural Development (Glen)
Department of Agriculture and Rural Development (Glen)
District Respondents:
Department of Health – Thabo Mofutsanyane
Department of Health – Fezile Dabi
Department of Health – Fezile Dabi
Department of Social Development - Fezile Dabi
Department of Social Development - Fezile Dabi
Department of Agriculture and Rural Development – Fezile Dabi
Department of Social Development – Thabo Mofutsanyane
Department of Social Development – Thabo Mofutsanyane
Department of Agriculture and Rural Development – Thabo Mofutsanyane
Health Facilities
Qalabotjha Clinic, Villiers
Thusanang Clinic, Zamdela, Sasolburg
Harry Gwala Clinic, Sasolburg
Eva Mota Clinic (Dinkweng Clinic inaccessible in a sedan)
Rearabetswe Clinic – Petrus Steyn
Kokelong Clinic, Marquard
Ladybrand Clinic
NGO Respondents:
Lethabong Creche, (ECD) Bluegumbush – Phuthaditjhaba
CARE South Africa, Bethlehem
Lebone Village, Bloemspruit