planning, monitoring & evaluation
Department:
Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

PSPPD
PROGRAMME TO SUPPORT PRO-POOR POLICY DEVELOPMENT

POLICY BRIEF SERIES

Evidence for policy-making and implementation

Nutrition interventions for children from conception to age five

BACKGROUND

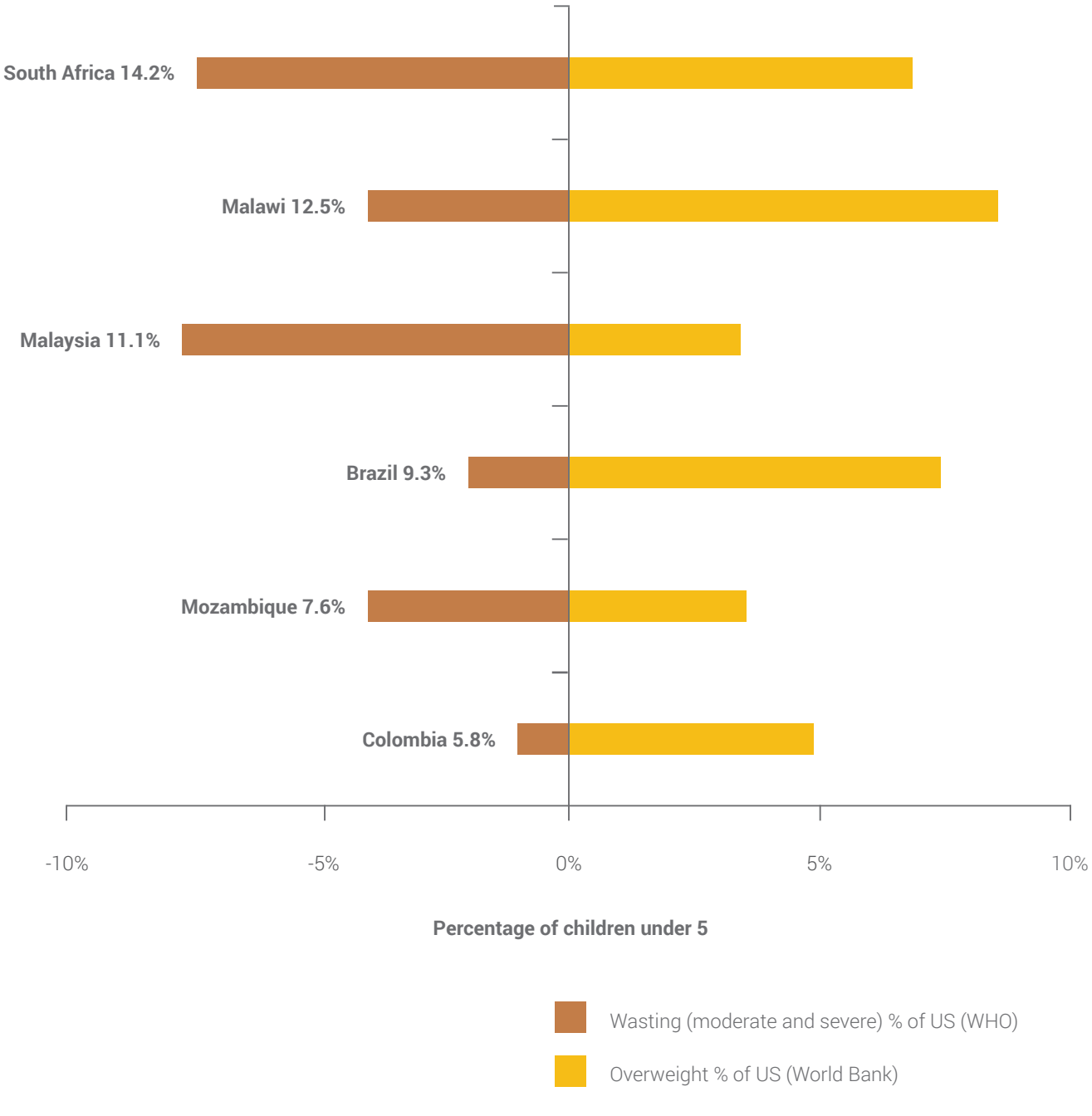
Access to basic nutrition is a universal right. The right to nutrition during the first 1 000 days of a child's life (from conception to two years) has a profound impact on a child's long-term ability to grow, learn, and thrive. This in turn has a lasting effect on a country's overall health and prosperity. Failure to provide adequate nutrition has contributed to stagnating child mortality and morbidity in South Africa, and has seen the country lag behind in achieving the 2015 Millennium Development Goals (MDGs).

When compared to countries that have successfully improved their nutrition standards, such as Malawi, Malaysia, Brazil, Mozambique and Colombia, South Africa ranks highest in the double burden of disease observed among children under the age of five, and is the only one of these countries that lacks a common operational plan (and budget) for consolidating nutrition activities with targets across sectors and at all levels of implementation. Furthermore, there is no coordinating body above line departments which can hold departments accountable in terms of their contribution to nutrition. National level strategic coordination of nutrition is based on the participation of government departments in a forum usually led by the Department of Agriculture, Forestry and Fisheries (DAFF).

Urgent attention is needed from policy-makers and programme implementers to ensure all children under five are accessing their rights to adequate food and nutrition. This policy brief recommends that the Early Childhood Development (ECD) Policy (2015) be strategically linked to the National Food and Nutrition Security Plan (NFSNP), which was approved in September 2016. The plan addresses food and nutrition issues among the entire population, and will be rolled out from 2017 to 2022. An integrated plan of action between the ECD Policy and the NFSNP can lead to a lasting change in nutrition levels in the broader population, starting with obtaining good standards of nutrition during the critical years of 0-5.

MALNUTRITION DOUBLE BURDEN IN CHILDREN UNDER FIVE

WASTING AND OVERWEIGHT IN 6 COUNTRIES (2006-2010)



POLICY FRAMEWORK

Although nutrition programmes have been in place in South Africa since the 1960s, they have not generally been effective in reducing malnutrition, as they focused primarily on providing food to the needy and not on resolving the underlying causes of malnutrition. To this end, the Integrated Nutrition Programme (INP), introduced in the 1990s, aimed to address the underlying causes of malnutrition by emphasising collaboration between departments in order to improve nutrition levels in the long term. However, in spite of the INP, South Africa has made limited progress in improving child nutrition, resulting in the persistence of problems such as stunting, reflected in the 2013 South African National Health and Nutrition Examination Survey (SANHANES), which revealed that 26% of boys and 25% of girls aged 1-3 years old are stunted.

While the INP has been the main policy vehicle for achieving synergies in nutrition investments in the health, social welfare, and agriculture sectors, there are no readily available guidelines for governing the plan. Furthermore, the lack of structures and requisite systems for coordination poses one of the biggest obstacles to achieving the INP's objectives. None of the interventions of the departments which contribute to the INP are formally coordinated, nor do the departments demonstrate adequate sensitivity to nutrition or the first 1 000 days of a child's life. In addition, there have been no performance reviews of the INP to date, and it has therefore arguably existed mainly as an approach, rather than a formalised programme.

EVALUATION OF NUTRITION INTERVENTIONS FOR CHILDREN FROM CONCEPTION TO AGE FIVE

This policy brief is based on the results of an implementation/diagnostic evaluation which assessed 18 interventions across the Department of Health (DoH), Department of Social Development (DSD), and the DAFF. The evaluation aimed to identify factors which contribute to effective or non-effective implementation of government interventions. The host of interventions reviewed in the evaluation provide different levels of food and nutrition support to children and their mothers from the time of conception to the age of five years. Some of the programmes also tend to the needs of the general populace.

Methodology

Data for the evaluation was qualitatively collected in four case study provinces – KwaZulu-Natal, Western Cape, Free State and Eastern Cape – where participants from a sample of district health facilities and non-governmental organisations (NGOs) were selected.

Data was also collected through engagements with various stakeholders at national level. Of the 18 interventions evaluated, four were used as case studies for in-depth assessment of their implementation, namely Breastfeeding Support (DoH); Targeted Supplementary Feeding (DoH); Household Food Production and Preservation (DAFF); and a cluster of programmes falling under Access to Food (DSD).

A set of questions around effective implementation aimed to assess if the 18 interventions (1) were nutrition-specific, or at least nutrition-sensitive; (2) included clear targets for pregnant women and children under five; (3) had adequate guidelines, human, and material resources for implementation (i.e. institutional capacity); (4) included a monitoring and evaluation (M&E) system to monitor service delivery and the extent to which set targets were being met, and lastly; (5) if programmes were delivered jointly through partnerships between government departments, and/or corporate and NGO stakeholders. A scoring system giving weight to 'yes', 'partially' or 'no' responses was used to obtain an objective score for each intervention.

IMPLEMENTATION EFFECTIVENESS SCORES FOR THE 18 INTERVENTIONS

NUTRITION INTERVENTION * High impact interventions (Responsible government department)	TOTAL SCORE (% possible points)
BANC (Basic ante-natal care) – education and supplements, timing (DoH)	**81.3%**
Food fortification – Vitamin A, Iron and Iodine* (DoH)	**80.0%**
Early Childhood Development – food in ECD centres (DSD)	**75.0%**
Management of moderate malnutrition including targeted supplementary feeding* (DoH)	**68.8%**
Oral Rehydration Salts (ORS) and Zinc* (DoH)	**68.8%**
Micronutrient supplementation, including Vitamin A* (DoH)	**66.7%**
Deworming (DoH)	**66.7%**
Management of severe malnutrition* (DoH)	**66.7%**
IMCI (Integrated management of childhood illnesses) (DoH)	**66.7%**
Growth monitoring and promotion including the use of Mid-Upper Arm Circumference (MUAC) measurements (DoH)	**50.0%**
Access to (nutritious) food, food prices (DAFF)	**50.0%**
Breastfeeding support* (DoH)	**44.4%**
Complementary feeding* (DoH)	**37.5%**
Food access (e.g. food parcels, soup kitchens) (DoH)	**33.3%**
Food security (output 2 of outcome 7 in the National Priority Outcomes) (DRDLR and DAFF)	**25.0%**
Nutrition education and counselling (part of all of these) (DoH)	**22.2%**
Improving hygiene practice (including in relation to water and sanitation) (DoH)	**18.8%**
Household food production and preservation (home gardening) (DAFF)	**18.8%**

FINDINGS

Half the interventions (N=9) received implementation effectiveness scores over 66%. These were largely the clinical interventions implemented by DoH, along with ECD food security programmes. The remaining nine interventions had scores below 50%. These were all the DoH behaviour change interventions, food access programmes, and agriculture interventions.

The evaluation noted that despite the existence of the INP, 17 of the 18 interventions fall under the exclusive mandate and management of one of the three departments, with the exception of one food security programme that is implemented through a partnership between DAFF and Department of Rural Development and Land Reform (DRDLR).

The results measuring programme effectiveness also highlighted the crucial role that needs to be played by non-government stakeholders in achieving and sustaining positive nutrition outcomes for children. In essence, the effects of poor nutrition on generations of families are equally determined by the extent to which community participation is realised – particularly from mothers, fathers and caregivers of children under five years.

Parent responsibility and community participation

The evaluation found that services rendered at government facilities such as clinics and ECD centres (in other words, controlled environments where beneficiaries can receive one-on-one attention) perform significantly better than programmes that are community based (where government has historically had less direct control and contact with individuals). The success of the latter types of programmes largely depends on beneficiaries responding positively to the programme's government offers, and in turn shaping the programmes to be responsive to their needs.

Receptivity includes the willingness to make behaviour changes which lead to better food choices, improved meal preparation, and being consistent in programme uptake, even in the absence of government officials. An example of poor receptivity is seen country-wide in Breastfeeding Support – one of the top three interventions for preventing child death. Despite the benefits of breastfeeding, within the first two months of life, only 12% of infants are exclusively breastfed, while the majority are fed other liquids, milks, or solid foods. Exclusive breastfeeding practice drops consistently until by 4-6 months of age, only 2% of infants are exclusively breastfed.

Another intervention which has received generally poor reception is the Targeted Supplementary Feeding (TSF) programme. Although it is performing relatively well, TSF is wrongly stigmatised in communities as an intervention specifically targeted to HIV and AIDS patients. Uptake has therefore been lower than it should be, given the numbers of people who are moderately malnutritioned. In this case, government's key role is to improve information, education and communication (IEC) to promote the programme; while communities need to change their negative perceptions. The model introduced in KwaZulu-Natal and the Eastern Cape to use community health workers (CHWs) or community care givers (CCGs) for identifying, referring, and following-up underweight children and pregnant and lactating mothers, as well as to give talks to communities on nutrition and food preparation, is commendable. This model could extend the reach of TSF compared to the traditional implementation model, which relies on the programme being clinic based and delivered by dieticians.

Implementation weaknesses

Poor implementation systems can create a debilitating and intergenerational problem for South Africa in terms of longevity, educational outcomes, and productivity of people, and the related contribution to economic growth. Taking a closer look into the management systems and operational mechanisms of the four interventions used as case studies, a range of institutional weaknesses in government departments were found.

Human resources

Interviews with many of the implementers uncovered a lack of adequate skills and knowledge to deliver holistic nutrition and health services to young children and their mothers. Nursing staff in the DoH did not fully understand the nutritional benefits of certain supplements and food fortifications, and did not uphold standard counselling practices (such as ensuring privacy and sensitivity).
The results from interviews with DAFF and DSD officials showed that staff did not fully understand the significance of food quality and diversity over and above measuring the quantity of food consumed. KwaZulu-Natal, however, generally stood out as having knowledgeable and capable implementation staff in the nutrition support services.

Overall, most respondents were able to speak knowledgeably about nutrition interventions implemented by their specific department, although few officials from all the departments working at provincial, district, and local levels were able to comment on implementation done by other departments. Lack of a partnership approach to ensure cross-sector knowledge and collaboration prevents the maximisation of effective delivery in both food (DAFF/DSD) and nutrition (DoH) security programmes.

Material resources

Adequate infrastructure, materials, and supplies at health facilities were largely available, although stock-outs had been experienced in some clinics in the six months preceding the evaluation. Use of material resources was, however, misdirected due to overall weak coordination, including lack of formal patient referral systems between government departments. This was particularly observed in the Free State. Weak silo systems meant that the most vulnerable in society, pregnant women, and children under five were not accessing the full suite of available services.

Data management

The evaluation identified lack of M&E as one of the biggest challenges facing the nutrition interventions. M&E systems are fragmented within and across departments, with no integration pathways to speak of in coordinating the 18 interventions. Within DAFF, there were no standardised protocols for implementation, making coordinated M&E a difficult task. Weak coordination means indicators on data for food security (DAFF/DSD) and nutrition (DoH) are not designed to correlate. In addition, most of the data collected is not disaggregated to the under-five population.

Case management coordination

KwaZulu-Natal has put in place an exemplary programme, known as Operation Sukuma Sakhe (OSS) – a "war on poverty" campaign, located in the Office of the Premier. Unlike in any other province, OSS has led to effective prioritisation of nutrition outcomes. OSS has achieved many gains by using a task team-case management approach implemented at provincial and ward levels. This approach enables government to track the services received by individual beneficiaries across several departments through the ongoing holistic support provided to individual families by CHW or CCG.

The OSS circumvents misalignments as seen in other provincial structures like the Western Cape, for example, where an inter-departmental coordinating body exists, but implementation is still done through silo mechanisms. In this case, the structure for coordinating arguably has little to no authority to hold departments accountable.

RECOMMENDATIONS

The evaluation came with a number of short-, medium- and long-term recommendations to address challenges around personnel, finances, and the quality of care in the nutrition interventions. Firstly, the evaluators recommended that nutrition for under-five children be elevated to an output of Outcome 2 (i.e. Health), which would allow for a well-defined Nutrition Plan spanning across all sectors in order to streamline investments and operationalise national priorities towards achieving consolidated goals. Reducing stunting amongst under-five children was highlighted as one of the explicit goals of this plan. The Nutrition Plan should have common indicators to track food and nutrition across all departments, with reporting done at cluster management level nationally and directorate level in provinces. A National Nutrition Council similar to the South African National Aids Council (SANAC), with DoH as the champion and coordinator, should be established and pursue the following:

Short- to medium-term

1. High level coordination to hold departments accountable and achieve joint operational targets through existing line department policies/regulations;
2. Ring-fence budgets by including nutrition targets in annual performance plans to avoid stock-outs as seen in some clinics;
3. Focus on quality and diversity of food (i.e. nutrition value) in delivery of interventions, and not only on the quantity of food consumed;
4. Ensure departments adopt standard operating procedures and display these at facilities in easy-flow charts for community members to become familiar with the integrated suite of services;
5. Community-based delivery models (community-based workers/CHW/CCG), as seen in KwaZulu-Natal and Eastern Cape, with strong IEC to promote under-five nutrition – addressing both underweight and overweight health issues;
6. DAFF focuses on special high nutrient crops, such as morogo and orange sweet potato, to respond to food and nutrition insecurity.

Long-term

1. Establish and maintain good partnerships with NGOs and community-based organisations (CBOs), preferably through formal arrangements to eliminate sporadic collaboration;
2. Strengthen link between the child grant system and nutrition in order to monitor use of the grant towards achieving acceptable growth and development among child beneficiaries;
3. Staff trained adequately in nutrition as well as counselling support, giving due sensitivity to patients;
4. Case management approach tracking all services received by individuals using an adequate patient information database;
5. Increase ECD centres in order to effectively broaden nutrition service coverage as children receive a guaranteed quota of nutritious meals per day if they attend the centre.

POLICY IMPLICATIONS AND CONCLUSION

Moving towards integration

Policies have tended to frame food insecurity as primarily a lack of access to food challenge that must be addressed by DAFF and/or DSD; while nutrition continues to be framed as a DoH problem. To this end, the "Roadmap for Nutrition in South Africa" (2013-2017) focuses only on the roles and responsibilities of the health sector and lacks specific description around the contributions of agriculture, social development, and other sectors to broader strategic goals. When the evaluation was conducted, there was little awareness of its existence, particularly among provincial and district managers in the other sectors.

The National Integrated Early Childhood Development Policy is designed to integrate the provision of a comprehensive set of services towards the fulfilment of children's rights. Nutritional support at different stages of growth from conception to six years; maternal and child primary health interventions; and support for primary caregivers are three of the five essential components of this comprehensive package. The ECD Policy should be strategically linked to the INFSP, which sets food and nutrition goals for the broader population.

The Achilles heel of the new strategy will be its ability to hold government departments jointly accountable for nutrition targets. As the evaluation found, individual departments generally have good programmes (albeit that some struggle with implementation), but the biggest drawback to improving overall nutrition and food security in South Africa is the lack of integration and coordination across departments. KwaZulu-Natal OSS is a prime example of how formal collaboration structures/systems can efficiently improve nutrition outcomes.

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