

INTEGRATED NUTRITION PROGRAMME

STRATEGIC PLAN 2002/03 TO 2006/07

PREPARED BY THE NATIONAL DIRECTORATE: NUTRITION AND PROVINCIAL NUTRITION UNITS

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DEPARTMENT OF HEALTH
Republic of South Africa

INTEGRATED NUTRITION PROGRAMME

STRATEGIC PLAN 2002/03 TO 2006/07

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PREFACE

This document sets out the priorities of the Integrated Nutrition Programme for the period 1 April 2002 to 31 March 2007. It will form the basis of more detailed and specific plans that will be operationalised through annual business and operational plans at national and provincial levels.

The Plan is based on the current constraints and challenges facing the Programme not just in terms of the nutritional status of the population, but also in terms of programme development. In addition, it builds on the achievements of the Programme over the past five years.

The Strategic Plan needs to be read in conjunction with the following:

- The Health Sector Strategic Framework for 1999 to 2004.
- Strategic and Operational Plans of the National Department of Health.
- Strategic and Operational Plans of Provincial Departments of Health.
- National and Provincial Medium Term Expenditure Framework Plans.
- The Year 2001 to 2005: Health Goals, Objectives and Indicators.

In addition to the above, the many lessons from evaluations, assessments, discussions, conferences, workshops, etc. over the past five years have been considered in developing the Plan.

SUMMARY

The National Food Consumption Survey (NFCS) of 1999 showed that at least 21,6% of children between the ages of 1 and 9 years old are stunted, indicating chronic past undernutrition. Younger children (1 to 3 years of age) are most severely affected as well as those living on commercial farms (30,6%) and in tribal and rural areas. Underweight affects 10,3% of children in this age group (18% on commercial farms). Wasting, an indicator of acute current under nutrition, is not common in South Africa with a prevalence rate of 3,7% of children between 1 and 9 years old.

Micronutrient deficiencies are prevalent in the country and are affecting especially vulnerable groups such as children and women. The NFCS showed that most children appear to consume a diet low in energy and poor in protein quality and micronutrient density. It also found that one out of two children aged 1 – 9 years have an intake of approximately less than half the recommended level for vitamin A, vitamin C, riboflavin, niacin, vitamin B6, folate, calcium, iron and zinc. Iron deficiency and anemia are common problems among children in rural communities. Although anaemia could be a result of malaria and parasite infestations, dietary deficiency in iron is also a major concern.

The NFCS findings support the results from the 1994 SAVACG survey among children 6 – 71 months which found that 33,3% children are vitamin A deficient, a prevalence which indicates that vitamin A deficiency is a serious health problem in the country. The SAVACG survey also found a 21,4% prevalence of anaemia, 10% prevalence of iron deficiency and 5% prevalence of iron deficiency anaemia.

The National IDD Survey, which was conducted in 1998 among primary school children, has shown that the mandatory iodation of food grade salt in 1995 has dramatically improved the iodine and goitre status of children in the country. It found that learners in 89,4 % of primary schools surveyed have a normal iodine status. However learners in 10,6% of the schools, mostly in rural areas, were iodine-deficient. According to the Medical Research Council, 62.4% of households consume iodised salt.

Infectious diseases constitute one of the major factors contributing to child malnutrition. Conversely, malnutrition makes a child more susceptible to these infectious diseases. The most common infectious diseases in South Africa affecting the growth of children and which may lead to malnutrition and death are HIV/AIDS, measles, diarrhoea and acute respiratory infections. While the malnutrition-infection complex most commonly affects children, it is also significant where adult morbidity is concerned. Infections and diseases play a major role in loss of productivity through their impact on adult physical performance and work capacity.

Malnutrition in South Africa is not just manifested in undernutrition, but also in over nutrition. Many predisposing causes of chronic diseases are associated with lifestyle. The NFCS found that 7,6% of children in the 1 to 9 year age group is overweight in the urban areas with a higher prevalence among children of well-educated mothers (12,5%). Nationally, 6% of children in the 1 to 9 year age group

is overweight. The South Africa Demographic and Health Survey (SADHS) of 1998 found that 5.3% of adolescent males and 17.6% of adolescent females are overweight while 2% of adolescent males and 5.9% of adolescent females are obese. The same survey found that 19.8% of adult men and 26.1% of adult women are overweight while 9.3% of adult men and 30.1% of adult women are obese. Obesity is regarded as a major risk factor for diabetes mellitus, hypertension and other chronic diseases of lifestyle. The same survey found that 16% of adult women and 13% of adult men were hypertensive in 1998. It is estimated that 8% of the adult population have Type 2 diabetes.

The low prevalence on exclusive breastfeeding is a cause of concern. The SADHS found that in the first 3 months of life, only 10% of infants were exclusively breastfed, while the rate of bottle-feeding was 48.3% nationally.

Growth monitoring and promotion is one of the most useful tools available in infant and young child health, because it provides quick and easy information to detect disease early and to monitor the nutritional status of the child. Unfortunately, caregivers of infants and young children often show a lack of correct knowledge and incorrect practices around growth monitoring and promotion. The result is the late detection of disease and malnutrition thus impacting negatively on the health and well being of the infant and young child. In 1998, only 74.6% of mothers with young children between the ages of 12 to 13 months old had Road to Health Charts (RtHC).

The nutrition situation is exacerbated by a lack of nutritional information and knowledge. Added to this are undesirable dietary habits and nutrition-related practices, attitudes, perceptions and socio-cultural influences that could adversely affect nutritional status. To attain good health and nutritional status, people need sufficient knowledge and skills to grow, purchase, process, prepare, eat and feed their families a variety of foods in the right quantities and combinations.

In addition, the 1994 Project for Statistics on Living Standards and Development estimated that 39% of the population is vulnerable to food insecurity. According to the NFCS, only 25% of households appeared food secure at a national level. It is estimated that almost 57% of the South African population were living in poverty in 1996.

The Health Sector Strategic Framework (HSSF) requires the Integrated Nutrition Programme (INP) to prevent and manage malnutrition. Malnutrition is a major contributing factor to morbidity and mortality. The INP is one of the key strategic health programmes to decrease morbidity and mortality rates. In South Africa, malnutrition is manifested in both under nutrition and over nutrition.

This paradox of over and under nutrition, as well as the range of micronutrient deficiencies of public health significance, requires complementing strategies and an integrated approach to ensure optimal nutrition for all South Africans. The situation is further complicated by the many causes of malnutrition which could be direct factors such as inadequate food intake, or underlying factors such as household food insecurity or even basic factors such as a lack of resources.

It is within this context that seven focus areas or broad strategies have been identified and defined to improve the nutritional status of all South Africans. They are:

- Disease-specific nutrition support, treatment and counselling which encompasses the nutrition and dietetic practices for the prevention and rehabilitation of nutrition-related diseases and illnesses through counselling, support and treatment.
- Growth monitoring and promotion which entails the regular measurement, recording, and interpretation of a child's growth over time in order to counsel, act and follow up results with the purpose of promoting child health, human development and quality of life.
- Nutrition promotion to facilitate the objectives of nutrition in general and of the INP in particular; nutrition education to improve the nutritional status of the population, to prevent nutrition-related diseases and to improve the quality of life of people; and nutrition advocacy to support a nutrition cause or issue or to draw attention to a nutrition cause or issue to achieve a desired result.
- Micronutrient malnutrition control involving the activities to prevent, reduce or control dietary deficiencies of vitamins and minerals through direct supplementation of the vulnerable populations or groups with micronutrient supplements, dietary diversification and fortification of commonly consumed foods with micronutrients.
- Food service management that includes the activities of planning, development, control, implementation and evaluation of and guidance in respect of suitable food service systems (procurement, storage, preparation and service of foods and beverages) for the provision of balanced nutrition to groups in the community and in public institutions for healthy and/or ill persons.
- Promotion, protection and support of breastfeeding comprising of the activities to:
 - Protect, promote and support breastfeeding.
 - Ensure that practices and behaviours in health care settings are always protecting, promoting and supporting breastfeeding.
 - Building on good practices and removing constraints and discouraging practices that are detrimental to establishing, maintaining or sustaining breastfeeding.
 - Ensure exclusive breastfeeding for six months.
 - Ensure continued breastfeeding for up to 24 months of age with the introduction of appropriate complementary feeding at six months of age.
 - Provide appropriate information and adequate support to mothers/care takers where breastfeeding is contra-indicated to enable them to make decisions on the feeding option for their infants and to ensure that the option is successfully carried out.
- Contribution to household food security which are the nutrition-related activities to contribute to adequate access by households to amounts of foods of the right quality to satisfy the dietary needs and to ensure a healthy active life of all household members at all times through out the year

Implementation will be supported by the following support systems:

- Nutrition Information System consisting of nutrition surveys, nutrition surveillance and the management of information.

- Human Resource Plan which is a management tool to assist nutrition managers at the different levels of health management structures to coordinate programme activities and to meet the INP goals and objectives by having the right number of people with the right competencies in the right place at the right time. It includes human resource management and human resource development.
- Financial and Administrative System entailing the management of financial allocations, expenditure, assets and liabilities relating to the INP as well as administrative tasks.

The goals, objectives, strategies, activities and beneficiary/target groups for the five-year period can be summarised as follows:

FOCUS AREA	GOAL	STRATEGIC OBJECTIVE (2002 TO 2007)	OPERATIONAL OBJECTIVE	STRATEGIES	ACTIVITIES	BENEFICIARY GROUP/TARGET GROUP
DISEASE-SPECIFIC NUTRITION SUPPORT, TREATMENT AND COUNSELLING	Contribution to the prevention and reduction of morbidity and mortality rates due to malnutrition, nutrition-related diseases of lifestyle, communicable and infectious diseases and debilitating conditions	<p>To contribute to the reduction in the prevalence of:</p> <ul style="list-style-type: none"> • Low birth weight from 8% • Underweight among pregnant and lactating women <p>To contribute to the reduction of malnutrition in children under 5 years of age, specifically of:</p> <ul style="list-style-type: none"> • Underweight from 10.3% to 8% • Severe underweight from 1.4% to 1% • Stunting from 21.6% to 18% • Wasting from 3.7% to 2%. 	To formulate and implement national therapeutic dietary protocols and guidelines for disease-specific nutrition support, treatment and counselling	Nutrition and dietetic practices for the prevention and rehabilitation of nutrition-related diseases and illnesses through counselling, support and treatment	<p>Strengthening nutritional management in the IMCI</p> <p>Intersectoral action e.g. providing water and sanitation</p> <p>Nutrition support, treatment and counselling during disease</p> <p>Growth monitoring</p> <p>Promotion, protection and support of breastfeeding</p> <p>Encouraging appropriate feeding during illness and recovery</p>	<p>Malnourished persons</p> <p>Health workers</p> <p>Persons suffering from nutrition-related diseases of lifestyle</p> <p>People living with HIV/AIDS, TB and other communicable diseases and chronic debilitating conditions</p>

		<p>To contribute to the reduction of the under-five mortality rate from 61/1000</p> <p>To contribute to the reduction of morbidity and mortality associated with nutrition-related diseases of lifestyle, specifically:</p> <ul style="list-style-type: none"> • Overweight among children from 6% to 4 % • Overweight among adolescent males from 5.3% to 3% and among adolescent females from 17.6% to 15% • Obesity among adolescent males from 2% to 1% and among adolescent females from 5.9% to 4% • Overweight among adult males from 19.8% to 15% and among adult females from 26.1% to 20% 			<p>Nutrition education</p> <p>Dietary modification</p> <p>Management of malnutrition and severe malnutrition</p> <p>Follow up actions</p> <p>Referrals</p> <p>Support groups</p>	
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		<ul style="list-style-type: none"> • Obesity among adult males from 9.3% to 7% and among adult females from 30.1% to 25% • Coronary heart disease • Hypertension • Diabetes mellitus <p>To contribute to the reduction of morbidity and mortality of people living with TB, HIV/AIDS and other chronic debilitating conditions</p>				
GROWTH MONITORING AND PROMOTION	Contribution to optimal growth of infants and young children	<p>To prevent and reduce growth faltering among children 0-24 months of age through regular growth monitoring and promotion</p> <p>To ensure that at all new born babies are provided with a Road to Health Chart (RtHC)</p>	<p>To provide provincial nutrition units with RtHCs for growth monitoring and promotion</p> <p>To build the capacity of health workers on growth monitoring and promotion</p> <p>To promote growth monitoring and promotion</p>	Regular measurement, recording, and interpretation of a child's growth over time in order to counsel, act and follow up results with the purpose of promoting child health, human development and quality of life	<p>Provision of Road to Health Chart to all children under 2 years</p> <p>Regular growth monitoring through measurement, recording and interpretation of child growth</p> <p>Detection of disease, growth faltering and malnutrition</p> <p>Promotion of growth</p> <p>Counselling of care givers</p>	<p>Population</p> <p>Care givers of infants and young children</p> <p>Health workers</p>

					<p>Follow up actions</p> <p>Nutrition education</p> <p>Strengthening growth monitoring and promotion in IMCI</p>	
<p>NUTRITION PROMOTION, EDUCATION AND ADVOCACY</p>	<p>Sensitised and supportive policy and decision makers as well as other relevant stakeholders on nutrition</p> <p>Improved nutritional knowledge, behaviour, perceptions and attitudes of the population</p> <p>Awareness of the INP, its focus areas and nutrition in general</p>	<p>To ensure the development of policies that would support and contribute to the goals and objectives of the INP</p> <p>To improve nutrition-related knowledge, practices, perceptions and attitudes</p> <p>To improve awareness of the INP, its focus areas and nutrition in general</p>	<p>To develop and implement nutrition education activities</p> <p>To develop and implement nutrition promotion activities</p> <p>To develop and implement the INP advocacy strategy</p>	<p>Nutrition education</p> <p>Nutrition promotion</p> <p>Nutrition advocacy</p>	<p>Facilitation of the objectives of nutrition in general and of the INP in particular</p> <p>Activities to improve the nutritional status of the population, to prevent nutrition-related diseases and to improve the quality of life of people</p> <p>Activities to support a nutrition cause or issue or to draw attention to a nutrition cause or issue to achieve a desired result</p>	<p>Population</p> <p>Health Workers</p> <p>Nutritionally vulnerable groups/People with special dietary needs</p> <p>Decision makers</p> <p>Policy makers</p> <p>Intra- and intersectoral partners</p>

<p>MICRONUTRIENT MALNUTRITION CONTROL</p>	<p>Prevention, reduction and control of micronutrient deficiencies</p>	<p>Elimination of micronutrient deficiencies among the population, focusing on vulnerable populations or groups especially:</p> <ul style="list-style-type: none"> • Child Vit A deficiency from 33.3% to 19% • Child iodine deficiency from 10.6% to 5% • Child iron deficiency from 10% to 7.5% <p>To decrease the proportion of children with an intake of <50% of the recommended levels of vitamins and minerals from 50% to 40%</p> <p>To contribute to increasing the proportion of households consuming adequately iodised salt from 62% to 80%</p>	<p>To develop and implement an Integrated Micronutrient Control Strategy (IMNCS)</p> <p>To implement support systems for the IMNCS</p>	<p>Strategies to prevent, reduce or control dietary deficiencies of vitamins and minerals through direct supplementation of the vulnerable populations or groups with micronutrient supplements, dietary diversification and fortification of commonly consumed foods with micronutrients</p>	<p>Dietary diversification</p> <p>Micronutrient supplementation</p> <p>Food fortification</p> <p>Nutrition promotion, education and advocacy</p> <p>Supporting and promoting agricultural and horticultural interventions to increase the availability of micronutrient rich foods</p> <p>Quality control of food</p> <p>Linkages with other public health measures i.e. immunisation, parasite control, promotion of breastfeeding, etc</p>	<p><u>Vit A Supplementation</u></p> <ul style="list-style-type: none"> • All post-partum women • Children 0 to 5 years <p><u>Food fortification</u></p> <ul style="list-style-type: none"> • Population <p>Health workers</p> <p>Industry</p>
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FOOD SERVICE MANAGEMENT	Contribution to the institutional care of clients through food service systems for the provision of balanced nutrition	To ensure that clients of at least 80% of public institutions receive meals that are acceptable (including culturally acceptable) and adequate in quality and quantity	To facilitate and coordinate Food Service Management To develop and implement Food Service Management Implementation Guidelines	Planning, development, control, implementation and evaluation of and guidance in respect of suitable food service systems (procurement, storage, preparation and service of foods and beverages) for the provision of balanced nutrition to groups in the community and in public institutions for healthy and/or ill persons	Provision of meals Maintaining food service systems Technical support by dietitians	Clients of public institutions Health workers
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<p>PROMOTION, PROTECTION AND SUPPORT OF BREASTFEEDING</p>	<p>Contribution to child survival and maternal health</p>	<p>To increase the proportion of mothers who breastfeed their babies exclusively for six months from 7% to 10%</p> <p>To increase the proportion of mothers who continue to breastfeed their babies with appropriate complementary foods up to 24 months of age and beyond</p> <p>To ensure that mothers of infants under 24 months who are not breastfeeding, practice appropriate replacement feeding options</p> <p>To ensure that at least 15% of health facilities with maternity beds are baby-friendly</p>	<p>To formulate and implement a legislative framework for the promotion, protection and support of breastfeeding in SA</p> <p>To implement IEC activities that will promote, protect and support breastfeeding</p> <p>To coordinate the implementation of Baby Friendly Hospital Initiative in health facilities with maternity beds</p> <p>To provide input on replacement feeding aspect of Prevention of Mother to Child Transmission programmes</p> <p>To provide support on training on infant feeding options</p>	<p>Facilitation of practices and behaviours in health care settings to protect, promote and supporting breastfeeding.</p> <p>Building on good practices and removing constraints and discouraging practices that are detrimental to establishing, maintaining or sustaining breastfeeding.</p> <p>Provide appropriate information and adequate support to mothers/care takers where breastfeeding is contra-indicated to enable them to make decisions on the feeding option for their infants and to ensure that the option is successfully carried out.</p>	<p>Baby Friendly Hospital Initiative</p> <p>Implementing the Code on the Marketing of Breast Milk Substitutes</p> <p>Provision of information and support to care givers</p> <p>Nutrition education, promotion and advocacy</p> <p>Support groups</p> <p>Lactation management</p> <p>Supportive monitoring</p>	<p>Pregnant and breastfeeding women</p> <p>Infants</p> <p>Health workers</p> <p>Industry</p> <p>Public institutions</p>
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CONTRIBUTION TO HOUSEHOLD FOOD SECURITY.	Contribution to the improvement of household food security	<p>To ensure that other sectors dealing with household food security receive adequate technical support and advice on nutrition</p> <p>To ensure that Integrated Sustainable Rural Development Nodal Sites have nutrition activities incorporated into their Integrated Food Security and Nutrition Projects</p> <p>To alleviate short-term hunger among primary school learners</p>	<p>To participate in and support the development and implementation of an Integrated Food Security and Nutrition Programme</p> <p>To facilitate the effective and efficient implementation of school feeding to ensure 100% coverage of targeted schools and feeding days as well as 100% compliance of actual servings for school feeding with the requirements and specifications of the standardised menu options</p>	<p>Nutrition-related activities to contribute to adequate access by households to amounts of foods of the right quality to satisfy the dietary needs and to ensure a healthy active life of all household members at all times through out the year</p>	<p>Nutrition education, promotion and advocacy</p> <p>Technical support and nutritional advice to other sectors dealing with household food security</p> <p>School feeding</p>	<p>Nutritionally vulnerable groups and individuals</p> <p>Inter- and intrasectoral partners</p>
NUTRITION INFORMATION SYSTEM	Efficient and effective nutrition information system for planning, policy formulation and management	<p>To assess the nutritional status of the population through regular surveys</p> <p>To continuously collect, analyse and utilise data on specific nutrition indicators to monitor the nutritional status of the population</p>	<p>To conduct, facilitate and coordinate appropriate nutrition surveys</p> <p>To monitor the nutritional status of South Africans</p> <p>To monitor and report on the implementation of the INP</p>	<p>Surveys</p> <p>Surveillance</p> <p>Management information</p> <p>Monitoring</p> <p>Evaluation</p> <p>Research</p>	<p>Conducting/outsourcing surveys</p> <p>Using the DHIS to monitor the nutritional status of the population</p> <p>Monitoring visits and assessments</p> <p>Data collection, collation and reporting</p>	<p>Decision makers</p> <p>Management</p> <p>Population</p>

		To implement a minimum data set to manage information for programme development, implementation, monitoring and evaluation	To evaluate the processes, outputs and outcomes of the INP To conduct, facilitate and coordinate appropriate research according to the needs of the INP		Conducting or outsourcing research	
HUMAN RESOURCE PLAN	Effective and efficient management and development of human resources for the INP	To develop and implement the INP human resource plan to ensure that 100% of posts are filled, 100% of new staff completed the induction course and 70% of staff received in-service training	To develop and implement a HRP for the INP To facilitate and coordinate the human resource management activities of the INP To facilitate and coordinate human resource development of nutrition staff To technically support nutrition units with the implementation of the INP through visits and regular operational meetings	Assisting nutrition managers at the different levels of health management structures to coordinate programme activities and to meet the INP goals and objectives by having the right number of people with the right competencies in the right place at the right time. Human resource management Human resource development.	Recruitment, placement, remuneration and performance management of staff Capacity building and training	Management

<p>FINANCIAL AND ADMINISTRATIVE SYSTEM</p>	<p>Efficient and effective financial management and administration in support of nutrition goals and objectives</p>	<p>To adhere to the requirements of the Financial Management Act and the Distribution of Revenue Act by ensuring 100% expenditure in terms of Conditional Grant, at least 80% expenditure in terms of Poverty Relief Allocation and best practices in most provinces</p>	<p>To maintain an effective and efficient administrative system for the INP</p> <p>To facilitate and coordinate planning processes for the INP</p> <p>To administer the normal budget allocation for Nutrition</p> <p>To administer the INP Conditional Grant Allocation</p> <p>To administer the Special Allocation for Poverty Relief</p> <p>To review the financial measures for the funding of activities across the scope of the INP</p>	<p>Financial management</p> <p>Planning</p> <p>Administration</p>	<p>Management of financial allocations, expenditure, assets and liabilities</p> <p>Office administration</p> <p>Conducting strategic, operational and programme planning</p>	<p>Management</p> <p>Treasury</p> <p>Public (Tax payers)</p>
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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BFHI	Baby-friendly Hospital Initiative
BMI	Body Mass Index
HSSF	Health Sector Strategic Framework
HIV	Human Immuno Deficiency Virus
IHD	Ischaemic heart disease
IMCI	Integrated Management of Childhood Illnesses
INP	Integrated Nutrition Programme
IDD	Iodine Deficiency Disorder
IVACG	International Vitamin A Consultative Group
MRC	Medical Research Council
NFCS	National Food Consumption Survey
RtHC	Road to Health Chart
SADHS	South Africa Demographic and Health Survey
SAVACG	South African Vitamin A Consultative Group
TB	Tuberculosis
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

1. CONTEXT FOR PLANNING

Planning for the Integrated Nutrition Programme (INP) takes place within the context of the Health Sector Strategic Framework (HSSF). The HSSF indicates the following strategic health priorities for the period 1999 to 2004:

- Reorganisation of support services.
- Legislative reform.
- Improving quality of care.
- Revitalisation of hospital services.
- Speeding up delivery of an essential package of services through the district health system.
- Decreasing morbidity and mortality rates through strategic interventions.
- Improving resource mobilisation and the management of resources without neglecting the attainment of equity in resource allocation.
- Improving human resource development and management.
- Improving communication and consultation within the health system and between the health system and the communities we serve.
- Strengthening cooperation with international partners.

The INP is discussed under the strategic objective to decrease morbidity and mortality rates through strategic interventions where the objective for nutrition is to strengthen nutrition interventions to prevent and manage malnutrition. The relevant key implementation strategies for the INP are indicated as follows:

- Intensify efforts to implement the INP.
- Promote community-based growth monitoring.
- Strengthen nutrition interventions at both health facility and community levels to rehabilitate malnourished children.
- Work with other sectors to tackle the root causes of poor nutrition and poverty.
- Promote food fortification.

In terms of objectives, indicators and targets for the INP, the HSSF states the following:

OBJECTIVE	INDICATOR	TARGET
Improve child health	<ul style="list-style-type: none"> • Prevalence of wasting and stunting among children and underweight for age among children under 6 	<ul style="list-style-type: none"> • Reduce prevalence of wasting from 2.6% to 1%, stunting from 23% to 15% and underweight children from 9% to 5% by 2004
Strengthen poverty alleviation and food security programmes	<ul style="list-style-type: none"> • Number of districts implementing INP • Number of districts that has strategies that promote community-based growth monitoring • Number of facilities and community-based projects that provides nutrition interventions for 	<ul style="list-style-type: none"> • INP implemented in all districts by 2004 • All districts promoting growth monitoring • All districts where appropriate

	malnourished children <ul style="list-style-type: none"> • Number of districts with intersectoral plans to tackle the issues of poverty and poor nutrition • Legislation to ensure food fortification promulgated 	<ul style="list-style-type: none"> • Intersectoral action to reduce levels of poor nutrition and poverty implemented in all districts • Legislation in place by 2002
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Unfortunately, the context, objectives and activities stated for the INP in the HSSF do not adequately reflect the context and scope of the INP. For example, in terms of objectives, which will be used to measure the INP's performance, the INP is only reflected within the context of improving child health and strengthening poverty alleviation and food security programmes. In addition, the HSSF uses different indicators and targets than those formulated for nutrition in the Department of Health's 2005 health goals, objectives and indicators. It is, therefore, suggested that the performance of the INP and its contribution to the priorities of the HSSF be measured by using the goals, objectives, targets, and indicators in this Strategic Plan.

In terms of the INP, the following linkages with and contributions to the strategic health priorities of the HSSF have been identified:

STRATEGIC HEALTH PRIORITY	INP ACTIVITY
Transformation of certain support services, especially the Health Information System	<ul style="list-style-type: none"> • Nutrition Information System to support the National Health Information System
Legislative reform	<ul style="list-style-type: none"> • Legislation on food fortification • Legislation on the Code of Ethics for the Marketing of Breast Milk Substitutes
Improving quality of care	<ul style="list-style-type: none"> • Development and implementation of clinical, therapeutic and nutrition management guidelines on- <ul style="list-style-type: none"> • severe malnutrition; • Human Immune Deficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS); • chronic diseases of lifestyle; and • Debilitating conditions • Active participation in Integrated Management of Childhood Illnesses (IMCI) strategy • Ensure the inclusion of technically correct nutrition information and participate in the training of health personnel in strategies to improve quality of care • Development and implementation of a human resource development plan or INP that would, among other, address issues on quality of care • Ensure that nutrition services are rendered within the Batho Pele principles, guided by the Patients Charter and in line with the national policy and implementation guidelines on quality
Better communication within the health system and between the health system and its stakeholders, including communities who use the public health sector	<ul style="list-style-type: none"> • Marketing and communication of INP • Improve information flow from national Directorate to community levels.
Revitalisation of public hospitals	<ul style="list-style-type: none"> • Develop and implement effective referral systems for malnourished children • Promote and facilitate the implementation of the Baby-friendly Hospital Initiative (BFHI)

	<ul style="list-style-type: none"> • Improve food service management within public health facilities • Ensure that the planning framework for hospitals includes nutrition services as integral part of the services that are offered • Ensure that hospitals provide for lodger mothers of children being treated for severe malnutrition
Implementation of a comprehensive package of primary health care services through the district health system	<ul style="list-style-type: none"> • Ensure that human resources at all levels are adequate and appropriately trained to render nutrition services as part of their duties • Develop a guideline for the implementation of the INP at district level
Strategic interventions to decrease mortality and morbidity	<ul style="list-style-type: none"> • Disease-specific nutrition support, treatment and counselling • Growth monitoring and promotion • Nutrition promotion, education and advocacy • Micronutrient malnutrition control • Food service management • Promotion, protection and support of breastfeeding • Contribution to household food security • Participate in National Programme of Action for Children • Participate in IMCI • Collaborate with relevant directorates such as HIV/AIDS & Sexually Transmitted Diseases, Tuberculosis, Child & Youth Health, Women's Health & Genetics, Chronic Diseases, Disabilities & Geriatrics, Pharmaceutical Services & Programmes, and Food Control to ensure coordinated responses in terms of improving nutritional status
Improved resource mobilisation, allocation and management	<ul style="list-style-type: none"> • Lobby for provincial equity resource allocation of the Special Allocation for Poverty Relief and INP Conditional Grant Allocation • Build public and private partnerships around the focus areas and support systems of the INP. • Improve the financial and administrative support system of INP through the Implementation of recommendations of the assessment of the financial and administrative procedures of the INP • Build capacity in terms of programme and project management
Human resource development and management	<ul style="list-style-type: none"> • Develop and implement the Human Resource Plan for the INP
International health collaboration	<ul style="list-style-type: none"> • Follow protocols/Know the protocols • Utilise donor funding and assistance for the INP • AU, SADC and WHO/FAO/UNICEF collaboration

2. VISION

The vision of the INP is optimum nutrition for all South Africans.

3. MISSION

The INP's mission is to improve the nutritional status of all South Africans through implementing integrated nutrition activities.

4. SCOPE OF THE INP

The scope of the INP is determined by its focus areas and support systems. The INP is organised around seven focus areas or broad strategies namely:

- Disease-specific nutrition support, treatment and counselling.
- Growth monitoring and promotion.
- Nutrition promotion, education and advocacy.
- Micronutrient malnutrition control.
- Food service management.
- Promotion, protection and support of breastfeeding.
- Contribution to household food security.

The support systems for the INP are the following:

- Nutrition Information System.
- Human Resource Plan.
- Financial and Administrative System.

The specific problem statements and definitions for each focus area and support system are discussed below.

4.1 Focus area: Disease-specific nutrition support, treatment and counselling

4.1.1 Problem statement

Inadequate dietary intake and disease are the most significant immediate causes of malnutrition. Disease, in particular infectious disease, affects food intake and nutrient absorption and leads to increased nutritional requirements. In most cases, malnutrition is the combined result of inadequate dietary intake and disease.

Malnutrition manifests itself in both under nutrition and over nutrition and continues to be a major problem in South Africa. Under nutrition manifests itself in low birth weight, under weight and stunting. Over nutrition manifests itself in overweight and obesity.

~~The current prevalence of low birth weight in children is unknown but is estimated at between 10.7% (1992: Human Sciences Research Council Survey) and 16% (1997: Towards a National Health System).~~ According to the South Africa Demographic and Health Survey (SADHS) of 1998, South Africa has a low birth weight prevalence of 8.3%. The National Food Consumption Survey (NFCS) of 1999 showed that at least 21,6% of children between the ages of 1 and 9 years old are stunted. Stunting (height for age) indicates chronic past under nutrition. Younger children (1 to 3 years of age) are most severely affected as well as those living on commercial farms (30,6%) and in tribal and rural areas. Under weight (weight for age) affects 10,3% of children in this age group (18% on commercial farms). Wasting (weight for height), an indicator of acute current under nutrition, is not common in South Africa with a prevalence rate of 3,7% of children between 1 and 9 years old.

Infectious diseases constitute one of the major factors contributing to child malnutrition. Conversely, malnutrition makes a child more susceptible to these infectious diseases. The most common infectious diseases in South Africa affecting the growth of children and which may lead to malnutrition and death are HIV/AIDS, measles, diarrhoea and acute respiratory infections. While the malnutrition-infection complex most commonly affects children, it is also significant where adult morbidity is concerned. Infections and diseases play a major role in loss of productivity through their impact on adult physical performance and work capacity.

According to the SADHS of 1998, almost 19% of children under five were ill with symptoms suggestive of an acute respiratory tract infection. The greatest prevalence of diarrhoeal diseases occurred in children aged between 12 – 23 months (24%) according to the SADHS of 1998. The low prevalence recorded in children <6 months may be explained by the protective effect of breastfeeding.

According to the recorded deaths for 1995 (Stats SA), the major causes of death in infancy (infants < 1 year) are conditions that occur during the perinatal period (22%), low birth weight (20%) and diarrhoea (16%). Lower respiratory infections caused the death of 8.9% of infants in 1995. In the case of children 1 to 4 years old, the most common cause of death is injury (24%), followed by diarrhoea (20%), malnutrition (13%) and lower respiratory infections (9%). In 1995, AIDS accounted for 3.2% and tuberculosis (TB) for 3.1% of deaths of children aged 1 to 4 years. Since only 75% of deaths were registered in 1995, the figures are likely to have changed in recent years, also as a result of HIV/AIDS.

In recent year, the incidence of measles has declined dramatically following the national measles campaign. This also resulted in a marked reduction in the number of deaths due to measles.

In terms of nutrition, the child mortality rate is a good indicator of malnutrition associated with poor hygiene and infections. In general, the infant mortality rate reflects the socio-economic development of society, but specifically it directly reflects the magnitude of the problems of diarrhoeal and respiratory infections and malnutrition. It also reflects the level of health in mothers, their ante-natal and post-natal care

and that of their infants. According to the SADHS of 1998, South Africa has an under five-mortality rate of 61/1000 and an infant mortality rate of 45/1000.

With regard to adults, TB caused 7.1% of deaths of males 15 to 44 years old and 10% of deaths of males 45 to 59 years old. Concerning females, TB caused 9.5% of deaths of females 15 to 44 years old and 5.2% of deaths of females 45 to 59 years old (Stats SA: 1995 recorded deaths). According to data from the TB Control Programme, the current incidence rate of TB is 345/100 000 population in 1999. An estimated 40 to 50% of TB patients are co-infected with HIV.

According to the South African Health Review of 2000, approximately 13% of all South African adults aged 20 to 64 were HIV infected in 2000 and these levels could rise to 20-23% by 2005 and 22-27% by 2010. The effects of HIV on the nutritional status of people infected with the virus are numerous. HIV/AIDS increases nutritional needs. Due to a weakened immune system, other infections start to occur which raise the need for nutrients. HIV/AIDS also lowers food intake and causes physical problems. These include a decreased ability to digest and absorb food, diarrhoea and constipation. The treatment regimen often affects the ability to taste, thus compounding the effects mentioned above. Thus, malnutrition is an important consequence of HIV infection. It is known that good nutrition can contribute to the wellness and sense of well being of the person with HIV/AIDS particularly when started in the early stages of the disease and may even prolong life. Nutritional support, treatment and counselling are an integral part of the treatment plan or regimen of people infected with HIV/AIDS and who are malnourished, irrespective of whether treatment forms part of home-based care or in a health facility.

An intersectoral approach is required to improve health and nutrition status e.g. providing health services and measures in conjunction with the provision of water and sanitation. Health measures could include proper nutrition support; treatment and counselling during disease; immunisation; early detection of growth faltering; promoting, supporting and protecting breastfeeding; and encouraging appropriate feeding during illness and recovery.

As stated before, malnutrition in South Africa is also manifested in over nutrition. Over nutrition is associated with some diseases of lifestyle such as obesity-related diseases, ischaemic heart diseases, hypertension, diabetes mellitus and certain cancers, which typically present in adulthood.

The NFCS found that 7,7% of children in the 1 to 9 year age group is overweight in the urban areas with a higher prevalence among children of well-educated mothers (12,5%). Nationally, 6% of children in the 1 to 9 year age group is overweight. In 1998, the SADHS found that 5.3% of adolescent males and 17.6% of adolescent females were overweight while 2% of adolescent males and 5.9% of adolescent females were obese. The same survey found that 19.8% of adult men and 26.1%% of adult women were overweight while 9.3% of adult men and 30.1% of adult women were obese. Obesity is a major risk factor for diabetes mellitus, hypertension and other chronic diseases of lifestyle. The same survey found that 16% of adult women and 13% of adult men were hypertensive in 1998. It is estimated that 8% of the adult population have Type 2 diabetes.

In 1995, 5.6% of the recorded deaths of males in the age group 45 to 59 years were caused by ischaemic heart disease and 3.1% by diabetes mellitus. In the same year, ischaemic heart disease caused 3.8% of deaths among females in the same age group, diabetes mellitus caused 6.8%, and hypertension 3.1% (Stats SA). The SADHS found that 16% of adult women and 13% of adult men were hypertensive in 1998.

Chronic diseases associated with lifestyle can be modified through targeted health promotion programmes. However, often there is a need to nutritionally manage these chronic diseases of lifestyle through dietary treatment, counselling and support. An integrated approach, including nutrition interventions, to reduce the morbidity and mortality associated with chronic diseases of lifestyle is essential in order to improve health and well being of individuals and communities. Dealing with diseases of lifestyle is critical especially given the pace of epidemiological transition in South Africa.

Debilitating conditions such as intestinal diseases, renal disease, pulmonary diseases and metabolic stress could easily lead to malnutrition, because of the following reasons:

- Poor appetite.
- Fear that eating will cause pain.
- Diarrhoea.
- Steatorrhea.
- Vomiting.
- Intolerance to certain foods.
- Use of medication.
- Increased loss of nutrients through the gut.
- Physiological stress.

The aim of nutrition care is to relieve and treat the condition and to improve the nutritional status of the person.

4.1.2 Definition

The nutrition and dietetic practices for the prevention and rehabilitation of nutrition-related diseases, debilitating conditions and illnesses through counselling, support and treatment.

4.2 Focus area: Growth monitoring and promotion

4.2.1 Problem statement

Caregivers of infants and young children often show a lack of correct knowledge and follow incorrect practices around growth monitoring and promotion. The result is the late detection of disease and malnutrition thus impacting negatively on the health and well being of the infant and young child. Growth monitoring and promotion is one of the most useful tools available in infant and young child health. It provides quick and easy information to identify disease early and to monitor the nutritional status of the child. In 1998, only 74.6% of mothers with young children between the ages of 12 to 13 months old had Road to Health Charts (RtHC). Every child under 5 years should have a RtHC to monitor their growth, immunisation status, vitamin A supplementation status and other vital health indicators.

4.2.2 Definition

Growth monitoring and promotion is the regular measurement, recording, and interpretation of a child's growth over time in order to counsel, act and follow up results with the purpose of promoting child health, human development and quality of life.

4.3 Focus area: Nutrition promotion, education and advocacy

4.3.1 Problem statement

To attain good health and nutritional status, people need sufficient knowledge and skills to grow, purchase, process, prepare, eat and feed their families a variety of foods in the right quantities and combinations. One of the causes of malnutrition, as manifested in both over and under nutrition, is a lack of nutritional information and knowledge. Added to this are undesirable dietary habits and nutrition-related practices, attitudes, perceptions and socio-cultural influences that could adversely affect nutritional status. Nutrition education will reinforce specific nutrition-related practices or behaviours to change habits that contribute to poor nutritional status.

A review of nutrition education programmes in developing countries concluded that many nutrition education efforts implemented during the 1970s and 1980s brought few changes in nutrition-related behaviour or nutritional status, not because nutrition education was a wrong strategy, but rather because the methods used have not led to desired behaviour change. The communication methods were found to be ineffective while the inappropriate content of the messages often ignored the specific cultural context of the community. Often the education methods consisted mainly of talks given at health centres. This conventional approach was also limited because it excluded analysis of the causes of malnutrition. It used only one isolated channel of communication.

The participation of the community/target group in nutrition education is important, because it aims at modification of behaviours that are deeply entrenched in the fabric of socio-cultural life. Nutrition education messages should be tailored to the food consumption patterns and also be pre-tested to make sure that they convey the intended message.

In addition to the above, the general lack of information on the nature of malnutrition and its causes can be effectively addressed through nutrition communication activities directed at the general public, but most importantly also at policy and decision makers.

There also appear to be misconceptions and a general lack of information on the INP, not just among the general public and policy and decision-makers, but also within the health sector especially at the lower levels of the health structures. Information does not seem to flow from lower to higher levels and from higher to lower levels. This can be addressed through advocacy and information activities which would also ensure commitment among policy and decision-makers.

4.3.2 Definition

Nutrition education is communication activities to improve the nutritional status of the population, to prevent nutrition-related diseases and to improve the quality of life of people.

Nutrition promotion is communication activities designed to facilitate the objectives of nutrition in general and of the INP in particular.

Nutrition advocacy is an activity supporting a nutrition cause or issue or drawing attention to a nutrition cause or issue to achieve a desired result - it is an action directed at changing policies, positions, views or programmes.

4.4 Focus area: Micronutrient malnutrition control

4.4.1 Problem statement

Micronutrient deficiencies are prevalent in the country and are affecting especially vulnerable groups such as children and women. Micronutrient deficiencies substantially affect the nutritional status, health and development of the population. These deficiencies contribute to growth retardation, morbidity, mortality, brain damage and reduced cognitive and working capacities among both children and adults.

The NFCS showed that most children appear to consume a diet low in energy and poor in protein quality and micronutrient density. It also found that 50% of children aged 1 – 9 years have an intake of approximately less than half the recommended level for vitamin A, vitamin C, riboflavin, niacin, vitamin B₆, folate, calcium, iron and zinc. Iron deficiency and anemia are common problems among children

in rural communities. Although anemia could be a result of malaria and parasite infestations, dietary deficiency in iron is also a major concern.

The NFCS findings support the results from the 1994 South African Vitamin A Consultative Group (SAVACG) survey among children 6 – 71 months which found that 33.3% children are vitamin A deficient, a prevalence which indicates that vitamin A deficiency is a serious health problem in the country. The SAVACG survey also found a 21.4% prevalence of anaemia, 10% prevalence of iron deficiency and 5% prevalence of iron deficiency anaemia.

The National IDD Survey, which was conducted in 1998 among primary school children, has shown that the mandatory iodation of food grade salt in 1995 has dramatically improved the iodine and goitre status of children in the country. It found that learners in 89,4 % of primary schools surveyed have a normal iodine status. However learners in 10,6% of the schools, mostly in rural areas, had an inadequate iodine intake. Marginal iodine deficiency existed in 10 schools surveyed resulting in 16.2% of schools showing evidence of persisting iodine deficiency. It is accepted that IDD occur in pockets in some areas of the country, for example in the central areas of Mpumalanga, Limpopo, especially Venda, parts of the Eastern Cape and the gold fields of Southern Gauteng, Free State and North West. According to the Medical Research Council, 62.4% of households consume iodised salt.

Vitamin A deficiency contributes to as many as one out of four childhood deaths and may be an important factor affecting maternal mortality. Vitamin A is essential for the functioning of the immune system. Vitamin A deficiency results from inadequate dietary intake of vitamin A. Vitamin A deficiency can also result from rapid utilisation of vitamin A during illness (particularly measles, diarrhoea and fevers), pregnancy and lactation and during phases of rapid growth in young children. Children between the ages of 6 and 59 months experience more serious effects of vitamin A deficiency than other groups. One of the first clinical signs of vitamin A deficiency is night blindness. However, the vast majority of children with vitamin A deficiency have no clinical signs. Vitamin A deficient children are more likely to have severe measles and severe or prolonged diarrhoea. Even moderate vitamin A deficiency significantly increases a child's risk of dying from infectious disease. Severe vitamin A deficiency can also cause blindness and is the first cause of childhood blindness worldwide. Correcting vitamin A deficiency can reduce child deaths by about 23%. A combination of interventions is usually used to prevent and eliminate vitamin A deficiency. Measures include breastfeeding protection and promotion, food fortification, vitamin A supplementation, public health measures and dietary diversification.

Iron deficiency anemia decreases individual potential and has adverse effects on learning, productivity and earnings. Anemia leads to reduced physical activity and decreased work performance while iron deficiency may also result in muscle dysfunction. Anemia together with malnutrition is among the major causes of childhood morbidity and mortality. When anemia occurs in infancy or childhood it is associated with significant loss of cognitive abilities as well as decreased physical activity and reduced resistance to disease. Providing iron supplements to school learners with iron deficiency results in improvement in selective learning and school achievement tests. Iron supplementation can also improve appetite in undernourished children and thus speed up their rate of recovery from malnutrition and

their subsequent physical growth. Iron deficiency in women of child bearing age increases the risks associated with complications of pregnancy, premature birth and low birth weight and causes infants to enter life with sub-optimal iron reserves. Frequent pregnancies often compound this problem and result in further deterioration in the health and nutritional status of the mother and her subsequent children. Health and nutrition education to improve dietary intake of foods rich in iron, folate and vitamin C and to reduce the consumption of interfering substances is a primary strategy to address iron deficiency anemia. Other supporting interventions include iron supplementation and food fortification as well as parasite control in areas where parasitic diseases and malaria are major contributions to anemia.

Iodine deficiency in communities causes endemic goitre, but also results in iodine-deficiency disorders. Severe iodine deficiency may cause disorders such as spontaneous abortions, perinatal mortality, cretinism, hypothyroidism and mental retardation. Even moderate iodine deficiency causes endemic goitre, hypothyroidism and abnormalities in the psychoneuromotor and intellectual development of children and adults. Thus, iodine deficiency disorders have economic and social consequences for development. However, iodine deficiency is the most common preventable cause of mental retardation and brain damage in the world. Meeting the iodine needs of school children can lead to better school performance. The treatment and prevention of iodine deficiency disorders depend on sufficient dietary iodine intake either through medicinal supplementation or by fortification of a component of the diet. The iodation of table salt has proved to be an effective way of addressing iodine deficiency disorders. However, in some areas in the country, for example in the Northern Cape, the Free State and the North West, the local people have access to non-iodated salt produced from the salt pans. They are more likely to use non-iodated salt and, therefore, more prone to suffer from iodine deficiency disorders.

In conclusion, it is clear that an integrated and multi-pronged approach is required to address micronutrient deficiencies. This should include dietary diversification as an overarching strategy as well as micronutrient supplementation, food fortification and nutrition education linked to other health measures such as immunisation and parasite control. Micronutrient rich foods on the menus of school feeding can also contribute significantly to meeting the micronutrient requirements of school-aged children.

Dietary diversification usually involves four types of strategies namely:

- Nutrition education, promotion and advocacy to improve practices related to the consumption of available micronutrient-rich food sources.
- Horticultural and agricultural interventions for example home, school and community gardening that aim to increase availability of micronutrient-rich foods.
- Economic and food policies affecting the availability, price and effective demand of micronutrient-rich foods.
- Technological advances concerning food preservation, plant breeding, etc.

4.4.2 Definition

The activities to prevent, reduce or control dietary deficiencies of vitamins and minerals through direct supplementation of the vulnerable populations or groups with micronutrient supplements, dietary diversification and fortification of commonly consumed foods with micronutrients focussing on the three main vitamin or mineral nutritional deficiencies of public health significance namely vitamin A deficiency, iron deficiency anaemia and iodine deficiency disorders.

More specifically:

- Dietary diversification aims to increase dietary availability, regular access and consumption of vitamin and mineral-rich foods in at-risk and micronutrient deficient groups or populations. Such efforts involve changes in dietary behaviour of the targeted populations.
- Micronutrient supplementation is the provision of micronutrients to increase a person's micronutrient intake for the purpose of preventing, reducing or controlling a deficiency.
- Food fortification is the addition of one or more essential nutrients to a food whether or not it is normally contained in the food to improve its quality for the people who consume it or for the purpose of preventing, reducing or controlling a deficiency of one or more nutrients in the population

4.5 Focus area: Food service management

4.5.1 Problem statement

Nutritional support forms part of the institutional care of clients in public institutions. Within this context, the purpose and function of food service management is to provide food to clients of public institutions such as health care facilities, correctional service facilities, welfare care facilities, and school hostels. Clients of public institutions include patients in health care settings, residents of care facilities, inmates of prisons, resident or non-resident personnel of institutions, etc.

Proper food service management should provide meals that are acceptable and adequate in quality and quantity and safe to clients of public institutions. Under normal circumstances, good nutritional care consists of supplying a normal diet that furnishes the nutritional, psychological and aesthetic needs of clients. Nutritional support must also be adapted to the needs of the individual client. In the case of certain disorders, nutritional care will require the therapeutic modification of the diet as part of the treatment.

In a hospital setting, the satisfactory intake of food by the patient is essential for the maintenance of tissue structures and body functions so that recovery from illness is not impeded. However, institutionally induced malnutrition is known to occur in public institutions and is linked to inappropriate serving of meals, inadequate intake, poor preparation, etc. In the case of hospital-induced malnutrition, the cost of

patient care is indirectly increased because of prolonged convalescent periods, increased need for medication, etc. Compromised food safety can result in patient deaths or complications. Food service management is often an underplayed aspect of health care as is evident from the common practice to reduce the food service management budget whenever budget constraints are being experienced.

4.5.2 Definition

The activities of planning, development, control, implementation and evaluation of and guidance in respect of suitable food service systems (procurement, storage, preparation and service of foods and beverages) for the provision of balanced nutrition to groups in the community and in public institutions for healthy and/or ill persons.

4.6 Focus area: Promotion, protection and support of breastfeeding

4.6.1 Problem statement

The low prevalence of exclusive breastfeeding is a cause of concern. The SADHS found that in the first 3 months of life, only 10% of infants were exclusively breastfed, while the rate of bottle-feeding was 48.3% nationally. The exclusive breastfeeding rate for 0 to 5 months was 7%.

Research has highlighted the variety of unique benefits of breastfeeding and the potential disadvantages for infants and mothers when breastfeeding is not established or sustained. These benefits range from biochemical, immunologic, enzymatic and endocrinologic to psychosocial, developmental, hygienic and economic.

Breastfeeding is the best feeding method for infants under the age of two years, while a full six months of exclusive breastfeeding is optimal. However, breast milk alone is insufficient to provide adequate nutrients to an infant beyond six months. In order to sustain growth development, additional food other than breast milk must be gradually introduced to an infant at the age of six months. The introduction of complementary feeding together with breastfeeding for up to two years of age should form a corner stone in the nutrition of young children. The use of locally available foods for complementary feeding should be strongly promoted. Regular weighing of children especially up to two years should be encouraged so that appropriate interventions are instituted, should growth faltering occur.

However, with the advent of the AIDS epidemic and the establishment that HIV is transmissible through breast milk, breastfeeding promotion is compromised. The results of a longitudinal observational study undertaken in KwaZulu/Natal and reported in the Lancet (354: 471 – 476,1999) suggest that exclusive breastfeeding may be less likely to transmit infection than mixed feeding. This is possibly because other foods can damage the infant's gut and make it easier for the virus to cross the intestinal mucosa.

The Department of Health currently recommends that the mother makes the final decision on the feeding option for her infant, with the health worker providing appropriate information especially to those mothers who are HIV positive. It further recommends that whatever feeding option the mother chooses, adequate support be given to ensure that the option is successfully carried out.

Suggested feeding options for HIV positive mothers are:

- Exclusive breastfeeding for ~~three to~~ six months.
- Feeding with expressed and heat-treated breast milk.
- Feeding from breast milk banks.
- Wet nursing.
- Feeding with home prepared formula.
- Feeding with commercial infant formula.

4.6.2 Definition

The activities to:

- Protect, promote and support breastfeeding.
- Ensure that practices and behaviours in health care settings are always protecting, promoting and supporting breastfeeding.
- Building on good practices and removing constraints and discouraging practices that are detrimental to establishing, maintaining or sustaining breastfeeding.
- Ensure exclusive breastfeeding for six months.
- Ensure continued breastfeeding for up to 24 months of age with the introduction of appropriate complementary feeding at six months of age.
- Provide appropriate information and adequate support to mothers/care takers where breastfeeding is contra-indicated to enable them to make decisions on the feeding option for their infants and to ensure that the option is successfully carried out.

4.7 Focus area: Contribution to household food security

4.7.1 Problem statement

Poverty, under nutrition, household food insecurity and hunger often co-exist. Their causalities overlap and mutually reinforce each other. As a result poor or vulnerable communities are caught in a vicious cycle of frequent illness, inadequate food intake, household food insecurity, under nutrition and poverty.

The 1994 Project for Statistics on Living Standards and Development estimated that 39% of the population is vulnerable to food insecurity. According to the NFCS, only 25% of households appeared food secure at a national level. Food security means that all people at all times have access to adequate, safe and nutritious food needed for an active, healthy and productive life. Currently, it is estimated that about 40% of the population live in abject poverty and are therefore at risk of becoming malnourished.

Children are at a greater risk of becoming malnourished compared to other age groups. Children's vulnerability to malnutrition in the presence of household food insecurity has been validated by the findings of the NFCS of 1999, which indicated that the majority of children consumed a diet deficient in energy and of poor nutrient density to meet their micronutrient requirements. Further more all variables associated with household food security were associated with a poorer dietary intake and poorer anthropometric status, particularly stunting and underweight.

Intersectoral poverty alleviation strategies will have a major impact in the long term. However, this require linking economic growth to human development, redistributing assets, improving access to resources and providing initiatives that would enhance access to socio-economic opportunities. This is a long-term process that does not necessarily provide in the immediate needs of the poor. Therefore, special interventions targeted at the poor are necessary as a way of stimulating development in areas with limited support.

From a nutritional perspective, various activities could contribute to household food security. The following provides a framework in this regard:

Nutrition education and promotion

- Promotion of the production of micronutrient-rich vegetables and the planting of indigenous fruit trees to contribute to household food security.
- Establishment of school food gardens through school feeding projects to teach learners about the food cycle and how to become self-reliant with regard to food and nutrition needs.

Advocacy

- Advocacy for appropriate technologies and methods of food production, processing, preservation, preparation, distribution, storage and consumption in poor communities in consultation with appropriate sectors such as the Department of Agriculture.
- Advocacy for affordable food prices and the exemption of VAT on basic foodstuffs and fortified basic foods.

Technical support and nutritional advice to other sectors dealing with household food security.

- Provision of nutrition guidelines for sectors caring for children such as the social development sector who is responsible for feeding in emergency situations, the feeding of AIDS orphans and crèche feeding.

- Assistance to the educational sector to ensure that all children in Early Childhood Development Centres receive food of adequate quality and quantity to contribute to their daily nutritional requirements
- Women's groups involved in income generating activities or recipients of Poverty Alleviation Funds, should be encouraged to establish day care centres as part of their funded activities.
- Including nutrition interventions in the community projects of other sectors such as the Public Work Programme of the Department of Public Works.
- Encouraging new land owners in terms of the Department of Land Affairs' Land Distribution Programme to produce food either at a subsistence or commercial level in order to be household food secure.

School feeding

There is consensus globally that in countries where there is a high prevalence of poverty, unemployment, protein energy malnutrition, household food insecurity, micronutrient deficiencies and school learner drop out, school feeding should be considered and pursued as an intervention to reduce short-term hunger and to alleviate the effects of malnutrition on the development of school aged children. This is in view of the established interrelationships between education, health and nutrition in early childhood and school-aged children, and their combined implication on economic and human resource development.

More specifically, children who lack certain nutrients in their diet or who suffer from protein-energy malnutrition, short-term hunger, parasitic infections or other diseases do not have the same potential for learning as other children. Given the high incidence and severity of poverty in South Africa, hunger is a real problem affecting millions of primary school learners from poor households every day. School learners are particularly vulnerable to short-term hunger, especially where they consume poor quality diets. Many factors contribute to hunger in school learners such as long distances they have to walk/travel to school, extra chores they have to perform before going to school, meal patterns at home and a lack of family time or resources to provide food of adequate quality and quantity at home. Children, who come to school hungry, have diminished attentiveness, a greater likelihood of becoming distracted and a diminished interest in learning. The result is learners who are more vulnerable to failure, low achievement and repetition.

Although school feeding will not contribute significantly to an improvement in nutritional status, it could be another key strategy to contribute to household food security. Within the context of household food security, school feeding should form part of a comprehensive package to improve the health and general well being of a child. One of the biggest advantages of school feeding is that it can, if properly designed and effectively implemented, alleviate short-term hunger immediately. Although the cost is high, the benefits are also high especially among nutritionally at risk learners who have to benefit fully from the education system. There is sufficient evidence from studies that by simply alleviating hunger in school learners, their performance at school significantly improve. School feeding helps to increase the attention and concentration of school learners, thus producing gains in cognitive function and learning.

In addition to alleviating short-term hunger, school feeding can be used as a springboard for development. It can motivate parents to enroll their children in school and have them attend regularly. When programmes effectively reduce absenteeism and increase the duration of schooling, educational outcomes (performance, dropout, and repetition) improve. School feeding can also increase community involvement in schools, particularly where projects depend on the community to prepare and serve meals to children. Schools with their communities behind them are more effective than schools with less community involvement. In addition, it offers opportunities for the improvement of school infrastructure e.g. the provision of water and sanitation, electricity etc. to schools with school feeding projects will ensure a holistic, coordinated response to needs.

4.7.2 Definition

The nutrition-related activities to contribute to adequate access by households to amounts of foods of the right quality to satisfy the dietary needs and to ensure a healthy active life of all household members at all times through out the year.

4.8 Support system: Nutrition information system

4.7.14.8.1 Problem statement

South Africa lacks a comprehensive and integrated system for the assessment of the nutritional status of the population through regular cross-sectional sample surveys to identify the causes of nutritional problems and to provide information on the causes of nutritional problems. Such a system will assist with providing baseline data, assessing the overall nutritional status of the population, identifying vulnerable or at-risk groups, formulating the extent of the problem, allocating of resources to areas of need and formulating of policies.

In addition, South Africa lacks a comprehensive and integrated system for the monitoring of the nutritional status of the population. The result is a lack of information for targeting, planning, decision-making, monitoring and evaluation. It is therefore important to have an effective nutrition surveillance system from a programme planning and management perspective.

Any programme requires an effective and efficient management information system for planning, monitoring and managing service delivery. The information system should provide information on programme processes, outputs and outcomes to monitor and assess performance and to assist with programme planning. The system should cover the scope of programme activities at the different levels namely national, provincial, district and community level.

4.7.24.8.2 Definition

The Nutrition Information System consists of nutrition surveys, nutrition surveillance and the management of information.

Nutrition surveys is a system for the assessment of the nutritional status of the population through regular cross-sectional sample surveys.

Nutrition surveillance is the system for monitoring the nutritional status of the population over time and geographic location to develop appropriate interventions.

The management information system is the routine set of activities to manage information for programme development, implementation, monitoring and evaluation.

4.9 Support system: Human resource plan

4.9.1 Problem statement

The lack of a human resource plan for the INP is seriously affecting its successful implementation. Adequate numbers of staff with the required competencies should be available at all levels of implementation to ensure that the INP reaches its goals and objectives. Similarly, the human resource management and development requirements of the INP should be properly attended to ensure that the programme reaches its goals and objectives.

4.9.2 Definition

The Human Resource Plan is a management tool to assist nutrition managers at the different levels of health management structures to coordinate programme activities and to meet the INP goals and objectives by having the right number of people with the right competencies in the right place at the right time.

The Human Resource Plan includes human resource management, which involves recruitment, correct placement, remuneration and performance management of nutrition personnel. Human resource management for the INP implies a purposeful action aimed at assisting nutrition managers/supervisors at different levels of health management structures in the optimal utilisation and employment of personnel to achieve the goals and objectives of the INP. The Plan also includes human resource development, which is a process of building the capacity of personnel and providing them with the competencies required to achieve the goals of the INP.

4.10 Support system: Financial and administrative system

4.10.1 Problem statement

Public accountability requires effective and efficient management of financial allocations, expenditure, assets and liabilities. It requires accounting officers, managers and other officials to act in accordance with their delegated responsibilities and to account in various ways for their conduct and performance. It is, therefore, important to set up a proper financial management and administrative system for the INP to ensure adherence to the requirements of the Public Finance Management Act and the Division of Revenue Act.

4.10.2 Definition

The Financial and Administrative System entails the management of financial allocations, expenditure, assets and liabilities relating to the INP as well as administrative tasks.

The financial allocations include the normal budget allocations, the INP Conditional Grant Allocation and the Special Allocation for Poverty Relief and donor assistance.

5 GOALS AND OBJECTIVES: 2002 TO 2007

The table below indicates the strategic goals and objectives of the INP for the period 2002 to 2007. The current status and targets will be reviewed and updated as the results of assessments and surveys become available.

FOCUS AREA Disease-specific nutrition support, treatment and counselling				
GOAL Contribution to the prevention and reduction of morbidity and mortality rates due to malnutrition, nutrition-related diseases of lifestyle, communicable and infectious diseases and debilitating conditions				
STRATEGIC OBJECTIVE	PERFORMANCE INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To contribute to the reduction in the prevalence of underweight among pregnant and lactating women	Proportion of underweight pregnant and lactating women measured as the number of underweight pregnant and lactating women <-2 standard deviations of the National Centre for Health Statistics/World Health Organisation (NCHS/WHO) reference median value of weight for age out of the surveyed number of pregnant and lactating women	No data	No data	To be set when data become available
		<i>Source:</i>		
To contribute to the reduction in the prevalence of low birth weight	Proportion of live born infants born at health facilities with a birth weight of < 2 500 gram measured as the number of live born infants born at health facilities with a birth weight of < 2 500 gram out of the total number of live infants born at health facilities	1992: 10.7%	1998: 8.3%	National target not available
		<i>Source:</i> 1992: Human Sciences Research Council Survey 1998: South Africa Demographic and Health Survey (SADHS)		

<p>To contribute to the reduction of malnutrition in children under 5 years of age, specifically of:</p> <ul style="list-style-type: none"> • Underweight • Severe underweight • Stunting • Wasting 	<p>Proportion of underweight children <5 years of age measured as the number of children <5 years of age < -2 standard deviations of the NCHS/WHO reference median value of weight for age out of surveyed number of children <5 years of age</p>	<p>Primary schools learners: 1994: 9%</p> <p>Children 6 months to 6 years: 1995: 9.3%</p>	<p>Children 1 to 9 years: 1999: 10.3%</p>	<p>8%</p>
	<p><i>Source:</i> 1994: <i>Anthropometric Survey in Primary Schools in the RSA, Dept of Health</i> 1995: <i>South African Vitamin A Consultative Group (SAVACG)</i> 1999: <i>National Food Consumption Survey (NFCS)</i></p>			
	<p>Proportion of severely underweight children <5 years of age measured as the number of children <5 years of age below -3 standard deviations of the NCHS/WHO reference median value of weight for age out of surveyed number of children <5 years of age</p>	<p>Primary schools learners: 1994: 0.5%</p> <p>Children 6 months to 6 years: 1995: 1.4%</p>	<p>Children 1 to 9 years: 1999: 1.4%</p>	<p>1%</p>
	<p><i>Source:</i> 1994: <i>Anthropometric Survey in Primary Schools in the RSA, Dept of Health</i> 1995: <i>SAVACG</i> 1999: <i>NFCS</i></p>			

Proportion of stunted children <5 years of age measured as the number of children <5 years of age below –2 standard deviations of the NCHS/WHO reference median value of height for age out of surveyed number of children <5 years of age	Primary schools learners: 1994: 13.2%	Children 1 to 9 years: 1999: 21.6%	18%
	Children 6 months to 6 years: 1995: 22.9%		
<i>Source:</i> 1994: <i>Anthropometric Survey in Primary Schools in the RSA, Dept of Health</i> 1995: SAVACG 1999: NFCS			
Proportion of wasted children <5 years of age measured as the number of children <5 years of age below –2 standard deviations of the NCHS/WHO reference median value of weight for height out of surveyed number of children <5 years of age	Primary schools learners: 1994: 2.6%	Children 1 to 9 years: 1999: 3.7%	2%
	Children 6 months to 6 years: 1995: 2.6%		
<i>Source:</i> 1994: <i>Anthropometric Survey in Primary Schools in the RSA, Dept of Health</i> 1995: SAVACG 1999: NFCS			
Children <5 years of age showing undernutrition measured as children <5 years of age weighing less than the 3 rd centile, but more than 60% of the estimated weight for age as recorded on the RthC out of children <5 years of age weighed	No data	No data	To be set when data become available
	<i>Source:</i> DHIS		
Children <5 years of age with either very low weight or marasmus or kwashiorkor measured as children <5 years of age with either very low weight (i.e. weight less than 60% of estimated weight for age or visible severe wasting (marasmus) or oedema of both feet (kwashiorkor) out of target population <5 years of age	No data	No data	To be set when data become available
	<i>Source:</i> DHIS		

To contribute to the reduction of the under-five mortality rate through strengthening nutritional management in the IMCI	Total under-five mortality rate measured as the number of children < five years of age dying expressed per 1000 live births	1991: 69/1000	1998: 61/1000	30% reduction
	<i>Source:</i> 1991: Health Status Report, Department of Health – 1990/91 1998: SADHS			
To contribute to the reduction of morbidity and mortality associated with nutrition-related diseases of lifestyle, specifically <ul style="list-style-type: none"> • Overweight • Obesity • Coronary heart disease • Hypertension • Diabetes mellitus 	Proportion of overweight children 1 to 9 years of age measured as the number of children 1 to 9 years of age surveyed with a >+2 standard deviations of the NCHS/WHO reference median value of weight for height out of surveyed number of children 1 to 9 years of age	No data	1999: 6%	4%
	<i>Source:</i> 1999: NFCS			
	Proportion of overweight adolescent males and females 15 to 19 years of age measured as the number of males and females 15 to 19 years of age with a Body Mass Index (BMI) 25 to 30 out of surveyed number of males and females 15 to 19 years of age	Males: No data	Males: 1998: 5.3%	Males: 3%
	Females: No data	Females: 1998: 17.6%	Females: 15%	
<i>Source:</i> 1998: SADHS				

Proportion of obese adolescent males and females 15 to 19 years of age measured as the number of males and females 15 to 19 years of age with a Body Mass Index (BMI) >30 out of surveyed number of males and females 15 to 19 years of age	Males: No data	Males: 1998: 2%	Males: 1%
	Females: No data	Females: 1998: 5.9%	Females: 4%
<i>Source: 1998: SADHS</i>			
Proportion of overweight adult males and females >15 years of age measured as the number of adult males and females >15 years of age with a Body Mass Index (BMI) 25 to 30 out of surveyed number of adult males and females >15 years of age	Males: No data	Males: 1998: 19.8%	Males: 15%
	Females: No data	Females: 1998: 26.1%	Females: 20%
<i>Source: 1998: SADHS</i>			
Proportion of obese adult males and females >15 years of age measured as the number of adult males and females >15 years of age with a BMI >30 out of surveyed number of adult males and females >15 years of age	Males: 1995: 7.99%	Males: 1998: 9.3%	Males: 7%
	Females: 1995: 22.5%	Females: 1998: 30.1%	Females: 25%
<i>Source: 1995: SAVACG 1998: SADHS</i>			
Proportion of males and females 45 to 59 years of age who died from ischaemic heart disease (IHD) measured as the number of males and females 45 to 59 years of age who died from IHD out of the total number of males and females 45 to 59 years of age who died	Males 45 to 59 years: 1995: 5.6%	Males 45 to 59 years: No data	Targets not available from Dir: Chronic Diseases, Disabilities & Geriatrics
	Females 45 to 59 years: 1995: 3.8%	Females 45 to 59 years: No data	
<i>Source: 1995: Stats SA Recorded Deaths</i>			

	Proportion of hypertensive males and females measured as the number of hypertensive males and females out of surveyed number of males and females where hypertension is defined as blood pressure >160/95 mmHg and/or antihypertensive medication	No data	Males: 1998: 13% Females: 1998: 16%	Targets not available from Dir: Chronic Diseases, Disabilities & Geriatrics
		<i>Source:</i> 1998: SADHS		
	Proportion of adult population who has Type 2 diabetes measured as the number of adults who have Type 2 diabetes out of the surveyed number of adults	No data	1998: 8%	Target not available from Dir: Chronic Diseases, Disabilities & Geriatrics
		<i>Source</i> 1998: Dir: Chronic Diseases, Disabilities & Geriatrics		
To contribute to the reduction of morbidity and mortality of people living with TB, HIV/AIDS and other chronic debilitating conditions	Nutritional support, treatment and counselling are an integral part of the treatment plan or regimen of people living with TB, HIV/AIDS and other chronic debilitating conditions and who are malnourished, irrespective of whether treatment forms part of home-based care or in a health facility	No data	No data	To be finalised
		<i>Source:</i>		

FOCUS AREA Growth monitoring and promotion				
GOAL Contribution to optimal growth of infants and young children				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To prevent and reduce growth faltering among children 0-24 months of age through regular growth monitoring and promotion	Children < 5 years of age not gaining weight measured as children <5 years of age who have lost weighed during the previous month (or since the last clinic visit) irrespective whether they fall above or below the 97 th , 50 th , 3 rd and 60% of the estimated weight for age out of children < 5 years of age weighed	No data	No data	To be set when data become available
		<i>Source:</i> DHIS		
To ensure that all new born babies are provided with a Road to Health Chart	Proportion of new borns and children with RtHC at 12 months old, 24 months old and 60 months old measured as the number of mothers with children 12 months old, 24 months old and 60 months old with RtHC out of the surveyed number of mothers with children 24 months old and 60 months old	New borns: No data	New borns: No data	New borns: 100%
		12 to 13 months: 1994: 50%	12 to 13 months: 1998: 74.6%	12 to 13 months: 85%
		24 months: No data	24 months: No data	24 months: 85%
		60 months: No data	60 months: No data	60 months 85%
<i>Source:</i> 1994: Directorate: Child and Youth Health, Dept of Health 1998: SADHS				

FOCUS AREA				
Nutrition promotion, education and advocacy				
GOAL				
<ul style="list-style-type: none"> • Sensitised and supportive policy and decision makers as well as other relevant stakeholders on nutrition • Improved nutritional knowledge, behaviour, perceptions and attitudes of the population • Awareness of the INP, its focus areas and nutrition in general 				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To ensure the development of policies that would support and contribute to the goals and objectives of the INP	The number of policies that contribute to the achievement of nutrition goals and objectives measured as a percentage of the total number of policies reviewed	No data	No data	Will be set when data become available
		<i>Source:</i>		
To improve nutrition-related knowledge, practices, perceptions and attitudes	Pre- and post assessments at individual, group, community or population level of the following indicators: <ul style="list-style-type: none"> • Changes in knowledge • Changes in attitudes • Changes in opinions • Changes in intentions • Actions taken/practices implemented 	No data	No data	Will be set when data become available
		<i>Source:</i>		
To improve awareness of the INP, its focus areas and nutrition in general	Pre- and post assessments of: <ul style="list-style-type: none"> • Changes in knowledge • Changes in attitudes • Changes in opinions • Changes in intentions • Actions taken/practices implemented 	No data	No data	Will be set when data become available
		<i>Source:</i>		

FOCUS AREA				
Micronutrient malnutrition control				
GOAL				
Prevention, reduction and control of micronutrient malnutrition deficiencies				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
Elimination of micronutrient malnutrition deficiencies among the population focussing on vulnerable population and groups	Vitamin A deficiency rate measured as the number of children <5 years of age with serum retinol <20ug/dl out of total number of children <5 years of age	1995: 33.3%	No data	19%
		<i>Source:</i> 1995: SAVACG		
	Vitamin A supplementation coverage of children 6 - 11 months measured as the number of children 6 to 11 months who received 100 000IU vitamin A out of the total number of children 6 – 11 months			95%
		<i>Source:</i> DHIS		
	Vitamin A supplementation coverage of children 1 – 5 years measured as the number of children 1 – 5 years who received the first dose of 200 000IU vitamin A out of the total number of children 1 – 5 years			80%
		<i>Source:</i> DHIS		
	Vitamin A supplementation coverage of children 1 – 5 years measured as the number of children 1 – 5 years who received the second dose of 200 000IU vitamin A out of the total number of children 1 – 5 years			80%
	<i>Source:</i> DHIS			
Vitamin A supplementation coverage of post partum mothers measured as the number of women who received a dose of 200 000IU vitamin A within 8 weeks post partum out of the total number of (women with) live births			95%	
	<i>Source:</i> DHIS			
Iron deficiency rate measured as the number of children <5 years of age surveyed with iron deficiency out of surveyed number of children <5 years		1995: 10%	No data	7.5%
		<i>Source:</i> 1995: SAVACG		

	Iron deficiency rate measured as the number of women surveyed with iron deficiency (iron hemoglobin <11g/dl) (iron ferritin <12ug/dl)out of surveyed number of women	No data	No data	0%
		<i>Source:</i>		
	Iodine deficiency rate measured as the number of primary school learners surveyed with low urinary iodine (<100ug/dl) out of surveyed number of primary school learners	No data	1998: 10.6%	5%
		<i>Source:</i> 1998: National Iodine Deficiency Disorder (IDD) Survey		
To decrease the proportion of children with inadequate intake of the following vitamins and minerals: <ul style="list-style-type: none"> • Vitamin A • Zinc • Iron • Thiamin • Riboflavin • Niacin • Vitamin B₆ • Folic acid 	Proportion of children >6 months and <9 years with an intake of <50% of the recommended levels of the vitamins and minerals measured as the number of children >6 months and <9 years surveyed with an intake of <50% of the recommended levels of the vitamins and minerals out of the total number of children >6 months and <9 years	No data	1999: 50%	40%
		<i>Source:</i> 1999: NFCS		

To contribute to increasing the proportion of households consuming adequately iodised salt	Proportion of households consuming adequately iodised salt (15 ppm) measured as number of households surveyed using adequately iodised salt out of total number of households surveyed	No data	2000: 62% of households using adequately iodised salt of at least 15 ppm 1998: IDD Survey: 61% of household samples >20mg/kg	80%
<i>Source:</i> 2000: Medical Research Council (MRC) 1998: IDD Survey				
FOCUS AREA Food Service Management				
GOAL Contribution to the institutional care of clients through food service systems for the provision of balanced nutrition				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To ensure that clients at public institutions receive meals that are acceptable (including culturally acceptable) and adequate in quality and quantity	Proportion of public institutions with food services complying with the minimum norms and standards for food service management measured as the number of public institutions with food services complying with the minimum norms and standards for food service management out of the total number of public institutions rendering food services	No data	No data	80%
<i>Source:</i>				

FOCUS AREA Promotion, protection, support of breastfeeding				
GOAL Contribution to child survival and maternal health				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To increase the proportion of mothers who breastfeed their babies exclusively for six months	Exclusive breast-feeding rate at 6 months measured as the number of infants at 6 months of age receiving only breast milk or expressed breast milk and no other liquids or solids with the exception of drops or syrups containing vitamins, mineral supplements or medicines) out of total number of infants at 6 months of age	1995: 11.6%	1998: 0-3 months: 10.4% 4-6 months: 1.2% 0-6 months: 7%	12% 2.5% 10%
		<i>Source:</i> 1995: SAVACG 1998: SADHS		
To increase the proportion of mothers who continue to breastfeed their babies with appropriate complementary foods up to 24 months of age and beyond	Breastfeeding rate at 12 months and 24 months measured as the number of infants at 12 months and 24 months of age receiving breast milk as well as appropriate complementary foods out of total number of infants at 12 months and 24 months of age	12 months: 1995: 32.7%	12 months: 1998: 67.9%	12 months: 70%
		24 months 1995: No data	24 months: No data	24 months: To be set when data become available
<i>Source:</i> 1995: SAVACG 1998: SADHS				
To ensure that mothers of infants under 24 months who are not breastfeeding, practice appropriate replacement feeding options	Proportion of mothers of infants under 24 months who are not breastfeeding who practice appropriate replacement feeding options measured as the number of mothers of infants under 24 months who are not breastfeeding who practice appropriate replacement feeding options out of the total number of mothers of infants under 24 months who are not breastfeeding	No data	No data	To be set when data become available
		<i>Source:</i>		

To ensure that health facilities with maternity beds are baby-friendly	Proportion of health facilities with maternity beds that are baby-friendly measured as the number of health facilities with maternity facilities complying with at least 80% of the WHO/UNICEF Ten Steps for Successful Breastfeeding out of the total number of health facilities with maternity facilities	1995: 0.62% 3/480	2000: 4.79% (23/480) 2001: 8.0% 39/480 2002: 12% 58/480	15% (72/480)
		<i>Source:</i> <i>Directorate: Nutrition</i>		

FOCUS AREA				
Contribution to household food security				
GOAL				
Contribution to the improvement of household food security				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To ensure that other sectors dealing with household food security receive adequate technical support and advice on nutrition	Number of ISRDp nodal sites with nutrition activities such as nutrition education, growth monitoring and promotion, etc.	Nil	Currently being assessed	13/13
		<i>Source:</i>		
To alleviate short-term hunger among primary school learners	Proportion of targeted primary schools reached measured as the number of targeted primary schools reached out of the total number of primary schools targeted for school feeding	1994:83%	2000: 96%	100%
		1995:79%	2001: 91%	
	1996:77%			
	1997:81%			
		1998:90%		
		1999:96%		
<i>Source:</i>				
<i>Directorate: Nutrition (Provincial monitoring reports)</i>				
	Proportion of actual feeding days measured as the number of actual feeding days out of the total number of planned feeding days (Minimum number of feeding days: 156 school days)	No data	2000: 85%	100%
		<i>Source:</i>		
	<i>2000: External evaluation of certain aspects of school feeding</i>			
	Number of provinces where actual servings for school feeding comply with the requirements and specifications of the standardised menu options out of total number of provinces	No data	2000: 0/9 (Non-standardised menus)	100%
		<i>Source:</i>		
<i>2000: External evaluation of certain aspects of school feeding</i>				

SUPPORT SYSTEM				
Nutrition information system				
GOAL				
Efficient and effective nutrition information system for planning, policy formulation and management				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To assess the nutritional status of the population through regular surveys	Number of surveys completed out of number of planned surveys	1994: 1	2000: 4	Target to be finalised
		<i>Source: Directorate : Nutrition</i> <ul style="list-style-type: none"> • 1994: Anthropometric Survey in Primary Schools in the RSA, Dept of Health • 1995: SAVACG • 1998: IDD Survey • 1999: NFCS 		
To continuously collect, analyse and utilise data on specific nutrition indicators to monitor the nutritional status of the population	Number of nutrition indicators in DHIS	Nil	0/7	7/7
		<i>Source:</i> <i>Directorate: Nutrition</i>		

To implement a minimum data set to manage information for programme development, implementation, monitoring and evaluation	<ul style="list-style-type: none"> • Number of provinces submitting reports as required by minimum data set out of total number of provinces • Number of national evaluations conducted out of total number of planned evaluations 	Reports: No data	Reports: 2000: 4/9	Reports: 9/9
		Evaluations: Nil	Evaluations 8	Evaluations To be finalised
<p><i>Source:</i> <i>Directorate: Nutrition</i> <i>Evaluations:</i></p> <ul style="list-style-type: none"> • 1995 Rapid assessment of PSNP (Office of the Reconstruction and Development Programme) • 1997: Assessment of implementation of PMT recommendations (Internal) • 1997: Evaluation of PSNP (Independent) • 1998: Evaluation 17 community-based nutrition projects (Consultants) • 1998: Evaluations of training of trainers course in lactation management (Consultants) • 2000: Evaluation of school feeding (DoH Tender) • 2000: Assessment of financial and administrative procedures of INP (DoH Tender) • 2000: Assessment of Food Service Management (Consultant) 				

SUPPORT SYSTEM Human resource plan				
GOAL Effective and efficient management and development of human resources for the INP				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To develop and implement the INP human resource plan	Proportion of posts filled measured as percentage of posts filled out of total number of posts	No data	2000: National: 83% Provincial: 74% 2002: National: 100% Provincial: 61%	100%
	<i>Source:</i> <i>Directorate: Nutrition & Provincial INP Business Plans for 2001/02</i> <i>Directorate: Nutrition & Provincial INP Business Plans for 2002/03</i>			
	Proportion of new staff that completed the induction course measured as number of new staff that completed the induction course out of total number of new staff	N/a *	N/a *	100%
* Induction course will only be instituted in 2003 <i>Source:</i>				
Proportion of staff that received in-service training measured as the number of staff that received in-service training out of total number of staff	No data	No data	70%	
	<i>Source:</i>			

SUPPORT SYSTEM Financial and administrative system				
GOAL Efficient and effective financial management and administration in support of nutrition goals and objectives				
OBJECTIVE	INDICATOR	BASE LINE	CURRENT STATUS	TARGET
To adhere to the requirements of the Financial Management Act and the Distribution of Revenue Act	Level of application of best practices	No data	2000: National 100% good practices Provincial: Some good practices in some provinces	National: 100% good practices at national level Provincial: Good practices in most provinces
		<i>Source:</i> 2000: Report on assessment of financial and administrative procedures of INP		
	Proportion of funds spend measured as the amount of the INP Conditional Grant expended out of the total amount of the INP Conditional Grant Allocation	1998/99: 54% 1999/2000: 67%	2000/01: 87% 2001/02: 82%	100%
		<i>Source:</i> Directorate: Nutrition		
	Proportion of funds spend measured as the amount of the Special Allocation for Poverty Relief expended out of the total amount of the Special Allocation for Poverty Relief	1997/98 to 1999/00 : Average expenditure: 43%	2000/01: 17% 2001/02: 33%	80%
		<i>Source:</i> Directorate: Nutrition		