

**Exploring stakeholder commitment and capacity to address infant and young  
child nutrition in the capital of the Breede Valley, Western Cape Province,  
South Africa**

by

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*Dissertation presented for the degree of Doctor of Philosophy  
(Nutritional Sciences) at Stellenbosch University*



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December 2015

## **Declaration**

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December 2015

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## Summary

There is experience with - and documented evidence on multi-stakeholder processes (MSPs) on a global - and national level and on how to build and assess commitment and capacity to address infant and young child nutrition (IYCN) at these levels. Little experience and documented evidence, however, exist for such processes at local level. In countries with a decentralised government system, part of the lack of experience and evidence on MSPs lies in the challenge of building commitment and capacity at various political and bureaucratic levels. There is, thus, a need to build an evidence-base of how to engage stakeholders at implementation level and to assess and advance their commitment and capacity to implement responses to address IYCN. There is also a call to better define enabling environments for successful action in this field.

In this research, a qualitative study design and selected participatory research methods were used to explore a diversity of perceptions, willingness, abilities, relationships and powers of key stakeholders to address IYCN at sub-district level in the Breede Valley, Western Cape Province, South Africa. The study built on baseline research in the Community-based Nutrition Security Project (CNSP), which provided insight into maternal and child nutrition challenges in the Breede Valley. Stakeholders were identified and categorised during a focus group discussion (FGD) with individuals who knew the sub-district well. Subsequently, the researcher conducted semi-structured interviews with twenty seven key stakeholders to explore their perspectives, commitment and capacity concerning IYCN. Hereafter, they were invited to participate in a workshop to map stakeholder relationships and power related to IYCN governance. Lastly, FGDs were held to reflect on the research process and to explore elements of an enabling environment conducive to action on IYCN at implementation level.

Main themes from the overall research findings include: the value of local knowledge and information; the appeal of the 1000 days message and its link to development; the urgent need for IYCN advocacy; the value of stakeholder engagement and seeing the broad IYCN stakeholder landscape; the need for multi-sectoral work, while recognising the difficulty in functioning across sectors; realising the capacity inherent in “people” as a resource, the need for a “whole of society approach” in advancing the IYCN agenda and the importance of

strategic capacity in local forums, combined with national legislation, to advance action for IYCN.

The study provides insight into the elusive concepts of commitment and capacity in relation to IYCN governance at local level. The personal and professional perspectives of key stakeholders involved at this level offered distinct information about the unique challenges they experienced as well as practical responses required to ensure action. The barriers to multi-sectoral work at the sub-district level hinged on narrow sector-specific focus areas, mandates and budgets leading to poor integration around the social determinants of health, lack of resources and lack of targeted advocacy.

The core conclusion of the study is that a detailed exploration of initial stages of an MSP is a valuable practice - and research model to create awareness of IYCN as a development issue of crosscutting importance at implementation level. This process, though time and resource-intensive, has supported the development of commitment and revealed collective capacity that could be unlocked to address IYCN at the sub-district level in the Breede Valley. Such an approach, appropriately adapted to local conditions, could be helpful in scaling-up efforts to improve IYCN at sub-district level elsewhere in the country. The next phase of the CNSP should involve joint planning and concrete action to improve IYCN in the Breede Valley.

The proposed expansion of the definition of the enabling environment and adaptation of the nutrition governance framework could be introduced into international debates and agendas for continued deliberation, research and action to improve IYCN as a global, national and local priority.

## Opsomming

Daar is ondervinding in - en gedokumenteerde bewyse van multi-rolspeler prosesse (MRP) op 'n globale en nasionale vlak asook hoe om toewyding en kapasiteit te bou en te ondersoek om baba-en-jong-kind voeding (BJKV) aan te spreek op hierdie vlakke. Daar is egter min ondervinding en gedokumenteerde bewyse vir sulke prosesse op 'n plaaslike vlak. Die uitdaging om toewyding en kapasiteit op verskeie politieke en burokratiese vlakke te bou, dra by tot die gebrek aan ondervinding en bewyse oor MRP in lande met 'n gedesentraliseerde regering-sisteem. Daar is dus 'n behoefte om 'n bewys-basis te bou oor hoe om rolspelers te betrek op implementeringsvlak en om hul toewyding en kapasiteit te bou en te bevorder om oplossings te implementeer om BJKV aan te spreek. Daar is ook 'n versoek om bemagtigende omgewings vir suksesvolle aksie in die veld beter te definieer.

'n Kwalitatiewe studie-ontwerp en geselekteerde deelnemende navorsingsmetodes was in hierdie navorsing gebruik om 'n verskeidenheid van perspektiewe, gewilligheid, vermoëns, verhoudinge en mag van sleutelrolspelers te ondersoek om BJKV op sub-distriksvlak in die Breede Vallei, Wes-Kaap Provinsie, Suid-Afrika aan te spreek. Die studie het voortgebou op navorsing van die "*Community-based Nutrition Security Project*" (CNSP), wat insae verleen het in die moeder-en-kind voedinguitdagings in die Breede Vallei. Tydens 'n fokusgroepbespreking (FGB) met individue, wat wel bekend was met die sub-distrik, was rolspelers geïdentifiseer en gekategoriseer. Gevolglik het die navorser semi-gestruktureerde onderhoude gevoer met sewe en twintig sleutelrolspelers om hul persepsies, toewyding en kapasiteit ten opsigte van BJKV te ondersoek. Hierna was hul genooi om deel te neem aan 'n werkswinkel om verhoudinge en mag tussen rolspelers, ten opsigte van BJKV-bestuur op sub-distriksvlak, uit te plot. Laastens was FGB gehou om oor die navorsingsproses te reflekteer en om gunstige elemente vir 'n ondersteunende omgewing vir BJKV aksies op implementeringsvlak, te ondersoek.

Hooftemas uit die oorkoepelende navorsingsbevindinge sluit in: die waarde van plaaslike kennis en inligting; die aantreklikheid van die 1000 dae boodskap en die verband met ontwikkeling; die dringende behoefte aan voorspraak vir BJKV; die waarde van skakeling tussen rolspelers en om 'n breë perspektief van die BJKV rolspelerlandskap te sien; die

behoefte aan multi-sektorale werk, maar ook die besef dat dit moeilik is om oor sektorgrense te funksioneer; die besef van die inherente kapasiteit van “mense” as hulpbron; die behoefte aan ‘n “omvattende gemeenskapsbenadering” om die BJKV agenda te bevorder; die belang van strategiese kapasiteit in plaaslike forums en nasionale wetgewing om aksie vir BJKV te bevorder.

Die studie verskaf insig in die vae begrippe van toewyding en kapasiteit van BJKV-bestuur op plaaslike vlak. Die persoonlike en professionele perspektiewe van sleutelrolspelers betrokke by hierdie bestuursvlak, het spesifieke inligting verskaf rondom die unieke uitdagings wat hul ervaar en die praktiese response wat benodig word vir aksie. Die struikelblokke vir multi-sektorale werk op sub-distriksvlak het gewentel om eng sektor-spesifieke fokusareas, mandate en begrotings wat lei tot swak integrasie rondom die maatskaplike bepalings van gesondheid, tekorte aan hulpbronne en ‘n tekort aan geteikende voorspraak.

Die kern gevolgtrekking van die studie is dat ‘n gedetailleerde ondersoek na aanvanklike stappe in ‘n multi-rolspeler proses, ‘n waardevolle praktyk- en navorsingsmodel is om bewustheid van BJKV as ‘n deursnit ontwikkelingskwessie op implementeringsvlak te skep. Die proses, alhoewel tyd - en hulpbron intensief, het die ontwikkeling van toewyding en kapasiteit ondersteun en gesamentlike kapasiteit blootgelê wat bevorder en ontsluit kan word om BJKV op sub-distriksvlak in die Breede Vallei aan te spreek. So ‘n aanslag, toepaslik aangepas vir plaaslike toestande, kan behulpsaam wees om die skaal van pogings te vergroot om BJKV op sub-distriksvlak elders in die land te bevorder. Die volgende fase van die CNSP behoort gesamentlike beplanning en konkrete aksies in te sluit om BJKV in die Breede Vallei te verbeter.

Die moontlike uitbreiding van die definisie van die “ondersteunende omgewing” en die “voedingsbestuursraamwerk” kan voorgestel word aan die internasionale debatte en agendas vir voortgesette oorweging, navorsing en aksie vir die verbetering van BJKV as ‘n globale, nasionale en plaaslike prioriteit.

## Acknowledgements

I stand in awe with heartfelt gratitude when I reflect on the support and love bestowed on me during this PhD journey.

I thank My Heavenly Father for His grace in my life. I remain overwhelmed by Your greatness.

A myriad of family members, friends and colleagues have contributed to the successful completion of this work.

With exception I want to mention a few people. My husband, De Wet and sons, DW and Leslie – thank you for your unwavering love and support. I am forever indebted to you for the patience and endurance you bared during trying times.

To my mother, Anso, my father Basil, my sister Desmaré, brother Leslie, sisters-in-law Isabeau and Lizl, brothers-in-law Attie and Brink, nephew Fanus, niece Anne, cousin Marike and many dear friends - I am fulfilled because of your love and presence in my life.

Getti, Marlene, Linda, Wendy, Anmar and my extended family-in-law, thank you for all your prayers and messages of encouragement. I love you dearly.

To my mentors and friends Rose and Marietjie – your wisdom, love and reassurance are blessings in my life.

My Gingi-cat and faithful writing companion - your company made the long hours bearable.

Milla and Scott - thank you for your study leadership and guidance, sharing of your expertise and wisdom and especially for the commitment in investing your valuable time in the development of my professional and personal skills and capacity.

Liesbet, Lynette, Ronel, Alta, Ancois and Stacy-Leigh, my colleagues and “dream team” – thank you for your backing and assistance. Liesbet, Lynette and Ronel – a special thank you go out to you for keeping the Community Nutrition firm steadfast while I was on sabbatical.

To my fieldworkers, Rural School personnel, and every participant who enriched my work, a very special acknowledgement.

This research has been supported by the President’s Emergency Plan for AIDS relief (PEPFAR) through HRSA under the terms of T84HA21652. The Stellenbosch University (SU) HOPE project, Fund for Innovation in Rural Research (FIRRH), SU Rural Medical Education Partnership Initiative (SURMEPI) and SU Division of Research Development (DRD) are acknowledged for research funding received.

***“The true character of a society is revealed in  
how it treats its children”***

***~Nelson Mandela~***

*From: Launch of the Blue train speech, Worcester station,  
Worcester, South Africa. 27 September 1997*



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## Abbreviations/Acronyms

CDP	Community Development and Planning
CNSP	Community-based Nutrition Security Project of the Division of Human Nutrition, Faculty of Medicine and Health Sciences, Stellenbosch University
DOE	Department of Education
DOH	Department of Health
DSD	Department of Social Development
DAFF	Department of Agriculture, Forestry and Fisheries
DFID	Department for International Development
DHS	Demographic and Health Survey
DPME	Department of Performance Management and Evaluation
ECD	Early Childhood Development
HANCI	Hunger and Nutrition commitment index
HIV/AIDS	Human immunodeficiency virus/Acquired immunodeficiency syndrome
HPCSA	Health Professions Council of South Africa
FGD	Focus group discussion
FSI	Food Security Initiative (Stellenbosch University)
ICSU	International Council for Science
IFPRI	International Food Policy Research Institute
IUGR	Intra-uterine growth restriction
IYCF	Infant and Young Child Feeding
IYCN	Infant and Young Child Nutrition
LBW	Low birth weight
MBFI	Mother-Baby Friendly Initiative
MDGs	Millennium Development Goals
MIYCN	Maternal, Infant and Young Child Nutrition
MNCWH	Maternal, Neonatal, Child and Women's Health
MSP	Multi-stakeholder process
NCDs	Non-communicable diseases
NGO	Non-governmental Organisation
NTP	Nutrition Therapeutic Programme

NCI	Nutrition commitment index
PHC	Primary Health Care
PHN	Public Health Nutrition
PI	Primary Investigator
SA	South Africa
SASSA	South Africa Social Security Agency
SDGs	Sustainable Development Goals
SU	Stellenbosch University
SUN	Scaling Up Nutrition Movement
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation

## Glossary

Capacity:	The ability of governments, organisations or stakeholders to address a specific cause (Chopra <i>et al.</i> , 2009).
Commitment:	The willingness of governments, organisations or stakeholders to address a specific cause (Chopra <i>et al.</i> , 2009).
District health model:	A decentralised model of health governance, proposed by World Health Organisation. The South African Health System consists of a national policy-oriented function and 9 provincial health departments, which in turn are divided into districts and sub-districts (DOH, 2010; Mayosi <i>et al.</i> , 2012).
Enabling environment:	Political and policy processes that build and sustain momentum for the effective implementation of actions to address a specific issue (Gillespie <i>et al.</i> , 2013).
First 1000 days of life:	The period from conception through pregnancy, birth and up to a child's second birthday (Bhutta <i>et al.</i> 2008).
Infant and Young Child Feeding:	Refers to liquids and foods ingested by infants and young children, including breastmilk and complementary foods and drinks, provided by mothers and/or other caregivers (WHO, 2008c)
Infant and Young Child Nutrition:	Refers to food, health and care provided to infants and young children (WHO, 2008c) by various individuals, government sectors, community-based organisations and non-governmental organisations
Interdisciplinary:	Analyses, synthesizes and harmonizes knowledge and methods between disciplines into a coordinated and coherent whole (Choi & Pak, 2006; Harris & Drimie, 2012).

Multidisciplinary:	People from different disciplines working together, each drawing on their disciplinary knowledge (Choi & Pak, 2006; Harris & Drimie, 2012).
Multi-sectoral work:	Working together comprehensively to bring policies, programmes, resources and actions to bear at the same time and place on the same issue (Garrett <i>et al.</i> , 2014, p 2).
Multi-stakeholder process:	Entails a structured procedure used to facilitate participation of various stakeholders from different sectors on a specific issue (Hemmati, 2002).
Nutrition sensitive interventions:	Also referred to as indirect nutrition interventions, e.g. agriculture and food security; social safety nets; early child development; maternal mental health; women's empowerment; child protection; schooling; water, sanitation, and hygiene; health and family planning services (Ruel <i>et al.</i> , 2013).
Nutrition specific interventions:	Also referred to as direct nutrition interventions and include adolescent, preconception, and maternal health and nutrition; maternal dietary or micronutrient supplementation; promotion of optimum breastfeeding; complementary feeding and responsive feeding practices and stimulation; dietary supplementation; diversification and micronutrient supplementation or fortification for children; treatment of severe acute malnutrition; disease prevention and management; nutrition in emergencies (Ruel <i>et al.</i> , 2013)
South African Government:	South Africa is a constitutional democracy with a three-tier system of government and an independent judiciary. The national, provincial and local levels of government all have legislative and executive authority in their own spheres, and are defined in the

Constitution as "distinctive, interdependent and interrelated" (South Africa, 2015).

Stakeholders:

Actors who have a vested interest in the policy or programme that is being promoted and are considered patrons in the process (DFID, 2002; Schmeer, 1999).

Sub-national level:

A component of a decentralised government system. In South Africa the sub-national level refers to provincial, district and sub-district levels (South Africa, 2015).

Trans-disciplinary:

Integrates the natural, social and health sciences in a humanities context beyond the disciplinary perspectives. (Choi & Pak, 2006; Harris & Drimie, 2012)

## **Chapter 1: Introduction**

## 1.1 Identifying the research issue

Good nutrition lays the foundation for development outcomes linked to education, health and economic growth that in turn stand central to the sustainable development agenda crafted in the Sustainable Development Goals (SDGs) (International Food Policy Research Institute [IFPRI], 2014a; United Nations [UN], 2015). From a life cycle perspective, improving nutrition during the first 1000 days of life, i.e. from pregnancy up to a child's second birthday, is critical for the enhancement of growth, nutritional status, health and development of the future generation (Bhutta *et al.*, 2008; Dewey & Huffman, 2009; IFPRI, 2014a; Martorell *et al.*, 2010; Victora *et al.*, 2008).

Over the past few decades there have been important developments in the field of infant and young child nutrition (IYCN). These developments include evidence-based interventions, guidelines, policies and programmes (IFPRI, 2014a; United Nations Children's Fund [UNICEF], 2011) and commitments made by many national governments, international organisations and agencies (Gillespie *et al.*, 2013). Yet, progress towards achieving global IYCN targets<sup>1</sup> (World Health Organisation [WHO], 2015a) is slow and uneven (IFPRI, 2014a). Only slight improvement is evident for anemia in women of reproductive age, low birth weight, exclusive breastfeeding rates, and wasting and overweight in children under five years of age. Although more improvement has been seen in reducing stunting in children under five years of age, it is not sufficient to meet the global target (IFPRI, 2014a). South Africa (SA) is regarded as "on course" to meet the World Health Assembly (WHA) target (WHO, 2015a) of reducing childhood wasting. The country is, however, "off-course" in reducing the number of children under 5 who are stunted, anemia in women of reproductive age and not increasing overweight in children under the age of five (IFPRI, 2014b). The national reported exclusive breastfeeding (EBF) prevalence of ~8% (Mhlanga, 2008) also falls far short from the WHA target of at least 50% (WHO, 2015a).

A decade ago, Heaver pointed to governance challenges at the heart of slow progress, when he highlighted limited commitment of countries to address IYCN (Heaver, 2005). Ten years

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<sup>1</sup> In 2012, the World Health Assembly (WHA) adopted 6 nutrition targets for 2025, including: 1) 40% reduction in the number of children under five who are stunted; 2) 50% reduction of anemia in women of reproductive age (pregnant and non-pregnant); 3) 30% reduction in low birth weight; 4) no increase in childhood overweight; 5) increase the rate of exclusive breastfeeding in the first six months up to at least 50%; 6) reduce and maintain childhood wasting to less than 5 (World Health Organisation [WHO], 2015) ([http://www.who.int/nutrition/topics/nutrition\\_globaltargets2025/en/](http://www.who.int/nutrition/topics/nutrition_globaltargets2025/en/)).



on, the governance for IYCN, encompassing the complex interactions between public and private entities with the aim of reaching shared goals and actions to improve IYCN, (Nisbett *et al.*, 2014a) is receiving more attention on the global agenda (Mejia Acosta & Fanzo, 2012). More than fifty countries have pledged their commitment to addressing IYCN by joining one of the main drivers for its international momentum, the Scaling Up Nutrition (SUN) movement. More than one hundred entities (country partners, United Nations partners, academia and civil society organisations) have endorsed the movement's Framework for Action. The framework, aimed at policymakers and opinion leaders, outlines the importance of addressing child malnutrition and seeks to mobilise support for investment in a set of key interventions (Mokoro, 2015). With commitments publicly stated, the focus must now shift to creating the conditions i.e. the "enabling environment"<sup>2</sup> (Gillespie *et al.*, 2013) to realize those commitments, and to strengthen capacity to turn commitments into results, particularly at implementation level (Chopra *et al.*, 2009; Gillespie *et al.*, 2013; Haddad, 2012; IFPRI, 2014a; Mejia Acosta & Fanzo, 2012; Nisbett *et al.*, 2014a).

The well documented, evidence-based interventions to address poor IYCN (Bhutta *et al.*, 2008 & 2013) respond mainly to the immediate causes of malnutrition, as explained in the United Nations Children's Fund (UNICEF) Conceptual framework (UNICEF, 1990). These interventions primarily involve maternal - and health worker behaviours (Lele, 2014). A focus on the health sector alone is not enough, though. Addressing the underlying and basic causes of malnutrition requires action by multiple sectors<sup>3</sup> and collaboration among stakeholders across sectors (Gillespie *et al.*, 2013; Ruel, 2009). There is, however, no consensus on how best to do this (Garrett & Natalicchio, 2011; IFPRI, 2014a; Mejia Acosta & Fanzo, 2012). The literature from different disciplines also speaks differently about the required concepts, definitions and frameworks to study these processes (Garrett *et al.*, 2014; Harris & Drimie, 2012; Nisbett *et al.*, 2014a).

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<sup>2</sup> An enabling environment is defined as: "*political and policy processes that build and sustain momentum for the effective implementation of actions that reduce malnutrition*" (Gillespie *et al.*, 2013, p 553). The following elements are considered important in building an enabling environment: rigorous monitoring and evaluation, advocacy, co-ordination, accountability, leadership, capacity and resources (Gillespie *et al.*, 2013).

<sup>3</sup> A working definition of multi-sectoral work has been formulated as: "*Working more comprehensively to bring the policies, programs, resources and actions to bear at the same time and place on the same child*" (Garrett *et al.*, 2014, p 2).

There is a call to better define enabling environments for nutrition (Gillespie *et al.*, 2013) in order to build the commitment and capacity of multiple stakeholders to address IYCN, and on the use of multi-stakeholder processes (MSPs) and platforms at global and national levels to this effect (Harris & Drimie, 2012; Pelletier *et al.*, 2011a; Mokoro, 2014). The many different stakeholders referred to could include local, regional and central level stakeholders (community members, work places, business, media, state authorities or government departments in charge of policies), as well as food industry and international stakeholders (Heaver, 2005; Engesveen, 2005).

The literature is however largely silent on commitment and capacity for IYCN and the use and efficacy of MSPs at local levels. In fact, not much is known about how best to promote and support effective IYCN interventions by multiple stakeholders at decentralized levels (Garrett *et al.*, 2014; Gillespie *et al.*, 2013; Harris & Drimie, 2012). This challenge is particularly acute in countries, such as SA, with decentralised political and bureaucratic systems (Gillespie *et al.*, 2013; South Africa, 2015). Lessons learnt from international, national and sub-national multi-sectoral work for nutrition (Harris & Drimie, 2012; Garrett *et al.*, 2014; Mejia Acosta & Fanzo, 2012; Pelletier *et al.*, 2011a) are valuable in deliberating the nutrition challenges at local level. However, it cannot be accepted that political will to address nutrition issues happens spontaneously (Gillespie *et al.*, 2013), and the enforcement of international nutrition commitments happens automatically (Te Lintelo, 2014). Similarly it cannot be assumed that international and national multi-sectoral approaches can be adopted wholesale at implementation level.

In the nutrition context in SA, involvement by multiple stakeholders is often mentioned as being crucial for addressing malnutrition (Department of Health [DOH], 2013a; Du Plessis & Pereira, 2013; Swart *et al.*, 2008). However, systematic identification and analysis of and engagement with nutrition stakeholders are uncommon practices – as is research on these practices. In particular, little is known about stakeholders' commitment and capacity to address nutrition issues at district and sub-district levels in the country. There is also limited research and documentation on MSPs used to build and harness commitment and capacity (Department of Performance Monitoring and Evaluation [DPME], 2014; WHO, 2010a).

The lack of evidence of how to engage multiple stakeholders and to assess and advance their commitment and capacity to collectively plan and implement responses to address IYCN at implementation level, form the basis of the motivation for the research study.

## **1.2 Background to the research study**

In 2007, the newly appointed rector and vice-chancellor of Stellenbosch University (SU), the late Prof Russel H. Botman, articulated his vision of “pedagogy of hope” and a new positioning for the university. This vision was expressed in the “Overarching Strategic Plan” of the university and included a Food Security Initiative (FSI) funded by the SU Council, embedded in the “Hope Project” (Hope Project, 2010).

The Division of Human Nutrition, SU responded to a call to take part in the FSI and developed a protocol for a Community Based Nutrition Security Project (CNSP – baseline project; Ethics Committee Ref nr: N10/11/368). This project set out to investigate the community food and nutrition security situation in vulnerable communities (Avian Park and Zweletemba) in Worcester, Breede Valley sub-district, Cape Winelands District in the Western Cape Province, South Africa. The rationale for choosing this study site was two-fold. The administrative capital of the Cape Winelands District is situated in the semi-rural town Worcester (Figure 1.1), about a hundred kilometres from Cape Town, one of the largest towns in the Western Cape and the centre of the province’s interior region. This town and sub-district also form part of SU’s rural service and community engagement area. It is home to a recently established satellite campus of the university, referred to as the “Worcester Campus” where staff and students from the Faculty of Medicine and Health Sciences are involved in community engagement and internships. These characteristics made it an attractive site to study multi-sectoral arrangements for IYCN.



Figure 1.1: Map of the Western Cape Province of South Africa. An arrow indicates the town Worcester. Source: South African Couch Tours (n.d.)

The CNSP followed a phased approach, commencing with Phase 1 (year 1; 2011), a cross-sectional baseline nutrition assessment of a representative sample of the proposed study population. This was followed by the analysis of data (2012/2013) to determine the nutritional status of young children and their caregivers and factors contributing to the nutrition situation in the area. Findings of the baseline survey revealed poor IYCN, including poor feeding practices and childhood under- and overnutrition, with particular concern over high levels of stunting. This co-existed with maternal overweight and obesity. Dietary diversity of all mothers and primary caregivers as well as young children was low. (More detail is provided in Chapter 3 and in publications from the CNSP baseline study [Goosen *et al.*, 2014a & 2014b; Matthysen *et al.*, 2014]).

At the outset of Phase 1, the project team started to identify and interact with community leaders and residents, to build ownership of the project and to identify potential partners for the subsequent phases. Phase 2 was earmarked to include a process of stakeholder mapping

and engagement as well as intervention planning. Following on, Phase 3 would focus on the implementation, monitoring and evaluation of sustainable interventions. Phase 2 thus posed an opportunity to respond to the identified research issue, as summarised in section 1.1.

The researcher had a keen interest in pursuing this research opportunity, mainly due to her professional background, experience in community nutrition and curiosity about how people connect and engage. After completion of her BSc Dietetics degree she worked as a community dietitian in service of the Provincial Government of the Western Cape (1995-2002) and developed a keen interest in maternal, infant and young child nutrition (MIYCN) and health promotion. She later took up a lecturer's position at SU, Division of Human Nutrition (2003-present) and also developed a research interest in MIYCN and health promotion. She completed her Master of Nutrition degree (2007) and continued to work actively for the advancement of MIYCN on provincial and national government agendas as well as professional and media platforms. She applied for dual-registration as dietitian and nutritionist in 2012 and was granted this category of registration by the Professional Board for Dietetics and Nutrition of the Health Professions Council of SA (HPCSA), owing to her field of practice and experience in public health nutrition (PHN). Realising that some of the most pressing issues in PHN requires the application of trans-disciplinary and qualitative research methods she attended postgraduate courses<sup>4</sup> to build her research capacity in these fields (2011-present).

The project proposal began taking shape during discussions with the primary investigator (PI) of the CNSP and Director of Research and Information, Division of Human Nutrition, at the time, Prof Milla McLachlan, as well as with Prof Scott Drimie, Extraordinary Associate Professor, Division of Human Nutrition and the lead for a research and facilitation consultancy focussing on food security, food systems and livelihood issues. Both have extensive experience in facilitating stakeholder processes within the nutrition - and related fields and were subsequently appointed as study and co-study leaders to this project.

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<sup>4</sup> Introduction to Atlas.ti for qualitative data analysis workshop (23 May 2013 and 23 April 2014)  
Masters in Clinical Epidemiology - Qualitative Research Methodology module, Faculty of Medicine and Health Sciences, Stellenbosch University (2<sup>nd</sup> Semester 2012)  
Pre-Doctoral Course, Faculty of Medicine and Health Sciences, Stellenbosch University (20 Feb – 2 March 2012)  
Question of Doctorateness International course, Stellenbosch University (Sept 2011)  
TsamaHub Transdisciplinary Summer School - Sustainability Institute, Stellenbosch University (Jan 2011)

### **1.3 Research question, aim and objectives**

The research question, aim and objectives as well as a short description of the research project follow below.

#### **1.3.1 The research question**

Can a systematic approach to stakeholder identification, analysis and engagement support the development of commitment and capacity to address infant and young child nutrition in the Breede Valley sub-district?

#### **1.3.2 Aim**

To develop and test an MSP using a stakeholder mapping tool (Net-Map) and other participatory tools, to identify, analyse and engage multiple stakeholders to explore whether such an approach can support the development of commitment and capacity to address IYCN in the Breede Valley sub-district.

#### **1.3.3 Objectives**

1. To systematically identify and differentiate between stakeholders
2. To explore the perspectives, commitment and capacity of key stakeholders in relation to IYCN
3. To define relationships among key stakeholders as well as their priorities and powers
4. To critically reflect on the research process and explore local conditions conducive for action (an enabling environment) concerning IYCN
5. To develop a conceptual framework to address IYCN governance at implementation level by initiating, exploring and documenting initial stages of a multi-stakeholder process

The research described in this thesis set out to develop and test initial stages of an MSP using a stakeholder mapping tool and other participatory methods, to identify, analyse and engage multiple stakeholders who could impact IYCN at implementation level in the Breede Valley sub-district of the Cape Winelands district, Western Cape Province, SA. Drawing on methodology from business management and policy studies, the research was designed to

explore whether such a systematic stakeholder process can support the development of commitment and capacity to address IYCN at implementation level.

The theory of change for this stakeholder engagement process was that, if multiple stakeholders engage around a local IYCN challenge through a problem-solving approach that includes recognising their power relations and understanding the networks they belong to, they will begin to see themselves as agents of change in IYCN. Their commitment to the cause could support the advancing and unlocking of capacity to address IYCN in a more integrated manner. If government, private sector, civil society leaders and community members understand the power relations and networks of different stakeholders as well as their own, they could hold themselves and other stakeholders accountable to act on their commitments, and draw and build on existing capacity to strengthen an enabling environment for IYCN governance.

A study design appropriate to explore the identified research question, including commitment and capacity issues of broader stakeholder groups at a local level, requires a qualitative approach (Heaver, 2005). According to Heaver (2005), “narrow and deep” approaches, e.g. structured interviews and focus groups are more likely to be useful in such research than “broad and shallow” surveys of knowledge, attitudes and practices, even if they do not yield statistically valid results (Heaver, 2005). In an MSP, a structured process is used to facilitate participation on a specific issue with the aim to ensure participatory equity, accountability and transparency, and to investigate and develop partnerships and networks amongst different stakeholders (Hemmati, 2002). The purpose of a stakeholder analysis is to set the stage for such engagement; it is thus a necessary first step in this process (Department for International Development [DFID], 2002; Reed *et al.*, 2009). Following the stakeholder analysis, other participatory tools could be utilised to increase support or shape agreement for improvement of a specific issue. The information generated could in turn be used to develop and implement strategic communication, advocacy, and negotiation plans or to hold consensus-building workshops (Schmeer, 1999). In this way, setting in motion an MSP could aid the development of enabling environments for intervention planning and action (Pelletier *et al.*, 2011a).

The research explored the perspectives, commitment and capacity of key stakeholders in relation to IYCN at implementation level; assessed how these stakeholders relate to one another; determined which avenues and platforms they identify as catalysts for change; and how they see an enabling environment at implementation level for improving nutrition during the first 1000 days of life. Finally, a conceptual framework to address IYCN governance at implementation level is proposed based on the research findings.

#### 1.4 Conceptual framework for addressing the research question

The conceptual framework shown in Figure 1.2, illustrates how the proposed research process answers the research question and responds to the research objectives.

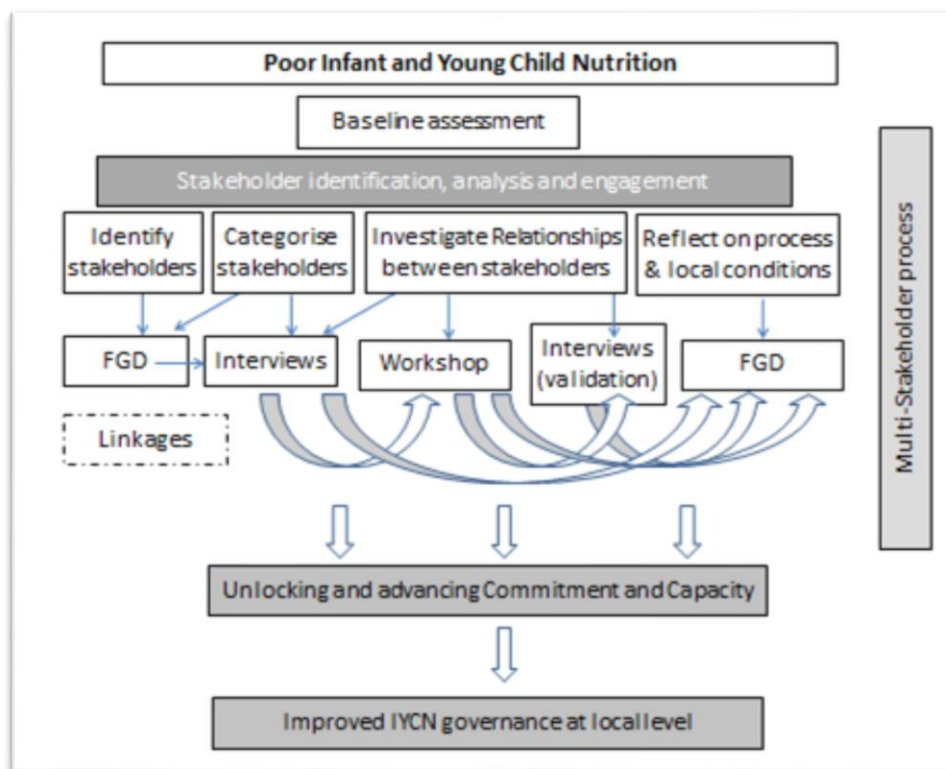


Figure 1.2 Conceptual framework on how the proposed research process answers the research question.

(C&C = commitment and capacity; FGD = Focus Group Discussion)



## 1.5 Outline of dissertation

This dissertation is presented in eight chapters commencing with this general introduction chapter (Chapter 1). A literature overview in Chapter 2 evaluates the relevant literature in order to understand and appraise the current thinking around multi-sectoral work and MSPs in the nutrition context, and how these apply to commitment and capacity building for IYCN. It aims to identify evidence gaps for multi-stakeholder work at implementation level to address IYCN governance.

Chapter 3 constitutes a submitted manuscript accepted for publication by the South African Journal of Child Health, entitled: *“Selected facets of nutrition during the first 1000 days of life in vulnerable South African communities”*. The data and results contained in this paper were used to set the scene for engaging with key stakeholders around the issue of poor IYCN at sub-district (implementation) level.

Following the literature overview (Chapter 2) and background paper (Chapter 3), Chapter 4 describes the Methodology followed in the research study.

Chapters 5, 6 and 7 each focus on the results of a particular phase of the multi-stakeholder research process. The titles of these 3 chapters are as follows:

- Chapter 5: Systematic stakeholder identification and initial engagement to start exploring commitment and capacity to address IYCN in the Breede Valley sub-district
- Chapter 6: Mapping the IYCN stakeholder landscape in the Breede Valley sub-district
- Chapter 7: What does an “enabling environment” look like for IYCN at implementation level? Reflections from a stakeholder process in the Breede Valley sub-district

Chapter 8 contains a general discussion on the full scope of the research, drawing on discussions and main conclusion in the results chapters, highlights limitations of the research and makes recommendations for further research and practice.

## **Chapter 2: Literature overview**

## **2.1 Introduction**

This literature overview underscores the importance of nutrition within the first 1000 days of life and reviews the evidence on interventions and approaches to address the immediate, underlying and basic causes of maternal and child malnutrition. The overview draws out the complexity of nutrition issues and highlights the need for multi-stakeholder and multi-sectoral approaches to address the underlying and basic causes of malnutrition. Then, taking a step back in history, past perspectives on multi-sectoral work and MSPs are defined in the health and nutrition contexts with the intention of learning from the past and thinking about the future of various sectors and stakeholders working together for nutrition. Barriers to working multi-sectorally as well as lessons learnt from global and national MSPs are contextualised to strengthen the case for thinking critically about these processes and their implications for implementation level. Collectively, the overview explores the literature for research and conceptual gaps on the potential of MSPs for building of commitment and capacity to address IYCN at implementation level.

To provide context to the setting of the research, the SA maternal, infant and young child nutrition situation is sketched, an outline of the healthcare system in the country is provided, with a focus on primary health care (PHC) in the district health system; and commitment and capacity for IYCN at national and provincial levels are deliberated. Lastly, a case is made for research that explores the potential contribution of an MSP to support the development of commitment and capacity to address IYCN at local level.

## **2.2 Maternal, infant and young child nutrition in the first 1000 days of life**

A growing body of evidence is drawing heightened attention to nutrition, with a specific focus on the importance of nutrition during the first 1000 days of life, i.e. from pregnancy up to a child's second birthday (Bhutta *et al.* 2008; Dewey & Huffman 2009; IFRPI, 2014a; Victora *et al.* 2008). This heightened level of attention has been facilitated by an increase in understanding of the biology of and consequences of malnutrition; evidence of the effectiveness of nutrition interventions; increased ownership of nutrition as a cross-cutting development issue of importance stretching over several disciplines; increased access to information; and a more aware and connected world (Black *et al.*, 2008; 2013; IFPRI, 2014a;

United Nations Standing Committee on Nutrition [UNSCN], 2014). Key pledges, documents, organisations and movements; including the United Nations (UN) Millennium Development Goals (MDGs); Lancet Series of 2008 and 2013; and the SUN movement, to name a few powerful entities, have contributed vastly to advocate for IYCN and the first 1000 days concept (Black *et al.*, 2008; 2013; IFPRI, 2014a; Pelletier *et al.*, 2013a). Achieving good nutrition and healthy growth during this delineated time-period in the lifecycle has been shown to reap lasting benefits throughout life, including improved cognitive development; better schooling attainment; increased earning potential; reduced risk for developing various non-communicable diseases (NCDs) and reducing the human and economic burden of communicable diseases, such as tuberculosis, malaria and the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV and AIDS) (Bhutta *et al.*, 2008; Dewey & Huffman 2009; Fall *et al.*, 2011; Martorell *et al.*, 2010; Victora *et al.*, 2008). The challenge is more complex in view of the findings of the Lancet Series on Maternal and Child Nutrition (2013) (Black *et al.*, 2013). This series states that maternal and child malnutrition is persistent and encompasses both undernutrition and a growing problem of overweight and obesity in low- and middle-income countries. Concerted efforts should therefore be made to curb malnutrition in women of childbearing age as well as newborns and young children (Black *et al.*, 2013).

### **2.3 Causes of child malnutrition and evidence-based interventions to address it**

The UNICEF conceptual framework (Figure 1) describes the causes of child malnutrition as basic, underlying and immediate factors (UNICEF, 1990). It is clear from this framework that addressing general dispossession and disparity through job creation and socio-economic development are long-term solutions that would result in extensive reductions in undernutrition. These efforts should be a global priority, but major strides against these key problems can also be achieved through programmatic health and nutrition interventions (Bhutta *et al.*, 2008).

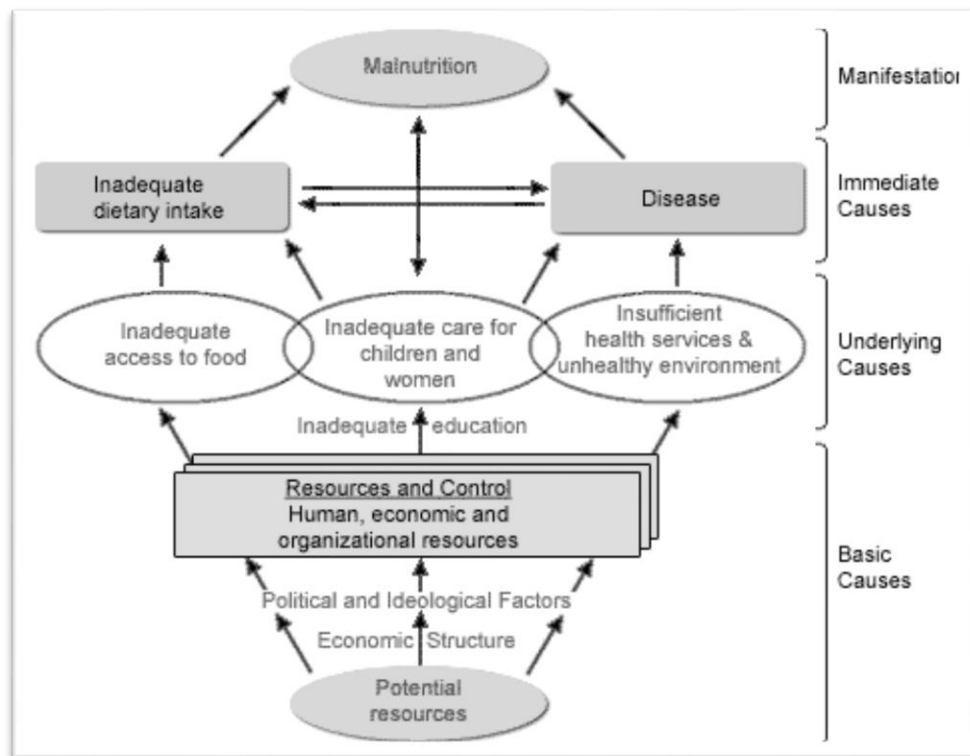


Figure 2.1: The UNICEF conceptual framework on malnutrition (UNICEF, 1990). Source: Adapted from UNICEF (1990).

The 2013 Lancet Series used an adapted framework (Figure 2.2) as guide to show “*the means to optimum foetal and child growth and development*”, rather than the causes or determinants of undernutrition depicted in the UNICEF conceptual framework. This adapted framework illustrates how *nutrition specific*<sup>5</sup> interventions and programmes support the dietary, behavioural, and health determinants of optimum foetal and child nutrition, growth, and development (Ruel *et al.*, 2013). These are affected by *nutrition sensitive*<sup>6</sup> programmes and approaches, including outcomes of food security, feeding and caregiving resources, as well as access to health care and environmental circumstances (Ruel *et al.*, 2013). These conditions are in turn supported or constrained by the social, economic, political and environmental context both at a national and global level; which should be maintained by an

<sup>5</sup> Nutrition specific include adolescent, preconception, and maternal health and nutrition; maternal dietary or micronutrient supplementation; promotion of optimum breastfeeding; complementary feeding and responsive feeding practices and stimulation; dietary supplementation; diversification and micronutrient supplementation or fortification for children; treatment of severe acute malnutrition; disease prevention and management; nutrition in emergencies (Ruel *et al.*, 2013).

<sup>6</sup> Nutrition sensitive interventions (indirect nutrition interventions) e.g. agriculture and food security; social safety nets; early child development; maternal mental health; women’s empowerment; child protection; schooling; water, sanitation, and hygiene; health and family planning services) (Ruel *et al.*, 2013).

enabling environment that shape and sustain momentum for the effective implementation of actions that reduce malnutrition (Black *et al.*, 2013).

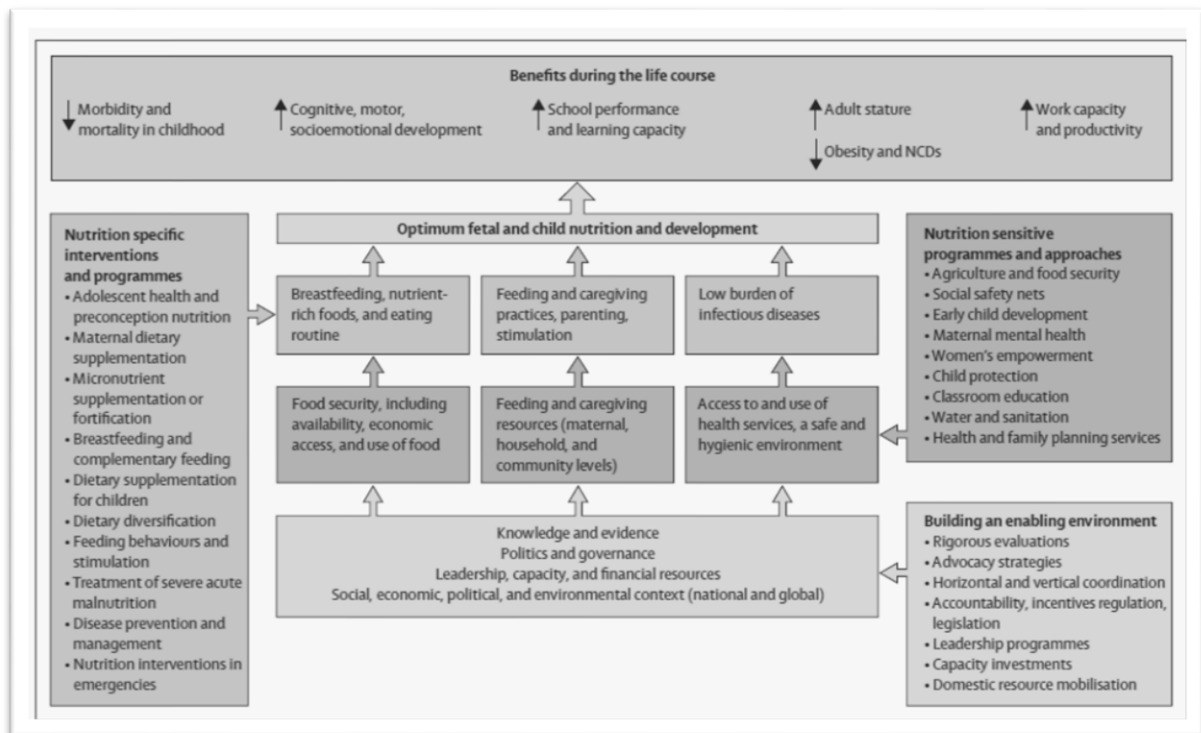


Figure 2.2: Framework for actions to achieve optimum foetal and child nutrition and development. Source: Black *et al.* (2013).

## 2.4 Need for multi-stakeholder and multi-sectoral approaches to address child malnutrition

It is now well recognized that *nutrition specific* interventions that address the immediate causes of malnutrition in children, delivered on platforms focussing on women of reproductive age, during pregnancy and on children in the first 2 years of life, must be advocated, implemented and strengthened without further delay (Black *et al.*, 2008 & 2013). It is, however, acknowledged in the Lancet series of 2008, and reiterated in the Lancet series of 2013, that IYCN is a complex issue and that addressing the underlying and basic causes of malnutrition requires multiple stakeholders and - sectors to be involved through participatory approaches (Gillespie *et al.*, 2013; Mejia Acosta & Fanzo, 2012). This complex nature of malnutrition may explain why it has not been effectively addressed, even though many of the solutions are now known (Harris & Drimie, 2012). The challenge is for the many

stakeholders to work together to create governance systems that deliver interventions in an economical and sustainable way (Mejia Acosta & Fanzo, 2012).

“Stakeholders” is a term that is used often, but time and again, as encountered in many disciplines, it is unclear who exactly are implicated in this collective and often elusive grouping (Reed *et al.*, 2009). Stakeholders can be defined as actors who have a vested interest in the policy or programme that is being promoted and are considered patrons in the process (DFID, 2002; Schmeer, 1999). Checkland (1981, cited in Reed *et al.*, 2009 p 1934) described stakeholders’ ownership and responsibility of a given issue in suggesting that those who own a problem should be co-owners of the process to solve it. It is important to recognise that stakeholders are not only local people, organisations and formal groups and that they can change over time (Renard, 2004).

In the context of IYCN there are many stakeholders at different levels in a mother’s environment who can either support or hinder her abilities to optimally feed her children (Kent, 2007). Kent (2007) suggested a set of nested rings of responsibilities that captures this statement. Engesveen (2005) depicted these responsible parties in a pictorial version of Kent’s diagram of rings (Figure 2.3). Those implicated could include the mother herself, the family, community, hospitals, work places, employers, business, industry, media, health services, and the state authority or local government in charge of policies (Engesveen, 2005).

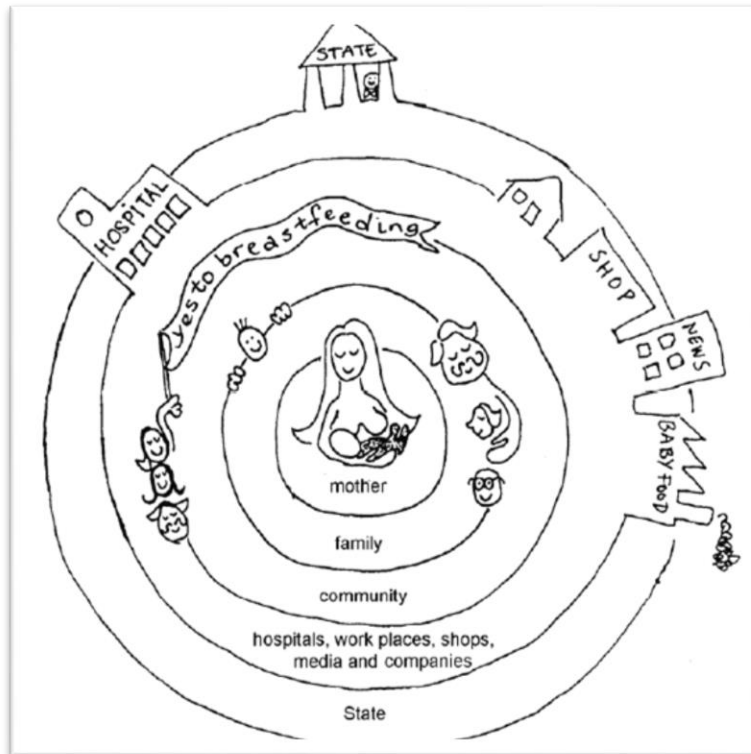


Figure 2.3: Role analysis of responsible parties for infant and young child nutrition. Source: Engesveen (2005) Adapted from Kent's rings of responsibilities (Kent, 2007). (Image used with permission from Kaya Engesveen)

A more comprehensive list of potential stakeholders in nutrition programmes is depicted in Table 2.1 (Heaver, 2005).



Table 2.1: Potential stakeholders in nutrition programmes

Stakeholder group	Members
Individual clients	Mothers, children
Local-level influencers	Fathers, in-laws, politicians, elders, religious leaders, schoolteachers
Local-level groups	Mothers' groups, peoples' organizations, NGOs, occupational groups, caste or class groups, groups of people living near each other
Local-level workers	Health extension workers, social welfare extension workers, agricultural extension workers, ration shop employees
Local-level planners	Planning officers, statisticians, doctors, other sectoral planners
Regional planners	Planning officers, sectoral planners Central planners, bureaucrats, Planning ministry, finance ministry, health regulators, technical experts ministry, social welfare ministry, agriculture ministry, food ministry, food regulation ministry, law ministry, water and sanitation ministry, interior and local government ministry, nutrition institutes, policy analysis institutes, data collection and evaluation agencies
Central-level influencers	Prime minister, minister of finance, minister of planning, minister of health, minister of agriculture, minister of social welfare, minister of water and sanitation, minister of interior, local government, parliament, congress, parliamentary and congressional committees, individual politicians with special interests, NGOs, newspapers, television, radio, Internet, celebrities
Food industry	Manufacturers, processors, advertisers
International	Development banks, bilateral development assistance agencies, United Nations technical assistance agencies, universities and research institutes, foundations, international NGOs, national legislatures, developing-country ministries of agriculture, food, and trade, World Trade Organization and other trade organizations, farmers' unions

Source: Heaver (2005)

Stakeholders can usually be grouped into the following categories: i) international, ii) public, iii) national political, iv) commercial/private, v) non-governmental organization (NGO) / civil society, vi) labour, and vii) users/consumers" (Schmeer, 1999). It is recognised that there are a range of ways for stakeholders from these categories to work in an integrated manner. The specific definition and level of such work will depend on the objectives of the work and the partners involved (Garrett *et al.*, 2014). Working together could include maintaining a line function, networking, cooperating, collaborating or integrating functions (Garrett *et al.*, 2014) as depicted in Figure 2.4.



Figure 2.4: A continuum for multi-sectoral collaboration. Source: Garrett *et al.* (2014).

The objectives of multi-sectoral teamwork are to resolve real world and complex problems, to provide different perspectives on problems, to create comprehensive research questions, to develop consensus on guidelines, and to provide comprehensive services (Choi & Pak, 2006; Garrett *et al.*, 2014). The priority requirement for collective efforts is that actions across sectors are aligned and harmonized and that each stakeholder fulfils his or her role to reach a common goal (Garrett *et al.*, 2014). An operational definition for multi-sectoral work for IYCN has been formulated as follows: “*Working more comprehensively to bring the policies, programs, resources and actions to bear at the same time and place on the same child*” (Garrett *et al.*, 2014).

The various terms used to describe working together have been explored at length in the health and social sectors, where a disciplinary focus (a study in one academic field or profession e.g. nursing, dietetics, psychology) is the point of departure (Choi & Pak, 2006). Moreover, within the medical professions, in SA and other countries, a certain degree of blurring of disciplinary lines is acceptable or allowed, but the scopes of professional practice are protected and constrained as defined by a statutory body e.g. the HPCSA, in order to

serve the professions and protect the public against misconduct of registered practitioners (Health Professions Council of SA, 2013).

Working within, between, alongside and across disciplines has given rise to a set of terms which are often used ambiguously and interchangeably, causing confusion about the specific nature of a particular collaborative effort (Choi & Pak, 2006; Harris & Drimie, 2012). A summary of the terminology is provided in Table 2.2, acknowledging that some sources define it differently.

Table 2.2 Description of different forms of disciplinary work

Disciplinaryity	Description
Intra-disciplinary	Working within a single discipline
Multidisciplinary	People from different disciplines working together, each drawing on their disciplinary knowledge
Interdisciplinary*	Analyses, synthesizes and harmonizes knowledge and methods between disciplines into a coordinated and coherent whole
Trans-disciplinary	Integrates the natural, social and health sciences in a humanities context beyond the disciplinary perspectives

Sources: Choi & Pak (2006) and Harris & Drimie (2012)

\*Interdisciplinary work is sometimes referred to in literature as “interprofessional” work. There is, however, an understanding that a *profession* is a vocation requiring specialised knowledge and skills. A *discipline* has an academic field of study, with a particular content, methodology, or skill set. Multiple disciplines are generally found within a given healthcare profession, for example, the profession of nursing has multiple disciplines such as midwifery, critical care or school nursing (Choi & Pak, 2006).

Bringing stakeholders together in an MSP entails a structured procedure used to facilitate participation of various stakeholders from different sectors on a specific issue. The aim of an MSP is to ensure participatory equity, accountability and transparency, and to develop partnerships and networks amongst different stakeholders (Hemmati, 2002).

To prevent getting lost in semantics, the aim of this literature overview is to focus on important stakeholders from various sectors who can work together in various ways to impact IYCN at different levels of influence. To ensure consistent use of terminology, the terms “multi-sectoral” and “multi-stakeholder” will be used drawing on the working definition of sectoral work (Garrett *et al.*, 2014) and referring to multiple stakeholders from different sectors working together for nutrition and/or IYCN in numerous ways, including through structured MSPs.

In moving on, it is acknowledged that multi-stakeholder and multi-sectoral action is important and increasingly recommended in addressing the complexity of malnutrition (Gillespie *et al.*, 2013; IFPRI, 2014a; United Nations Development Programme [UNDP], 2006; International Council for Sciences [ICSU], 2015) but to date there is no consensus on how multi-sectoral actions are best implemented or institutionalized (Garrett & Natalachio, 2011; Harris & Drimie, 2012; Nisbett *et al.*, 2014a). In order to substantiate this statement, it could be helpful to take a step back in history to review past approaches for planning in health and nutrition and in doing so, understand the context from which we should be taking forward the discussion on multi-stakeholder and multi-sectoral work for nutrition, and specifically IYCN, in 2015 and beyond.

## **2.5 History of planning approaches and commitments made in the health and nutrition fields**

A key lesson from history over the past 65 years is that international health agendas have fluctuated between a focus on technology-based medical care and public health interventions, with health being understood as a social phenomenon requiring more complex forms of multi-sectoral policy action (WHO, 2009a). One of the reasons for the pendulum swaying between these approaches can most likely be explained in the difficulty of different sectors working together in a sustainable manner (Garrett & Natalicchio, 2011).

The impact of social and political conditions on health was already clearly acknowledged in the World Health Organisation's (WHO) Constitution of 1948 and the need for collaboration with sectors such as agriculture, education, housing and social welfare was recognised (WHO, 2010b). However, the efforts of the time to address health and malnutrition were often characterised by single sector approaches and interventions, for example, attempts of the health sector or the agriculture sectors to improve population health. These interventions often reflected the research discoveries of the time (Jonsson, 2009) and the disciplinary expertise of the practitioners more than the real needs of communities (Garrett & Natalicchio, 2011). During the 1950's and 1960's, WHO and other global health actors emphasized technology-driven vertical campaigns targeting specific diseases with little regard for the social contexts (WHO, 2010b). Nutrition followed the same pattern with

vitamin deficiencies being the primary concern in the 1950's and protein deficiencies the focus from the early 1950's to 1970's (Garrett & Natalicchio, 2011).

By the 1970's, a shift away from the narrowly focussed technical interventions occurred and the notion of multi-sectoral work emerged as a key planning tool, including for nutrition, but it was poorly connected to development policy and practice (Garrett & Natalicchio, 2011). This prompted Berg (1973, quoted by Nisbett *et al.*, 2014 p 423) to state that nutrition is perceived as: *"everybody's business but nobody's main responsibility"*. Criticism for the multi-sectoral nutrition planning paradigm included the need for more data than what most developing countries could supply, the complexity inherent in this approach as well as the failure to mobilise the anticipated political action for nutrition at the time (Jonsson, 2009).

In 1978 the WHO held a conference in the city of Alma Ata, to develop a framework within which the health of communities and nations could be improved. This PHC approach shifted the focus back to communities and a strategy to achieve *"Health for all by the Year 2000"* was adopted. Two key areas for attention highlighted at this meeting was the need for re-orientation of health services away from high-technological, clinically focused healthcare towards PHC; redefining health services to include agriculture, food, industry, education, housing and communication; as well as the process of delivery of services, including principles of equity, empowerment and respect, participation and multi-sectoral activity with an emphasis on PHC (WHO, 1978).

Many governments embraced the principle of multi-sectoral action on the social determinants of health, but the global market liberalism and free trade (neoliberal) economic models that gained global dominance during the 1980s created obstacles to policy action (WHO, 2010b). These models commanded market-oriented transformation that accentuated efficiency over equity, often jeopardising disadvantage groups' access to health care services. Furthermore, international financial institutions imposed conditional loan or subsidy programmes on developing countries' macro-economic policies which lead to sharp reductions in government's social sector spending, limiting policy-makers' ability to address the social disparities impacting on peoples' health (WHO, 2010b).

National nutrition policy development and nutrition surveillance became popular during the 80's, but was skewed towards targeted assistance funds for nutrition by donor involvement. The importance of these nutrition policy and surveillance approaches started to fade due to low political commitment for nutrition as well as the realisation that information on the nutrition situation without appropriate action would not solve the nutrition problems of developing countries (Jonsson, 2009). Many of the principles of PHC were now reportedly forgotten and most work in health and nutrition reverted back to top-down and selective approaches.

During the latter part of the 1980's the principles of preventive healthcare and health promotion regained recognition as possibilities to reach "*Health for all by the Year 2000*". At the first conference on health promotion in 1986 Ottawa in Canada, this principle was defined as "*the process of enabling people to increase control over, and to improve, their health*" (WHO, 2009a, p 1). Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (WHO, 2009a). Five pillars guiding health promotion practice were also formulated and included: building healthy public policies; creating supportive environments; strengthening community action; developing personal skills and re-orientation of health services (WHO, 2009a). Community-based nutrition programming started growing as an approach to address nutrition problems in developing countries, spurred mainly by the discoveries made and lessons learnt in the Iringa project, a joint WHO/UNICEF supported project in Tanzania. The Triple A cycle of assessment, analysis and action was shaped as an innovation methodology for the identification of appropriate interventions within a country's given context. Central to this methodology a framework was proposed, "*Causes of malnutrition and death*" and later became known as the "*UNICEF conceptual framework on malnutrition*" (Figure 2.1) (UNICEF, 1990), as mentioned in section 2.2. This framework has become the favoured one for understanding the determinants of and interventions for malnutrition (Pelletier, 2002).

Towards the end of the 1990s, many developing countries had taken steps to liberalize their economies and integrate them into the world economy. Against that backdrop, international attention was focused on the benefits of globalization and the growing interdependence in the world economy (Jackson, 2008). In 1999, a WHO review of the Decade revealed that

development progress had been mixed and that economic growth, by itself, was not a sufficient factor of development. The focus had shifted to a number of institutional preconditions for development, including good governance, transparency and accountability, decentralization and participation, and social security (WHO, 2010b).

During the late 1990's and early 2000's increasing evidence was pointing to the failure of existing health policies to reduce inequities and there was a drive for new, equity focussed approaches. At the thirtieth anniversary of Alma Ata and the sixtieth of WHO's Constitution, the Commission on the Social Determinants of Health delivered a report and revived the values of "Health for All" (WHO, 2010b). Included in this report was a comprehensive framework for action on the social determinants of health (Figure 2.5). This framework highlights how social, economic and political processes bring about a set of socioeconomic positions. These positions stratify populations into, among other: income; education; occupation; gender; and race/ethnicity groupings which in turn give rise to specific determinants of health status. These intermediary determinants are reflective of people's societal standing and based on this, individuals experience differences in exposure and vulnerability to health-compromising conditions (WHO, 2010b).

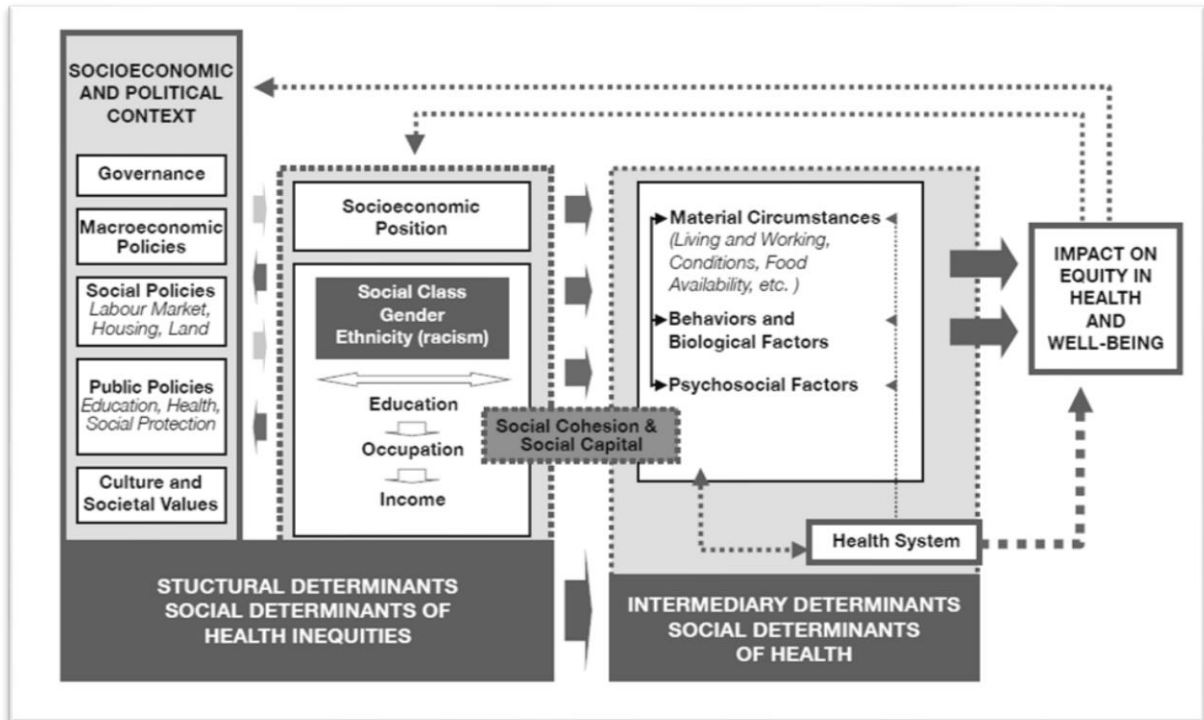


Figure 2.5: A conceptual framework of action on the social determinants of health. Source: WHO (2010b).

In September 2000 world leaders came together at the United Nations (UN) Headquarters in New York to adopt the UN Millennium Declaration. At this summit, with the largest ever gathering of world leaders, 189 committed their nations to a new global partnership to reduce extreme poverty and set out a series of time-bound targets with a deadline of 2015. These eight goals, related to the world’s main development challenges, became known as the Millennium Development Goals (MDGs). It synthesized in a single package many of the most important commitments made separately at the international conferences and summits of the 1990s (Jackson, 2008) (Table 2.3). It included an indicator specifically devoted to addressing child malnutrition (prevalence of underweight children under five) in MDG 1.



Table 2.3: The Millennium Development Goals

Goal 1	Eradicate extreme poverty
Goal 2	Achieve universal primary education
Goal 3	Promote gender equality and empower women
Goal 4	Reduce child mortality
Goal 5	Improve maternal health
Goal 6	Combat HIV/AIDS, malaria and other diseases
Goal 7	Ensure environmental sustainability
Goal 8	Develop global partnerships for development

Source: United Nations (2010).

Despite global progress on the public health MDGs, many low- and middle-income countries are not on track to reach these targets (Fehling *et al.*, 2013; Stuckler *et al.*, 2010). An evaluation in 2005 of the potential drivers of inequality in progress in achieving the MDGs calculated how far 227 countries were from their MDG targets for HIV, tuberculosis, and infant and child mortality using information collected by the UN. Unequal progress in health MDGs in low-income countries appears significantly related to burdens of HIV and NCDs at population level, after correcting for potentially confounding socio-economic, disease burden, political, and health system variables (Stuckler *et al.*, 2010). These findings suggest that programmes designed to achieve health MDGs must consider all the diseases and factors that can trap households in cycles of illness and poverty and should be considered in the deliberations of the post 2015-development agenda (Stuckler *et al.*, 2010).

Midway through the MDGs timespan, the UN's midterm report stated that, although there was slow progress on specifically the health-related MDGs: *"The single most important success to date has been the unprecedented breadth and depth of the commitment to the MDGs – a global collective effort that is unsurpassed in 50 years of development experience"* (Jackson, 2008).

The economic crisis with resultant food price spikes of 2007-8 was a red flag reminder that the food system is essentially exposed to external predicaments and that these kinds of shocks have lingering effects on the poorest within populations (Haddad, 2013). During the same time as this world recession, two series of Lancet papers on Maternal and Child Nutrition (2008 & 2013) put the spotlight firmly on the importance of nutrition within the first 1000 days of life and managed to raise substantial commitment for nutrition, focussed on this vulnerable period in the lifecycle. Evidence for the effectiveness of *nutrition specific*

and *nutrition sensitive* interventions to address maternal and child malnutrition, as discussed in section 2.3, continues to accumulate (IFPRI, 2014a).

The debate on the new set of Sustainable Development Goals (SDGs) for 2015 and beyond (Table 2.4) is well under way. Critiques of the MDGs and perspectives on the SDGs suggest the latter is a major improvement on the former, when considered from a science perspective (Fehling *et al.*, 2013; ICSU, 2015). The SDGs address some of the systemic barriers to sustainable development (e.g. disparity, untenable consumption patterns, weak institutional capacity, and ecological decline) neglected by the MDGs. It also covers the three dimensions of sustainable development (social, economic and environmental) more comprehensively, and highlights issues of governance. The SDG framework, however, lacks a “theory of change” leaving a vacuum in projecting how specific goals would lead to broader outcomes of social change; or the collective “ultimate end” to the SDGs (ICSU, 2015).

Table 2.4: The Sustainable Development Goals

Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5	Achieve gender equality and empower all women and girls
Goal 6	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10	Reduce inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development

Source: United Nations Sustainable Development - Open Working Group (2015)

As far as nutrition and the SDGs are concerned, Haddad posed a relevant question: “*How should the nutrition community be positioning nutrition within the post-2015 MDG debate?*”

(Haddad, 2013). He argues that the MDGs could not have done much more for nutrition due to the fragmented nature of the international leadership and governance of nutrition before 2008, as well as the relatively closed process within which the MDGs were developed. However, there is opportunity for positioning nutrition strongly in the post-2015 process since the nutrition community is more unified in certain respects compared to the time prior to the MDGs (Haddad, 2013). The Global Nutrition Report (IFPRI, 2014a) warns in this regard that the nutrition community must not take it for granted that nutrition will be properly featured within the SDG accountability framework. The SDGs are not legally binding and will require convincing; inspiring; and exciting advocacy to appropriately position nutrition. Furthermore, nutrition goals will need to be clear and simple with strong guidance for its achievement (IFPRI, 2014a).

In the current framework, Goal 2 (*End hunger, achieve food security and improved nutrition and promote sustainable agriculture*) places emphasis on nutrition and the targets include a focus on the first 1000 days of life. Achieving this goal will however be difficult, since it combines biological processes with social and economic processes. Also, most targets concern the promotion of sustainable agriculture; which creates one-sidedness within this goal. Furthermore, while nutrition features prominently in Goal 2, nutrition is interlaced with all 17 currently proposed goals (ICSU, 2015; UNSCN, 2014). The challenge for the nutrition community will be to find ways to lift the profile of nutrition and state its prominence as an important development entity in its own right, but also to portray it as an interwoven element that works in tandem to achieve the other SDGs. In essence it means that nutrition must be seen and understood as both an input to and an outcome of sustainable development (ICSU, 2015).

One thing is certain, multi-sectoral approaches involving multiple stakeholders will stand central among the components required for appropriate and focussed action for nutrition in the development agenda in years to come. The lingering dilemma is that multi-sectoral programme planning and coordination is arguably the most effective way to tackle malnutrition (Heaver, 2005), but the common view is that it is the most difficult route to take. This view of multi-sectoral work is hampering integrated approaches for nutrition action (Garrett & Natalicchio, 2011). Nevertheless, it seems that interest in multi-sectoral

approaches and such collaboration are moving forward, despite many questions remaining around how to initiate multi-sectoral initiatives, the dynamics and mechanisms about the process, sustainability issues and the environment that affects collaboration (Garrett & Natalicchio, 2011; Gillespie *et al.*, 2013). To this effect, multi-stakeholder platforms and forums, strongly promoted by international actors including donors, governments, and non-governmental organizations (NGOs), play an increasing role in efforts to address complex issues such as public health (Schiffer & Waale, 2008) and nutrition at global and national levels (IFPRI, 2014a).

The question of how to engage multiple stakeholders in addressing the complex issues of nutrition across sectors at every level, especially at the largely neglected implementation level, and to prevent the repeat in history of a partial focus on multi-stakeholder engagement in nutrition, seems to be nutrition's persistent predicament. It could be helpful to turn to the literature on MSPs, the barriers experienced in such work and the lessons learnt from global and national levels in further building the case for taking MSPs forward to implementation level.

## **2.6 Multi-stakeholder processes for nutrition at global and national levels**

Despite an abundance of literature that speaks about the need and value of involving multiple stakeholders for addressing nutrition issues and engaging them through multi-stakeholder processes (Garrett & Natalicchio, 2011; Gillespie *et al.*, 2013; IFPRI, 2014a; Makoro, 2015; Nisbett *et al.*, 2014a), there is little evidence on the impact of MSPs on development issues, including nutrition and more specifically, IYCN (IFPRI; Mokoro, 2015).

An international initiative that gives impetus to multi-sectoral action plan development for child nutrition, guided by MSPs at global programme - and national and sub-national policy levels, can be found in the SUN movement (SUN, 2014). The SUN movement was jointly created by individuals who were concerned about the persistent rates of malnutrition in many countries, perpetuated by malnutrition during the first 1000 days of life. They represented different governments, agencies and groups and launched the movement in September 2010. The focus is on strengthening political commitments and accountability for those commitments by empowering people to work together through multi-stakeholder

platforms and increased investments to reduce malnutrition. SUN is not a programme of nutrition interventions, but the movement's theory of change is that bringing multiple sectors and multiple stakeholders together will eventually lead to collaborative action for improved nutrition (SUN, 2014).

The SUN Movement Strategy 2012-2015 defines four processes which countries have used to conduct self-assessments of their annual progress: 1) bringing people into a shared space for action, 2) ensuring a coherent policy and legal framework, 3) aligning actions around a common results framework, and 4) tracking finances and mobilizing resources.

SUN-countries report noteworthy progress in bringing people into a shared space for action (process 1 - which refers to multi-stakeholder platforms more than the processes involved) and developing coherent policy and legislation frameworks (process 2). However, they have made relatively little progress in aligning actions around common results (process 3) and in tracking investments for nutrition (process 4). The self-assessment outcomes indicate that there has been remarkable and continuing hard work to coordinate multiple stakeholders, develop policies and legislation, and mobilize resources for nutrition. However, these efforts still have to be fully converted into scaled-up, focussed, consolidated and monitored actions and investments (IFPRI, 2014a) with effect at implementation level.

A recent independent evaluation of SUN echoed these findings in as far as the movement has been very successful in advocacy and mobilisation on nutrition, and specifically childhood undernutrition, at global and in some countries. Weaknesses in design (e.g. costed plans and results frameworks not in place; monitoring and evaluation not rigorous enough) and implementation (e.g. slow progress in developing practical methodologies for financial tracking; lagging in putting support structures in place) are likely reasons for limited impact on nutritional status to date. In countries with decentralised systems and with key nutrition interventions funded and/or implemented at the sub-national and district level, the challenge is described as even more profound (Mokoro, 2015). The assumption in the movement's theory of change, that stakeholders are ready and equipped to work in a collaborative way to prioritise nutrition, could also be seen as a weakness (Mokoro, 2015).

The Global Nutrition Report (IFPRI, 2014a) highlights some examples of countries which have made significant strides against childhood malnutrition, with specific reference to stunting reduction. In this regard, the Indian state of Maharashtra has managed to reduce childhood stunting by 15% in a time span of seven years; Bangladesh showed a decrease of 20% in ~20 years and Brazil 30% in ~30 years. One could ask, as is done in the report: *“But what are realistic timeframes for improving nutrition?”* Although no direct answer is provided, words such as “accelerate”; “time-bound”; “timeframe”; “real-time”; “timelines” and “rapidly” is echoed throughout the document to illustrate the urgency of scaling up efforts to address nutrition (IFPRI, 2014a).

A combination of factors is mentioned as leading to the mentioned impacts on stunting reduction. In Maharashtra and Brazil political commitment and associated arrangements for nutrition governance, including high rates of growth and poverty reduction and increased spending on nutrition interventions is cited as contributing to an enabling environment for nutrition. In Bangladesh, better sanitation and health care, particularly for pregnant women and in Brazil, supplementation targeted at mothers and children, and highly coordinated actions to promote optimal breastfeeding are some of the successful nutrition specific interventions. In all three countries, a reduction in fertility and increased schooling for females are nutrition sensitive interventions mentioned as impacting on reducing stunting. In Brazil cash transfer programmes targeted at the poorest people and in Bangladesh increased household assets are further nutrition sensitive interventions attributed to reductions in stunting levels (IFPRI, 2014a).

These country examples indicate that low-income countries can address childhood malnutrition. The overarching success points to a multi-dimensional approach drawing together all sectors, levels and stakeholders (IFPRI, 2014a). Evidence suggests that improvements in nutritional status can be achieved if stakeholders work strategically, effectively, in alliances, at scale, and with accountability (IFPRI, 2014a), essentially adopting a whole of society approach (Dube *et al.*, 2012; WHO, 2009b).

While recognising the worth of multi-stakeholder and multi-sectoral approaches for nutrition actions, substantial barriers exist for its successful coming together (Harris & Drimie, 2012; Garrett & Natalicchio, 2011). These barriers to multi-sectoral work will be further explored in the sections to follow.

## 2.7 Barriers to multi-sectoral approaches for nutrition

Three broad barriers to multi-sectoral approaches at international and national levels have been reiterated in the literature. These include:

- 1) low political commitment, leadership and mobilisation with poor accountability
- 2) sector-bound organisational structures and weak coordinating bodies, including a lack of targeted communication and/or advocacy campaigns; and
- 3) lack of human resources and capacity to bridge the high-level policy aims and implementation-level realities

(Bryce *et al.*, 2008; Haddad *et al.*, 2014; Morris, 2012; Pelletier *et al.*, 2011a)

These barriers resonate with the key themes identified from the nutrition policy and politics literature reviewed by Nisbett *et al.*, (2014a) (Box 2.1).

### Box 2.1: Key themes in the nutrition policy and politics literature

1. The importance of narratives, framings, and communication of evidence and knowledge surrounding the causes, consequences, prevention, and treatment of undernutrition
2. The political economy of different stakeholders, ideas, and interests which both shape the narratives and available knowledge and enable and constrain the processes by which this knowledge is turned into action
3. The capacity (both technical and strategic) and resources available throughout the system for successful implementation of nutrition specific or sensitive programs and public service delivery.

Source: Nisbett *et al.* (2014a).

The authors of this paper argue that the basic cause level of malnutrition is dominated by the political economy of nutrition. The political economy of nutrition refers to nutrition policy, programming and implementation being situated within the wider social, economic, political and ideological context (Nisbett *et al.*, 2014a). Many different stakeholder groups operating at the basic cause level of malnutrition are required to work in synergy to address

malnutrition, but they do not have nutrition outcomes as their priority focus. This makes nutrition specifically vulnerable at the basic cause level (Nisbett *et al.*, 2014a).

Furthermore, three linked themes or elements: 1) knowledge and evidence, 2) politics and governance and 3) capacity and resources (Gillespie *et al.*, 2013) correspond with the key themes in the nutrition policy and politics literature (Box 2.1). These elements were recognised as critical for sustaining an enabling environment (Gillespie *et al.*, 2013) (also refer to Figure 2.2). This implies that overcoming the identified barriers to multi-sectoral approaches can strengthen the political economy of nutrition in particular and contribute substantially to building supportive environments for nutrition action.

Part of the lack of understanding of the basic cause level of the UNICEF conceptual framework and inability to break down the barriers of multi-sectoral work is that it has received relatively little research attention compared to the underlying and immediate level causes of malnutrition (Nisbett *et al.*, 2014a). Indeed, new forms of research, referred to as action-orientated research, is required to direct the advancement and application of successful policies, programmes and interventions for nutrition (Pham & Pelletier, 2015). Currently, nutrition journals in contrast with public health journals publish only a small portion of articles which cover action-oriented research. Nutrition's rise on the development agenda provides considerable motivation to support the growth and development of this so-called "Mode 2"<sup>7</sup> research for the advancement in our understanding of the complexity of nutrition (Pham & Pelletier, 2015). "Mode 2" research, however, requires interaction with communities, government actors, non-governmental organisations (NGOs), and/or private-sectors actors. Some of the challenges related to this research include collaboration, partnering, and cross-disciplinary communication and understanding (Pelletier *et al.*, 2013b), which implies components of multi-stakeholder and multi-sectoral engagement. These difficulties experienced in conducting "Mode 2" research may, in part, explain the lack in such research and resultant paucity in its publication. It may also be that high impact

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<sup>7</sup> "Mode 1" research refers to the conventional production of scientific knowledge which takes place primarily in academic and scientific institutions and is governed by the norms of scientific disciplines. "Mode 2" knowledge production takes place through greater interaction with communities, government actors, NGOs, and/or private-sectors actors. These two research "modes" complement one another and is especially needed for addressing complex social problems (Pelletier *et al.*, 2013).



nutrition journals are not receptive to publish action-oriented research (Pham & Pelletier, 2015).

It is important to contextualise the identified barriers, themes and elements inherent to multi-sectoral work in order to overcome the obstacles to such approaches and form a clearer picture of what an enabling environment to address malnutrition should look like. The three broad barriers to multi-sectoral work will be further explored in the sections to follow in order to analyse and understand the difficulties faced in working multi-sectorally, and to identify possibilities that can be unlocked to do so successfully.

### 2.7.1 Low political commitment, lack of leadership and accountability

Political voices speaking up about nutrition challenges have led to commitments being made for this cause by many national governments, international organisations and agencies (Gillespie *et al.*, 2013). Yet, the implementation of the various evidence-based interventions have not been progressive enough, i.e. timeous and at scale (IFPRI, 2014a).

On a global level, the MDGs referred to in section 2.5 are possibly the most well-known worldwide commitment that includes a focus on nutrition. WHO developed the Landscape Analysis (LA) in its efforts to accelerate progress towards the achievement of the MDGs, in particular MDG 1, 4 and 5. Launched at the end of 2007, the LA is a readiness analysis<sup>8</sup> of countries for improving nutrition (Chopra *et al.*, 2009). The ultimate aim of the LA is to lay the foundation to implement consolidated and harmonized action at scale in the 36 high burden countries, classified as those countries with the highest levels of babies born with intra-uterine growth restriction (IUGR), and stunting and underweight among young children (Chopra *et al.*, 2009).

The Landscape Analysis looks at readiness as a function of "commitment" and "capacity", i.e.: "ready" being understood as "willing and able" to scale-up nutrition action. The LA used the interpretation of commitment as countries' "*willingness to act*" at scale and could be

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<sup>8</sup> The concept of "readiness analysis" has frequently been used in the private sector. Companies undertake this analysis before making investment decisions in order to assess the readiness for change in terms of technical and strategic capacity (Chopra *et al.*, 2009)

reflected in budget support and consolidated action from government, agencies and donors, in nutrition governance and legal protection of women and children (Chopra *et al.*, 2009). Capacity in this definition refers to countries' "*ability to act*" at scale. This includes gross domestic product per capita and annual growth rate, official development assistance, degree training in nutrition and adequate numbers of health workers that can ensure satisfactory nutrition services (Chopra *et al.*, 2009).

A framework was developed to assess commitment and capacity during in-depth country assessments (the methodology is summarised in Engesveen *et al.*, 2009) of the 36 high-burden countries in the world, including SA. Results pointed to general weak country commitment and capacity, but the report acknowledged the cumbersome nature of compiling the documentation for the assessments by the countries as well as limitations in the methodology (Engesveen *et al.*, 2009).

More recent attempts to assess commitment to addressing malnutrition have been developed, and include the Global Hunger Index, Global Food Security Index, the Hidden Hunger Index, Hunger Reduction Commitment Index (HRCI), Nutrition commitment index (NCI) and the Hunger and Nutrition commitment index (HANCI) (Te Lintelo, 2014).

In summary, the different nutrition commitments made over the last few years at international forums have been described as a potpourri of global commitments for nutrition with a vast array of fledgling-status monitoring and answerability mechanisms with no clear accountability chains (Te Lintelo, 2014). A similar point was made in the recent independent evaluation report of SUN (Makoro, 2015) indicating that it cannot be assumed that the enforcement of international nutrition commitments happens automatically. Te Lintelo stated that it actually depends to a great extent on the willingness of the stakeholders who make these commitments to deliver on them (Te Lintelo, 2014).

This being said, reasons for slow progress on nutrition actions have been documented, including some countries' inability to design and manage large-scale nutrition programmes or spending of large amounts of funds on ineffective interventions, while some other countries, particularly in Africa, are so poor that they cannot afford nutrition programmes

without outside assistance (Heaver, 2005; UNICEF, 2011). Involvement of multiple stakeholders with different interests can weaken intervention attempts, especially when focus or funds for interventions are not aligned and/or spread too thinly to have impact. Other countries have been at war; a situation that has shifted their focus away from development (Heaver, 2005). Unfortunately these reasons do not complete the picture. Most countries with serious malnutrition problems allocate fewer resources to nutrition than they should and, what they allocate is less than what they could. This suggests weak country commitment to reducing malnutrition (Heaver, 2005) with nutrition below the political radar and treated as “*a-business-as-usual*” issue (Benson, 2004, p x). This leads to low political demand for action against malnutrition (Benson, 2004).

More reasons why nutrition policies and programmes are trapped in a “low priority cycle” (Natalicchio *et al.*, 2009, p 41) include the fact that nutritionists are often not given equal standing compared to other healthcare workers, particularly medical staff (Natalicchio *et al.*, 2009). As a consequence, their opinions within the health system are frequently undervalued or disregarded. Nutrition Departments are often relatively small, regardless of the Ministry in which they are positioned. These departments are generally under-funded, and are therefore unable to employ sufficient personnel or implement programmes and activities at scale. Furthermore, even among existing personnel, few have the training and experience needed to design and implement comprehensive nutrition programmes (Natalicchio *et al.*, 2009). Many of the high burden countries have poor quality, out-of-date, impractical training programmes that are not aligned with local nutrition priorities (Gillespie *et al.*, 2013). This leads to nutrition departments with little organisational capacity and the resultant inability to execute well planned projects and programmes within a well-defined and focussed nutrition strategy (Gillespie *et al.*, 2013; Natalicchio *et al.*, 2009). Nutrition champions and strong leadership are key in developing and sustaining political commitment and capacity at national levels to ensure action (Bryce *et al.*, 2008). Lack of such capacity as well as training and support for such individuals are barriers to effective and sustained commitment for nutrition (Bryce *et al.*, 2008; Nisbett *et al.*, 2014b).

Following the description of the terms “commitment and capacity” in the WHO LA (Engesveen, 2009), the expression became popular in the greater public health nutrition vocabulary, with reference to the broad spectrum of stakeholders with specific abilities

needed to scale up nutrition actions (Hughes & Margetts, 2011). The terms are often used loosely in documentation to indicate accountability, but reflecting on the review of available monitoring tools and indices to measure these components, as well as the low political commitment, lack of leadership and capacity for nutrition, the meaning of these terms become elusive (Hughes & Margetts, 2011; Mejia Acosta & Fanzo, 2012; Te Lintelo, 2014). This vagueness of the terminology contributes to low commitment and difficulty in formulating accountability measures for action on malnutrition.

#### 2.7.2 Sector-bound structures, weak coordination and ineffective advocacy

The institutional position of nutrition has been a long debate. Although nutrition straddles many spheres and sectors, it often becomes trapped in one of government's vertical departments or programmes; e.g. health or social development, each with its own specific strategic and performance focus which result in vertical flows of budgets, resources and reporting lines (Garrett & Natalicchio, 2011; Harris & Drimie, 2012). The position of nutrition could result in low visibility. Together with poor co-ordination of targeted communication and/or advocacy campaigns nutrition's "voice" becomes further jeopardised (Benson, 2004).

Rigorous evaluation and advocacy strategies need to be in place to effectively communicate nutrition issues (Gillespie *et al.*, 2013). Benson (2004) argued that advocacy groups should generate a perception of crisis related to malnutrition to ensure significant, urgent and high-profile action by governments. While planning nutrition communication and advocacy, it should be born in mind that nutrition issues are often misunderstood by the many non-nutrition sectors that need to be engaged for multi-sectoral action. Families, communities and governments often lack information on the extent, consequences and causes of malnutrition which can lead to low commitment to nutrition (Pelletier *et al.*, 2013a). This begs for better communication about nutrition by nutritionists and everyone involved in advocacy for nutrition. Well-thought-through and well-executed advocacy can result in substantial accomplishments, even in a short space of time. It does, however, require time, commitment, conversations, identification of the target group, and central to these: human, organisational and financial capacity and resources (Pelletier *et al.*, 2013a).

### 2.7.3 Lack of human resources and capacity

There is a worldwide shortage of healthcare workers, with the highest deficits in the poorest countries (WHO, 2008a). Moreover PHC is still overshadowed by a disproportionate focus on specialist tertiary care (also referred to as “hospital-centrism”) (WHO, 2008b) despite numerous calls for a renewed focus on PHC (WHO, 2008b; 2010b). Furthermore, a critical report on the status of professional health education (Frenk *et al.*, 2010) highlighting how fragmented, outdated and static curricula have not kept pace with current global health challenges, made an urgent call for the re-design of education syllabi. The global shortage of appropriately trained staff combined with unfitting training of professional healthcare workers essentially points to a lack of capacity required to address the health needs of a changing world (Frenk *et al.*, 2010; WHO, 2008b).

In the nutrition context Bryce *et al.* (2008) commented that, even if extensive experience and skill is evident at a country level to address the socio-political and operational challenges of nutrition, the same is not necessarily the case for staff working at implementation level. The national level often does not provide the necessary support to their staff at implementation level and the human resources for nutrition are often scarce. The low visibility and power predicament often faced by nutrition programmes, as well as the nutrition training dilemma experienced in numerous countries, have been mentioned in section 2.7.1. To this effect, numerous forms of capacity have been stipulated as needed to successfully scale-up priority nutrition interventions. These include: i) individual capacity, ii) organisational capacity and iii) systemic capacity (Gillespie *et al.*, 2013).

Individual capacity focusses on the availability of resources as well as the appropriately skilled staff to perform the tasks at hand. Organisational capacity relates to sufficient staff with the appropriate skill mix functioning within an environment with suitable monitoring and reporting systems that ensures accountability as well as incentives and sanctions. Also included in this form of capacity is the availability of proper training and support facilities. Systemic capacity concentrates on accessibility and utilisation of executive forums or multi-stakeholder platforms for discussing, debating and deciding on nutrition issues. Furthermore, this type of capacity allows for information, funds and command flow in a timely and effective manner and advances links with private sector, the community and

NGOs. These collaborations happen when individuals, teams and committees are empowered to make decisions for effective performance (Gillespie *et al.*, 2013).

In the past, the field of capacity development focused on strengthening individuals or single organisations. More recently there has been the addition of facilitating multi-stakeholder processes (MSPs) to this field (Greijn, 2010). MSPs have tended to be understood as consensus-building, participatory decision-making and programme implementation, not as capacity development. However, practical experience has shown that working with multiple stakeholders can be an effective form of capacity development in its own right (Acquaye-Baddoo *et al.*, 2010).

## **2.8 Lessons learnt from multi-sectoral work at national and sub-national levels**

The lessons learnt from multi-sectoral work draws on experience and case studies from across the globe (Garrett *et al.*, 2014; Gillespie *et al.*, 2013; Harris & Drimie, 2012; Mejia Acosta & Fanzo, 2012; Pelletier *et al.*, 2011a & 2013a).

The experience at global level indicates that it is difficult to get all the different stakeholders and sectors to work together. It also takes time for nutrition interventions to show impact, and this could lead to stakeholders losing interest and efforts for improving nutrition running out of steam (Garrett *et al.*, 2014). Strong leadership is therefore needed at various levels along the continuum of multi-sectoral collaboration (Garrett *et al.*, 2014) to ensure focus and momentum for nutrition is retained (Mejia Acosta & Fanzo, 2012).

An important lesson is that nutrition should be put and kept on the development agenda (Garrett *et al.*, 2014; Mejia Acosta & Fanzo, 2012) at a high power level in order to raise the profile of nutrition (Mejia Acosta & Fanzo, 2012). The danger is always there that nutrition can fall off the agenda when high-level authorities simply turn their attention elsewhere. Therefore, nutrition leaders should continually engage with political powers-that-be, who often change positions, to ensure constant understanding of nutrition and to safeguard support for initiatives (Garrett *et al.*, 2014). Different sectors need to be able to see reciprocal advantages of and for their involvement, which in turn could galvanise the political will needed for action (Harris & Drimie, 2012). New political leadership,

development partners and civil society could act as motivational powers to keep a focus on nutrition (Garrett *et al.*, 2014); especially through communication of the problem at hand in order to define exactly what the focus should be and supported by well-designed advocacy (Harris & Drimie, 2012; Pelletier *et al.*, 2011a; 2013a).

Capturing the critically window of opportunity for highest nutritional impact in the catchphrase: “*the importance of the first thousand days of life*” has been very successful in creating a focal point for advocacy on the topic of IYCN and the full potential of this situation should be capitalised (Pelletier *et al.*, 2013a). Strong leadership from experienced persons, especially from within government sectors, who possess skills in negotiation, persuasion and mobilisation, is a key driver for such advocacy campaigns. On the other hand, without strong and broad public recognition and concern for a specific issue, political momentum for IYCN may dwindle. It is therefore important to see society at large as change agents for the cause and not merely targets or objects of behaviour change (Pelletier *et al.*, 2013). Moreover, stakeholders’ perspectives on a specific problem should be explored in order to successfully communicate the requirement for actions (Heaver, 2005; Pelletier *et al.*, 2013a). To this effect, each country should write its own storyline for nutrition by means of engaging in rigorous research, interpreting these results and communicating it clearly to the powers-that-be and in so doing put pressure on politicians to act (Garrett *et al.*, 2014; Gillespie *et al.*, 2013; Mejia Acosta & Fanzo, 2012). While generating commitment for nutrition from various stakeholders in this way, different forms of capacity need to be built and resources secured (Gillespie *et al.*, 2013).

A wide array of capacity is needed, including organizational arrangements (convening or coordinating bodies with multi-sectoral credibility to facilitate mobilizing and resourcing power) and technical and strategic capacity, to manage multi-sectoral relationships for improved nutrition outcomes (Gillespie *et al.*, 2013; Harris & Drimie, 2012; Mejia Acosta & Fanzo, 2012). Lessons learnt from the Mainstreaming Nutrition Initiative (MNI) elaborate on this aspect and states that strengthening of the full spectrum of policy activities is necessary for the achievement of large-scale and sustained reductions in undernutrition. Also, high priority should be given to strengthening strategic capacity, which is fundamental for

advancing commitment building, agenda setting, policy formulation and capacity building for operations in nutrition (Pelletier *et al.*, 2011b).

Furthermore, when stakeholders establish monitoring and evaluation processes, they should create accountability measures that can also serve as incentives to keep momentum and a sense of eagerness for the joint initiatives (Garrett *et al.*, 2014). In addition, managers should be creative in providing partners with incentives to work together (Garrett *et al.*, 2014).

An essential lesson is that value-based collaborations; i.e. built on respect, transparency, inclusion and ownership are more likely to lead to successful partnerships. Likewise, people and not the structures they work in, are most important and should not be directed through top-down leadership, but should be appropriately guided (Garrett *et al.*, 2014).

It is imperative to note that the documented approaches and lessons learnt have to be custom-made to fit each country's specific environments (Harris & Drimie, 2012).

Working multi-sectorally is key to successful governance. Haddad *et al.* (2012) propose a "Nutrition Governance Framework" to understand how good nutrition governance can contribute to positive changes directly related to nutrition outcomes. The framework finds inspiration from Heaver's (2005) work on the reasons for weak commitment to nutrition and builds on experience from a handful of global studies (Pelletier *et al.*, 2011; Shiffman, 2010; Engesveen *et al.*, 2011; Mejia Acosta & Fanzo, 2012). Overlapping themes from these studies include: the importance of data, visibility, commitment, accountability and leadership, responsiveness and transparency. These elements are similar to those captured in the lessons learnt from working multi-sectorally, described in this section, as well as from the definition of an enabling environment in the Lancet 2013 framework (Gillespie *et al.*, 2013).

The Nutrition governance framework acknowledges, on the left of the figure, the importance of relevant stakeholders, their interests and capacities, as well as their existing organisations and policy frameworks, which are country-specific and reflective of its history, political, geographic and demographic challenges. In the middle part, four dimensions of nutrition governance are considered as it plays out from national to local levels and suggests that



enhanced inter-sectoral coordination or horizontal co-operation, strong vertical connections, adequate and sustainable funding streams and monitoring of timeous data sources and indicators as well as advocacy will contribute to improved nutrition outcomes, as indicated on the right side of the framework (Mejia Acosta & Fanzo, 2012).

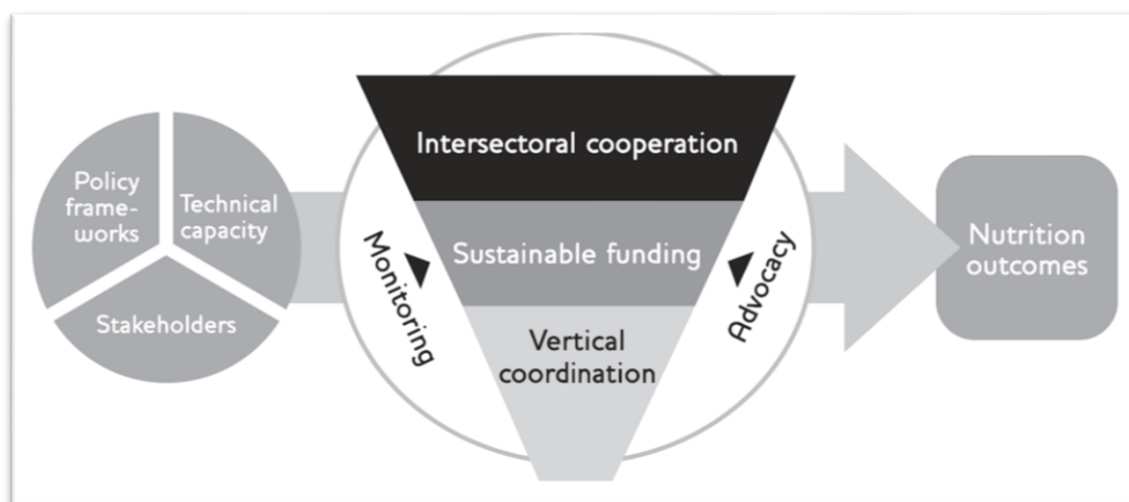


Figure 2.6: The Nutrition Governance Framework. Source: Mejia Acosta & Fanzo, 2012

Reflecting on the literature concerning multi-sectoral work for improved nutrition governance, it is clear that integrating nutrition into sectors less oriented to nutrition is challenging. Furthermore, the research base of experiences with stakeholders at local levels are limited and various questions around models of engagement or best practices for such engagement remain unanswered (Gillespie *et al.*, 2013). This prompted researchers to express a need for building experiential learning and systematic evidence about processes related to multi-sectoral integration of actions for nutrition (Garrett & Natalicchio, 2011; Gillespie *et al.*, 2013; Nisbett *et al.*, 2014a).

The global, national and sub-national level lessons on MSPs are valuable when turning to local levels where service delivery and implementation take place, and where the waters seem to be largely untested in the domain of MSPs for nutrition action.

In order to interpret the literature overview discussed so far in the SA context, the following sections will focus on the broad health and nutrition country profile, including maternal and

child malnutrition, as well as healthcare governance, with reference to the National Development Plan, nutrition governance, commitments made to address nutrition in SA and a focus on unresolved areas in need of attention. Although some of the discussion refers to “nutrition” in general and not always “IYCN”, some processes work in synergy for the greater good of nutrition intervention management and implementation and will imply a focus including IYCN.

## 2.9 The health and nutrition profile for South Africa

South Africa has a long history of injustices and resultant inequitable healthcare shaped by apartheid and worsened by poor health policies (Mayosi *et al.*, 2012). From the 1980’s and early 1990’s the “double burden of disease”<sup>9</sup> was observed in SA. This double burden of disease was, however, accompanied by relatively high rates of injuries in the country and this led to SA’s health situation being described as the “triple burden of disease”. In recent years, the profile has rapidly changed into a “quadruple burden of disease” with the major addition of HIV and AIDS (Academy of Sciences in South Africa [ASSAf], 2007). Currently the country’s health status is described as impacted by the four so-called “colliding epidemics”: HIV and tuberculosis; chronic illness and mental health; injury and violence; and poor maternal, neonatal, and child health. Advances have been made to curb child mortality, mainly via the world’s largest programme of antiretroviral therapy rolled-out in SA. However, more attention to postnatal feeding support has been highlighted as a gap in current approaches to the concurrent epidemics (Mayosi *et al.*, 2012).

## 2.10 Maternal, infant and young child nutrition in South Africa

Over the past 2 decades, four major national nutrition surveys<sup>10</sup> investigated, among other issues, the nutritional status and nutrient intake of women and children aged 1-9 years old.

The major nutritional problems of SA children were found to be:

- Stunting (1 in 5 of SA children were stunted)
- Underweight (1 in 10 children)

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<sup>9</sup> The “double burden of disease” term has been used internationally to describe the health transition experienced by many developing countries whose populations experience both diseases related to unhealthy lifestyles and diseases associated with underdevelopment (Popkin, 2002).

<sup>10</sup> The four major nutrition surveys included: The SA Vitamin A Consultative Group (SAVACG, 1994) (Labadarios *et al.*), the National Food Consumption Survey (NFCS, 1999) (Labadarios *et al.*), the National Food Consumption Survey Fortification Baseline (NFCS FB-1, 2005) (Labadarios *et al.*) and the most recent South African National Health and Nutrition Examination Survey (SANHANES-1) (Shisana *et al.*, 2013).

- Overweight (1 in 10 children were overweight and 4% were obese)
- Vitamin A deficiency
- Iron deficiency
- Inadequate levels of a number of other micronutrients

SA has very limited available national data on infant and young child feeding (IYCF). However, the anthropometric status of young children, coupled with the presence of micronutrient malnutrition, described earlier, is indicative of poor IYCF. There is a paucity of national data concerning breastfeeding rates but available data suggest that initiation of breastfeeding remains relatively high at around 88% (Mhlanga, 2008). It is stated in the SA Health review (2008) that only 8% of babies are exclusively breastfed at the age of 6 months and more than 70% of infants receive solid foods before the age of 6 months (Mhlanga, 2008). Smaller studies have confirmed the practice of introducing solids and other complementary foods or liquids too early (Du Plessis *et al.*, 2013). These poor figures for exclusive breastfeeding and early introduction of complementary foods pose a significant threat to child health and nutrition.

Overweight and obesity in females (15 years and older) of 25% and 40%, respectively, in SA, described in the most recent nutrition survey performed in the country, the South African National Health and Nutrition Examination Survey (SANHANES-1) (Shisana *et al.*, 2013), is of particular concern. Coupled with a moderate public health problem with Vitamin A deficiency as well as maternal anaemia, SA women of childbearing age face a predicament in the context of maternal nutritional health and resultant birth outcomes (Shisana *et al.*, 2013).

Twenty years post democracy (1994-2015), despite some concerted efforts to address the nutrition situation in the country, mainly via the National DOH - Nutrition Directorate: Integrated Nutrition Programme (INP)<sup>11</sup> (Iverson *et al.*, 2011 & 2012; DPME, 2014), the

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<sup>11</sup> The INP adopted the Triple A approach together with UNICEF's Conceptual Framework on malnutrition and targets nutritionally vulnerable communities and groups, including children under 5 years of age. The INP has established a broad framework to address the nutrition problems in SA. Policies, strategies and guidelines have been put in place to this effect, notably mandatory salt iodisation since 1995, the national school nutrition programme (1995), a national vitamin A supplementation programme since 2002 and fortification of staple foods since 2003. Targeted supplementary feeding to

country is considered one of the 36 high burden countries, classified as those countries with the highest global levels of babies born with IUGR, and childhood stunting and underweight figures (Engesveen *et al.*, 2009; DOH, 2013a).

### **2.11 The South African health system and Primary Health Care governance**

SA is a constitutional democracy with a three-layer arrangement of government and an independent judicial system. The national government, nine provinces as well as the local levels (municipalities) each have legislative and executive authority in their own domains. Racial and gender inequalities in the managerial structures have been largely eliminated (South Africa, 2015). Much has been done to gear up the health system since 1994. The current SA health system is structured in terms of the health district model with nine provincial Health Departments established out of the fragmented state of pre-1994, which in turn are divided into 52 districts and 252 sub-districts (DOH, 2010a; Mayosi *et al.*, 2012).

There has been a substantial investment in infrastructure and building of new clinics and facilities to make health services more accessible. Services have been largely scaled up to deal with the HIV and associated TB epidemic. However, there has been insufficient attention given to the implementation of the PHC approach. For the most part there has not been a population focus and insufficient attention has been given to the improvement of and the measurement of health outcomes. A re-engineered PHC strategy<sup>12</sup> was developed to strengthen the current DHS through health promotion and preventive activities (DOH, 2010a). Although the intention was displayed to “re-engineer” (DOH, 2010a, p 1) the PHC approach in SA, the inherent sector-bound approach and strong focus on a technical delivery of services remain and might jeopardise the intentions of the revamped plan. The responsibility for IYCN at national level rests with the National DOH Programme: HIV/AIDS, TB, Maternal & Child Health. In the nine provinces, the INP resorts under different Provincial Health Department Programmes. Nutrition is mentioned in the re-engineered PHC document, but the focus is mostly on clinical services, despite the PHC scope of the INP

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malnourished individuals (a replacement of the PEM scheme) via health facilities has been the intervention with the highest budget allocation over many years (Iverson *et al.*, 2011 & 2012; DOH, 2013a).

<sup>12</sup> The new PHC package incorporates community based services; an increased emphasis on preventive and promotive services, especially at household level; additional services related to HIV; services related to common health problems not traditionally offered in clinics (including those related to oral health, vision, hearing, mental health and disability); and school health services (DOH, 2010a).

(DOH, 2013a). No mention is made of nutrition trained staff and their role in PHC. This “business as usual” and “no drama” approach to nutrition displayed in the document, implies that nutrition is trapped in a “low priority cycle” in the country.

In the broader development context, South Africa’s National Development Plan (NDP)<sup>13</sup> aims to eliminate poverty and reduce inequality by 2030. The plan states that SA can realise the set goals by drawing on the energies of its people; growing an inclusive economy; building capabilities; enhancing the capacity of the state; and promoting leadership and partnerships (National Planning Commission [NPC], 2012) by adopting a whole of society approach (NPC, 2012; WHO, 2009b).

Nutrition features prominently in the plan and is explicitly linked to elements of a decent standard of living with an emphasis on women and children, imbedded in social security; health for all; and improving education training and innovation - with a focus on early childhood development (ECD) and schooling. For achieving the 2030 Vision for Education, Training and Innovation (Chapter 9), the 1000 days period is specifically mentioned and acknowledged as the most cost-and-time-effective window of opportunity for development interventions central to ECD (NPC, 2012). To this effect a national ECD Policy has been drafted under the guidance of the National Department of Social Development (DSD) to initiate a process of delivering a comprehensive and essential package of ECD services, across four service domains, namely: health care and nutrition; social protection; parenting support; and opportunities for learning, with an age-differentiated package of services starting in pregnancy.<sup>14</sup> For food and nutrition security, the agriculture-nutrition linkages are also firmly recognised in the NDP. To achieve the objectives of broader social security coverage, a commitment to household food and nutrition security involving public- and private-sector action is proposed (NPC, 2012).

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<sup>13</sup> The NDP was drafted by the National Planning Commission (NPC), appointed by the President of South Africa in May 2010. Located in the Presidency and headed by the Minister in the Presidency for National Planning, the NPC is an advisory body. It does not formulate government policy and its recommendations do not bind the President or his Ministers to any particular policy direction. The purpose of the NPC is to draw on expert opinion and consult with stakeholders in order to craft a vision and a set of recommendations that the government may or may not use (NPC, 2030). Objectives are set for issues pertaining to: Economy and Employment; Economic infrastructure; Environmental sustainability and resilience; Inclusive rural economy; South Africa in the region and the world; Transforming Human Settlements; Improving education, training and innovation; Health care for all; Social protection; Building Safer Communities; Building a capable and developmental state; Fighting corruption and Nation building and social cohesion.

<sup>14</sup> This document is in draft format and cannot be cited as government policy or the official position of the Government of South Africa yet).

The NDP is comprehensive and ambitious, showing insight in the most pressing development issues stifling the SA population. Translating the set objectives into action will ultimately show if there is true commitment to the cause.

## **2.12 Commitment and capacity to address infant and young child nutrition in South Africa**

Swart *et al.* (2008) evaluated trends in the nutrition situation in the country between 1994 and 2008 and reviewed selected nutrition services in relation to the PHC principles embedded in the SA health system. Sub-optimal implementation and the resultant lack of progress was attributed to, among other, inadequate human resources and lack of appropriate capacity at technical, operational, programme, information management and strategic levels. It was recommended that the development of these capacities should cover a range of different cadres of staff, not only through in-service training, but also in pre-service training. It was further recommended that it might be wise to prioritise interventions by limiting the focus and/or variety of interventions to ensure that impact is not compromised by spreading resources too thinly (Swart, *et al.*, 2008).

In 2007 the WHO carried out a Landscape Analysis (mentioned in section 2.7.1) in 36 high burden countries, including SA. SA had no score for a Poverty Reduction Strategy Paper (PRSP)<sup>15</sup>, since such a process had not been undertaken in the country and was rated at a “medium” for the UN Development Assistance Framework (UNDAF)<sup>16</sup> and “medium” for nutrition governance<sup>17</sup> (Engesveen *et al.*, 2009). In 2009 SA undertook a country-wide WHO-

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<sup>15</sup> A PRSP is prepared by the government through a participatory process involving civil society and development partners, including the World Bank and the International Monetary Fund (IMF). It should articulate development priorities and specify the policies, programmes, and resources needed to meet the poverty reduction goals. It should result in a comprehensive country-based strategy for poverty reduction. The emphasis given to nutrition in a PRSP reflects to what extent the government considers it essential to improve nutrition for poverty reduction and national development. (Engesveen *et al.*, 2009)

<sup>16</sup> The UNDAF document is the strategic programme framework and focussed on three to five priorities where the UN agencies together can make the biggest difference, in addition to other agency-supported activities that respond to specific country demands. The evidence-based nutrition interventions were broadly classified into three areas: micronutrients (supplementation and/or fortification), promotion of breastfeeding and/or improved complementary feeding, and treatment of severe malnutrition. (Engesveen *et al.*, 2009)

<sup>17</sup> The following components were considered in the scoring of Nutrition Governance: existence of inter-sectoral mechanism to address nutrition; existence of a national nutrition plan or strategy; adoption of a national nutrition plan or strategy; whether a national nutrition plan or strategy is part of a national development plan; existence of a national nutrition policy; existence of national dietary guidelines; allocation of a budget for implementation of a national nutrition plan, strategy or policy; implementation/existence of regular nutrition monitoring and surveillance; existence of a budget-line for nutrition in health budget

led landscape analysis (LA) in all 9 provinces to identify bottlenecks in the development of responsive solutions and opportunities to scale up good practices. The LA revealed that at national level, and more specifically in the health sector, SA has the potential and resources to scale-up key nutrition interventions to reduce maternal and child undernutrition. Many challenges were, however, identified with policy and programme implementation, including: lack of a multi-sectoral working group; lack of a comprehensive monitoring and evaluation plan and nutrition surveillance system and poor use of information for decision making; budget constraints and shortage of human resources (WHO, 2010a). The LA conducted in the 9 provinces in SA did not reflect the same commitment and capacity seen for the country level. Although performed on a small sample size, it showed many shortcomings with weak capacity and commitment at health sector implementation level (DOH, 2013a). Readiness to act on the burning issue of IYCN at a national, provincial and district level therefore remains a concern.

A limitation in the WHO LA country assessment was a prominent focus on the perceptions of health workers from public institutions. The LA included some NGO's but none of the academic and research institutions nor the private sector were interviewed (DOH, 2010a). Yet, as previously pointed out, there are numerous other stakeholders in nutrition who need to be engaged to ensure commitment and capacity for implementing quality nutrition programmes and to sustain these over many years while the fight against malnutrition will continue.

The National Nutrition Directorate has demonstrated commitment in furthering the maternal and child nutrition agenda over the past decade and more so within the last three years. A significant milestone event was the National Consultative Breastfeeding Meeting, held in August 2011, which culminated in the signing of the Tshwane Declaration of Support for Breastfeeding in SA (Tshwane Declaration, 2011). It was convened by the National Minister of Health, Dr Aaron Motaale, and included representatives from NGOs, non-profit (NPOs) and academic organisations and institutions, as well as government officials and independent experts. The Tshwane Declaration symbolises a commitment of political will at the highest level, as well as a commitment by all stakeholders in SA, to work together to ensure the promotion, protection and support of breastfeeding.

Subsequently, there has been progress on some commitments from the Tshwane Declaration (Du Plessis & Pereira, 2013). The IYCF policy of 2008 has been updated (DOH, 2013b) and incorporates the new guideline that all HIV-infected mothers should breastfeed their infants and receive ARVs to prevent HIV transmission. Furthermore, a progressive step was the legislation of the Code of Marketing for Breastmilk Substitutes and other foodstuffs for infants and young children in Regulation 991 (Foodstuffs, Cosmetics and Disinfectant Act, No 54 of 1972, Regulation, 2012:991)<sup>18</sup> in December 2012. The various regulations contained in this legislation have been phased in over a 3 year period from 2013 to 2015.

Acknowledging that a more focussed and targeted nutrition strategy is required to achieve the National Department of Health's health priorities, a Nutrition Roadmap 2013-2017 was developed by the National Nutrition Directorate (DOH, 2013a). Based on the SUN Road Map, although the country is not a SUN-signatory, it has a strong focus on the first 1000 days and provides a framework to position nutrition as a key contributor to achieving wellness and longevity of all South Africans. The roadmap's function is therefore to ensure human and financial resources are rerouted from low priority interventions to high priority interventions and that nutrition is integrated into other core sectors and strategies, namely agriculture, rural and social development and education. The plan thus embraces a multi-sectoral approach for addressing nutrition problems in the country, as recommended, among other, by SUN (DOH, 2013a).

The country's first comprehensive Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition (2012-2016) was launched in 2012. The plan aims to reduce mortality and improve the health and nutritional status of women, mothers, newborns and children through promotion of healthy lifestyles and provision of integrated, high quality health and nutrition services. The nutrition interventions listed under the priority actions for child health include: early and exclusive breastfeeding with the introduction of appropriate complementary feeding from six months of age and continued breastfeeding for up to two

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<sup>18</sup> Regulation 991 applies to designated products and covers the following aspects: labelling, composition, packaging and manufacturing matters; promotion of formulas, complementary foods and related products to the general public and mothers, health care personnel and health care establishments; financial contributions or sponsorship to health care personnel working in IYCN; and information and educational material on IYCF (Foodstuffs, Cosmetics and Disinfectant Act, No 54 of 1972, Regulation 991, 2012).



years of age and beyond; growth monitoring and promotion; vitamin A - and supplementation with other micronutrients (DOH, 2012). The plan provides a focus on identifying and strengthening a core set of priority interventions delivered through improved coverage, quality and equitable access to services (DOH, 2012).

Despite certain acknowledged reservations from some sectors about the NDP 2030, the national minister of Health stated the confidence DOH has in this plan for promotion of health in the country. In his 2015/2016 Budget speech he reiterated *“that every single vision in health, every single policy, plan, programme, decision or campaign will from now henceforth be based on and be directed by the dictates of the National Development Plan without any reservations whatsoever”* (Motsoaledi, 2015). He mentioned the success over the past 5 years in vertical programmes; specifically routine immunization and the ARV programme. Furthermore, a health promotion programme initiated in 2014, focussed on maternal and child health, the *“MomConnect”*<sup>19</sup> programme (Reducing Maternal and Child Mortality through strengthening Primary Health Care in South Africa, 2013) is foreseen as a programme that could advance the health of children within the 1000 days period in SA in future (Motsoaledi, 2015).

Although there is political commitment at national level to improving the IYCN situation in SA, many challenges still remain, primarily as not all the commitments have been translated into concrete actions, specifically at implementation level, to improve the nutritional well-being of all South Africans (DOH, 2014; Du Plessis & Pereira, 2013). Some unresolved areas in need of attention are deliberated in the following section.

### **2.13 Unresolved nutrition governance issues in need of attention**

Various evaluations and reports have pointed out the need for more human resources for the successful implementation of the INP. Several studies have recommended a national audit of nutrition personnel in the country, and highlighted the need for the formalization

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<sup>19</sup> The programme uses cellphone technology to register pregnant women in both public and private health care. Information and instructions are communicated to pregnant mothers to ensure a healthy pregnancy and delivery of a healthy baby. After delivery, the messages switch over to focus on information on the health needs of a new-born (including messages on exclusive breastfeeding, immunisation, family planning for the mother, oral rehydration during diarrhoea, check-up periods at the clinic) and continue for up to one year after birth (Reducing Maternal and Child Mortality through strengthening Primary Health Care in South Africa, 2013).

and implementation of a human resource strategy for nutrition in the public health sector (ASSAf, 2007; Labadarios *et al.*, 2005; Swart *et al.*, 2008) but this has not materialised yet.

The low government health sector budgetary allocation to nutrition (less than 0.3% of the health budget) is also problematic. In the current expenditure, most funds are spent on targeted supplementary feeding. Funds are also not always available for nutrition interventions due to reallocation to other priorities and a call has been made for further analysis to determine what proportion of the allocated nutrition budget is actually spent on priority nutrition interventions. There is a concern that the returns on the nutrition expenditures are not as high as it could be, due to inappropriate interventions, and weak implementation (DOH, 2013a).

Furthermore, according to the 2014 Global Nutrition Report, SA is “on course” to meet the WHA target of reducing childhood wasting, but “off-course” in reducing the number of children under 5 who are stunted, anemia in women of reproductive age and not increasing overweight in children under 5 (Table 2.5) (IFPRI, 2014b).

Table 2.5: World Health Assembly Nutrition Targets 2025

World Health Assembly target	Baseline year/s	Baseline status	Target for 2025
40% reduction in the number of children under five who are stunted	2012	162 million	~100 million
50% reduction of anemia in women of reproductive age (pregnant and non-pregnant)	2011	29%	15%
30% reduction in low birth weight	2008-2011	15%	10%
No increase in childhood overweight	2012	7%	7%
Increase the rate of exclusive breastfeeding in the first six months up to at least 50%	2008-2012	38%	50%
Reduce and maintain childhood wasting to less than 5%	2012	8%	<5%

Notes: Currently it is only possible to determine whether a country is on or off course for four of the six WHA targets. The year refers to the most recent data available; on/off-course calculation is based on trend data. WRA = women of reproductive age. More recent data on under-5 overweight are not available; this result should be interpreted with caution as it could change when new data become available.

Source: WHO (2015b).

Moreover, a recent independently prepared report on the “*Evaluation of Nutrition Interventions for Children from Conception to Age 5*” in South Africa echoed the findings of the reviews and assessments mentioned in sections 2.9-2.12. Despite all the efforts, a lack of real progress on nutrition outcome level has contributed to stagnation in child mortality and

morbidity resulting in SA lagging in achieving its MDGs by 2015 (DPME, 2014). Although the DOH, DSD, Agriculture, Forestry and Fisheries (DAFF) as well as the Department of Rural Development and Land Reform (DRDLR) each have sufficient policies, regulations, and strategies to guide their respective portfolios of nutrition interventions, the evaluation points to unequal commitment to nutrition across departments with varying levels of leadership, management, planning, budgeting, and staffing (DPME, 2014).

The thrust of the country evaluation points to a lack in all forms of capacity (i.e. individual, organisational and systemic capacity) to effectively address IYCN in a comprehensive manner. Key recommendations from the evaluation are listed in Box 2.2 (DPME, 2014).

Four provincial case study reports were also documented in the DPME report (2014), including KwaZulu Natal (KZN), Eastern Cape, Free State and the Western Cape. KZN and the Western Cape were highlighted as provinces with good progress in reducing severe stunting and underweight in children under 5 years of age, since 2003. Eastern Cape and Free State have not managed to make significant progress in this regard and nutrition governance issues were not portrayed to be favourable. The Western Cape has some coordination between government departments, but implementation of programmes, are department-specific. Management is regarded as satisfactory and monitoring and evaluation are in place, but not consolidated for nutrition interventions. KZN has good interdepartmental coordination and service linkages, partnerships with NGOs, a more balanced budget for nutrition and a clear vision and commitment to implementation of nutrition actions. The one feature that separates KZN from the rest of the provinces in the country is the fact that nutrition is situated at a Directorate level with a higher profile and power base compared to the other provinces where it is situated at Sub-Directorate level. The realisation of this success factor in KZN prompted Key recommendation #2 in the report (Box 2.2) (DPME, 2014).

## Box 2.2: Key recommendations from the “Evaluation of Nutrition Interventions for Children from Conception to Age 5 in South Africa” (2014)

### Key recommendation #1:

- Nutrition of under 5s should be elevated to the level of an output of Outcome 2 (Health), and so included in the Medium-Term Strategic Framework and the Delivery Agreement. A well-defined Nutrition Plan should be developed for the output across all sectors that operationalize national priorities and investments in nutrition to achieve integrated and consolidated goals (including an explicit goal to reduce stunting in children under 5), objectives, and budgets. This plan should be developed in time for the approval of the Mid-Term Strategic Framework after the elections and cascading into strategic plans. This should have common indicators for tracking Food and Nutrition across all sectors with a common and consolidated M&E framework for tracking both the delivery and the effects of nutrition interventions prioritised under the Plan.

### Key recommendation #2:

- Elevating nutrition to the level of an output should be accompanied by elevation of the status of nutrition, to at least a cluster manager in national DoH and to a directorate level at provincial DoH, as in KZN. Districts also need a nutrition-trained person. Other national and provincial departments need a nutrition-trained focal person to manage their component of their work.

### Key recommendation #3:

- Stronger coordination is needed of the implementation of nutrition interventions by relevant government departments, and monitoring that the nutrition programme plan is being followed. The National DoH is the natural champion as most interventions are within its domain. Support is needed from the Presidency to elevate the political profile of nutrition. The integrated nutrition plan will facilitate cross-sectoral collaboration, as well as more effective planning, budgeting and oversight of each ministry’s performance in achieving nutrition goals. DPME needs to look at lessons in terms of strengthening programme coordination mechanisms across departments.

### Key recommendation #4

- A National Nutrition Council should be established as a coordinating council, like SANAC for HIV/AIDS, which has broad representation from key government sectors and programmes, civil society, suitable involvement of the private sector, to mobilise all sectors around nutrition. The DoH will provide the secretariat for this. As has been done for maternal mortality and morbidity (COMMiC), this Council should be served by a committee of experts – a Committee on Nutrition (COMMoN). Other committees addressing infant and child health should also have a nutrition focal point.

### Key recommendation #5

- Change focus of services and communication across relevant sectors to focus more on nutrition promotion, exclusive breastfeeding, complementary feeding, dietary diversity, hygiene education and to help create an enabling environment. DoH to create a specific, well-defined, and dedicated promotion and communication strategy on nutrition for under 5s, as happened for HIV/AIDS, and interventions to address the growing problem of overweight and obesity among children under 5 years of age.

### Key recommendation #6

- Clarify the champion for food security. DAFF’s current food security strategy does not address nutrition in a substantive way. If DSD is to be the food security and food gardens champion, Agriculture or NGOs will need to provide significant technical expertise at all levels.

Source: Department of Performance Monitoring and Evaluation (2014).

Subsequent to the release of this evaluation report, a Human and Social Dynamics (HSD) Research Seminar Series was held in Pretoria on 27 March 2015 and focused on the topic “*Food, Nutrition and Care Security during the first 1000 days*”. It was jointly arranged by The Department of Science and Technology and the Human Sciences Research Council (HSRC) with national and provincial departments of health, social development, local government, education and agriculture, as well as academia as target groups. The purpose of this seminar was to chart the way forward for the advancement of interventions designed to improve care and nutritional status of women and their children during the first 1000 days. During the event the National DOH Chief Director: Child, Adolescent and School Health shared with the audience that a tender has been put forward for a national advocacy campaign on the first 1000 days of life, as suggested by various calls (Personal communication)<sup>20</sup>. This will be an exciting space to watch in SA in future, but in the meantime other efforts and activities will have to be aligned or put in place to move the IYCN agenda forward and to feed off and continue the momentum of the advocacy campaign, once it is launched. In particular, nutrition governance, also described as the commitment to act, capacity to act and power to act (Mejia Acosta & Fanzo, 2012), takes time to develop and will need to be understood, embraced and cemented at the different political and bureaucratic layers in the country in the interest of timeous and appropriate action for IYCN from national to implementation levels.

## 2.14 Summary

There have been important developments in the field of IYCN over the past few decades (IFPRI, 2014a; UNICEF, 2011), yet progress towards achieving global nutrition goals is slow and uneven (IFPRI, 2014a). Evidence-based interventions to address the situation have been documented (Bhutta *et al.*, 2008 & 2013), but these mainly respond to the immediate causes of malnutrition and primarily involve maternal - and health worker behaviours (Lele, 2014).

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<sup>20</sup> The research seminar series are designed to showcase research and knowledge production in the Social Sciences and Humanities (SSH) generated by the National System for Innovation (NSI), serve as a vehicle for disseminating research evidence to wider and diverse audiences, operate as a platform for the sharing of local and international expertise and promote research and knowledge production in the SSH that benefits and enhances NSI. The researcher was invited by the HSRC to participate as a key note presenter at the event on the topic: “The environment affecting Infant and Young Child Feeding”, where she stressed, among other issues, the importance of framing and communicating the importance of nutrition during the first 1000 days.

The underlying and basic causes of malnutrition require bringing together stakeholders from multiple sectors (Gillespie *et al.*, 2013; Ruel, 2009). This complex nature of malnutrition may explain why it has not been effectively addressed, even though many of the solutions are now known (Harris & Drimie, 2012). Furthermore, multi-sectoral programme planning and coordination is arguably the most effective way to tackle malnutrition (Heaver, 2005) but also the most difficult route to take with substantial barriers to its successful implementation (Garrett & Natalicchio, 2011).

There is experience with - and documented evidence on MSPs on a global - and national level and on how to build and assess commitment and capacity to address IYCN at these levels (Garrett *et al.*, 2014; Garrett & Natalicchio, 2011; Harris & Drimie; Mokoro, 2014; Pelletier *et al.*, 2011a). Little experience and documented evidence, however, exist for such processes at local level. In countries with a decentralised government system, part of the lack of experience and evidence on MSPs lies in the challenge of building commitment and capacity at various political and bureaucratic levels (Gillespie *et al.*, 2013; Mejia Acosta & Fanzo, 2012). There is, thus, a need to build an evidence-base of how to engage stakeholders at local (implementation) level inside and outside the health sector and to assess and advance their commitment and capacity to implement solutions or responses to address IYCN (Mejia Acosta & Fanzo, 2012). There is also a call to better define enabling environments for successful action in this field (Gillespie *et al.*, 2013).

In the nutrition context in SA, the involvement of multiple stakeholders is often mentioned as being crucial for addressing malnutrition (DOH, 2013a; Du Plessis & Pereira, 2013; Swart *et al.*, 2008). However, systematic stakeholder identification, analysis and engagement are uncommon practice – as are research methods on these processes. Indeed, there is limited research and documentation on MSPs and exploration of stakeholder commitment and capacity to address nutrition issues at national and local levels in the country (DPME, 2014; WHO, 2010a).

Recognizing the need for multi-sectoral action to address IYCN at implementation level and to engage with many different stakeholders who can impact this issue, this research project was designed to explore whether a systematic stakeholder process can support the

development of commitment and capacity to address IYCN governance at implementation level.

The research concept was considered a potential valuable contribution to the nutrition community in SA, with possible feedback into international agendas. It responds to a documented research call for action-oriented research (“Mode 2” research) to advance the application of nutrition policies, programmes and interventions (Pelletier *et al.*, 2013b; Pham & Pelletier, 2015). It also responds to an expressed need for experiences with stakeholders at local levels around models of engagement and an enabling environment for nutrition actions (Gillespie *et al.*, 2013).

In considering the country’s IYCN landscape, described in Sections 2.9-2.13, the question arises: what would one expect to find during an exploration of commitment and capacity of multiple stakeholders to address IYCN at implementation level?

The chapters to follow will take the reader on a journey to the Breede Valley sub-district, Western Cape Province, South Africa, to answer this question.

### **Chapter 3: Submitted manuscript on data from baseline assessment**

This chapter constitutes a manuscript, entitled:

**“Selected facets of nutrition within the first 1000 days of life in vulnerable South African communities”**

It has been accepted for publication by the South African Journal of Child Health (<http://www.saich.org.za/index.php/SAJCH>).

The main objective of this sub-section of the CNSP baseline survey, reported in the manuscript, was to describe the feeding practices of infants and young children aged 0-23 months, using data gathered in the mentioned communities through an IYCF questionnaire, based on the core WHO validated IYCF indicators (WHO, 2008c). The IYCF practices are discussed within the context of selected anthropometric measurements of mother/caregiver-child pairs to provide a broad profile of nutrition during the first 1000 days of life in the two vulnerable communities in the study area.

The information presented in this manuscript, in part, served as motivation to engage with multiple stakeholders in the Breede Valley sub-district who can influence IYCN. The information was also used in presentations to the stakeholders during the research process to provide background information to the research study and objectives.



## **Selected facets of nutrition during the first 1000 days of life in vulnerable South African communities**

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Keywords: Infant-and-young-child-feeding, breastfeeding, complementary feeding, WHO indicators, anthropometry.

Word count: 3739 (excluding abstract and references)

Tables: 3

### **Acknowledgements**

The project manager, the management team and fieldworkers of the CNSP study as well as the participants are gratefully acknowledged for their contributions. Prof S.E. Drimie is acknowledged for providing insightful comments on drafts of the paper.

### **Source of funding**

The CNSP project received funding from Stellenbosch University's (SU) Food Security Initiative (FSI), which forms part of the SU HOPE project. The first author also received funding from the Fund for Innovative Research in Rural Health (FIRRH) and the Stellenbosch University Rural Medical Education Partnerships Initiative (SURMEPI) [supported by the President's Emergency Plan for AIDS relief (PEPFAR) through HRSA under the terms of T84HA21652] both administered by SU, Faculty of Medicine and Health Sciences.

### **Conflicts of interest statement**

The authors declare that they have no conflicts of interest.

### **Contributions**

LdP and MH conceptualized the research study, assisted in data collection, interpreted the data and drafted the manuscript. MM assisted with interpretation of the data and critical revision for important intellectual content. JN made substantial contributions to data capturing, analysis and interpretation as well as critical revision for important intellectual content. All authors read and approved the final version of the manuscript.

## **Abstract**

**Background:** Optimal nutrition during the first 1000 days of life can reap lasting benefits throughout life.

**Objectives:** To assess infant-and-young-child-feeding (IYCF) practices and mother/caregiver-child anthropometry in two vulnerable Breede Valley communities, Western Cape.

**Methods:** Mothers of children aged 0-23 months (N=322) were interviewed to assess IYCF practices. Anthropometric measurements of mothers/caregivers and children were performed according to standard procedures.

**Results:** Mothers reported early breastfeeding (BF) initiation in 75.2% (n=242/322) of cases. Thirty eight and a half percent (38.5%; n=45/117) of infants <6 months were recorded as exclusively breastfed (EBF). Cross-checking this figure with other research from the area, however, suggests significant over-reporting of EBF. One in five infants <6 months were exclusively bottle fed (19.4%; n=23/117) and 48.4% (n=156/322) aged 0-23 months received bottle feeding in the preceding 24-hours. Eighty four percent (n=36/43) of 6-8 month infants were receiving complementary foods. BF was continued in 32.5% (n=13/40) of children 12-15 months old. In children 6-23 months, 44% (n=90/205) received foods from  $\geq 4$  food groups, 71% (n=145/205) received complementary foods the minimum number of times or more and 44.4% (n=91/205) received a minimum acceptable diet. The prevalence of stunting and overweight in children was 28.9% and 21.79% respectively. The prevalence of overweight in mothers/caregivers was 28.85%; and 33.65% were obese, with a mean waist circumference of 88.63 cm.

**Conclusion:** Indicators showed sub-optimal IYCF practices with child under- and overnutrition co-existing with maternal/caregiver overnutrition. This profile signals a need for urgent and appropriate interventions focussing on the first 1000 days of life.

**Word count: 250**

## Introduction

A growing body of evidence is intensifying the focus and interest around the importance of nutrition during the first 1000 days of life, i.e. from pregnancy up to a child's second birthday.<sup>[1-3]</sup> Achieving good nutrition and healthy growth during this well delineated time-period in the lifecycle has been shown to reap lasting benefits throughout life.<sup>[1-6]</sup> This statement is more profound in view of the findings published in the Lancet Series on Maternal and Child Nutrition, 2013<sup>[7]</sup> stating that maternal and child malnutrition is persistent and encompasses both undernutrition and a growing problem of overweight and obesity in low- and middle-income countries. Concerted efforts should therefore be made to curb malnutrition in women of childbearing age as well as newborns and young children.<sup>[7]</sup>

It is very important to assess infant-and-young-child-feeding (IYCF) practices on a continuous basis in order to act on problem areas appropriately and timeously.<sup>[8]</sup> A World Health Organisation (WHO) Working Group developed valid and reliable indicators to assess IYCF practices.<sup>[9]</sup> These indicators focus on selected food-related aspects of child feeding that could be measured using data from population surveys.<sup>[9,10]</sup> It was mainly designed for use in large-scale surveys or national programmes, but it was proposed that it could also be used in smaller local and regional programmes.<sup>[9]</sup> The United Nations Children's Fund (UNICEF) Programming Guide (2011) recommends that these WHO indicators be used for the situation assessment in the core process in development, planning and implementation of a comprehensive approach to improving IYCF.<sup>[8]</sup>

A review of the IYCF practices around the world, using data derived from 86 developing countries with trend data on key indicators, painted a dismal picture.<sup>[8]</sup> The global rate for early initiation of breastfeeding remains below 40% and the rate of exclusive breastfeeding (EBF) during the first 6 months of life has only increased slightly (33 to 38%) over the past decade. The global data is showing very slow advancement in improving overall EBF, but countries that have shown strong commitment and have devoted serious attention to improving IYCF have shown significant progress.<sup>[8]</sup>

There is a less clear global picture for complementary feeding, since the indicators to measure this were finalized after those for breastfeeding.<sup>[9]</sup> However, according to the State of the World's children (2010) report, in developing countries only 58% of breastfed children aged 6-9 months old had received any complementary foods in the previous 24 hours.<sup>[11]</sup> When stunting figures (29% on a global level in 2010) are reviewed to inform this picture, it becomes evident that a large proportion of young children are not receiving a varied diet on a frequent basis.<sup>[11]</sup>

South Africa (SA) is classified as one of the 36 high burden countries for child malnutrition; with specific reference to a stunting prevalence of higher than 20%.<sup>[12]</sup> In the absence of trend data on IYCF in SA, other information and indices have to be used to inform the IYCF profile. The anthropometric status of young children in SA (i.e. >20% stunting, ~10% underweight and >30% overweight and obesity combined) is coupled with the presence of micronutrient malnutrition; including deficiencies in vitamin A, iron and a range of other micronutrients.<sup>[13,14]</sup> National breastfeeding data for SA is scarce, but there are reports of 88% of mothers initiating breastfeeding after birth.<sup>[15]</sup> The very low rates of reported EBF of ~8% at six months of age is of concern.<sup>[15]</sup> The majority of infants are formula fed or mixed fed and more than 70% receive other fluids and foods before the age of six months.<sup>[15,16]</sup>

Female overweight and obesity (25% and 40% respectively) in SA described in SANHANES-1, are also of concern.<sup>[14]</sup> Coupled with a vitamin A deficiency (VAD) prevalence of 13%, which indicates a moderate public health problem and anaemia prevalence of 23%, SA

women of childbearing age (15 years and older)<sup>[14]</sup> face a predicament in the context of maternal nutritional health and resultant birth outcomes.<sup>[7]</sup>

The Community Based Nutrition Security Project (CNSP) of the Division of Human Nutrition, Stellenbosch University, investigated the community food security situation in two vulnerable communities (Avian Park and Zweletemba) in the Breede Valley sub-district, Western Cape Province. This baseline survey provided an opportunity to investigate, among other, IYCF practices at household level in this area.

The main objective of this sub-section of the CNSP baseline survey was to assess the feeding practices of infants and young children aged 0-23 months with the core WHO validated indicators. The IYCF practices will be discussed within the context of selected anthropometric measurements of mother/caregiver-child pairs.

### **Study design and sample selection**

A descriptive cross-sectional study was conducted. The sampling frame of the CNSP baseline survey consisted of all households within the selected communities. A simple random selection of households was performed. Households with young children (0–36 months) were the basic unit for selection and assessment in the CNSP study. A qualifying household was defined as “any household with at least one child (0–36 months) and mother/primary caregiver pair”. Age was verified with a birth certificate or Road-to-Health-Booklet (SA tool to assess and monitor the health status of children younger than 5 years). In situations where more than one household lived at an address and both households had a qualifying mother/primary caregiver-and-child pair, participation was determined through random selection.

Participants were stratified according to age (0–11 months, 12–23 months and 24–36 months) If more than one qualifying mother/primary caregiver-child pair in a household qualified for inclusion, the participating pair was randomly selected. The same procedure was followed if more than one child of the same mother/primary caregiver qualified for inclusion. Households with infants or children between the ages of 0-36 months, who resided in Zweletemba or Avian Park for at least 27 weeks of the year, were eligible for inclusion.

#### *Sample Size*

A power analyses on one way Anova with a 5% significance design provided 90% power with a sample size of 170 per group (2 groups in two areas). To allow for a response rate of 85%, the total sample size was calculated at 200 per group per area. The final, slightly oversampled, sample size of the CNSP study was 443 mother/primary caregiver and child pairs. For the focus of this article, complete data was captured for 322 infants/young children in the age range 0-23 months (n=117 aged 0-6 months; n=205 aged 6-23 months), and a total of 312 for the mothers/caregivers.

### **Methodology**

The complete methodology of the CNSP baseline survey is described in the parent protocol (Ethics Committee Ref nr: N10/11/368).

The assessment of IYCF practices for children aged 0-23 months as well as a description of selected demographic and anthropometric data for these children and their mothers/caregivers will be provided here.

*IYCF Questionnaire*

A one-page questionnaire consisting of ten questions was formulated based on the wording of the eight WHO validated IYCF core indicators<sup>[9]</sup> (Table 1; column 1).

**Table 1: Definitions and calculation of WHO core indicators for assessing infant and young child feeding practices**

Definition of indicator	Calculation
1. <b>Early initiation of breastfeeding:</b> Proportion of children born in the last 24 months who were put to the breast within one hour of birth	Children born in the last 24 months who were put to the breast within one hour of birth <hr/> Children born in the last 24 months
2. <b>Exclusive breastfeeding under 6 months:</b> Proportion of infants 0–5 months of age who are fed exclusively with breast milk	Infants 0–5 months of age who received only breast milk during the previous day <hr/> Infants 0–5 months of age
3. <b>Continued breastfeeding at 1 year:</b> Proportion of children 12–15 months of age who are fed breast milk	Children 12–15 months of age who received breast milk during the previous day <hr/> Children 12–15 months of age
4. <b>Introduction of solid, semi-solid or soft foods (complementary foods):</b> Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods	Infants 6–8 months of age who received solid, semi-solid or soft foods during the previous day <hr/> Infants 6–8 months of age
5. <b>Minimum dietary diversity:</b> Proportion of children 6–23 months of age who receive foods from 4 or more food groups	Children 6–23 months of age who received foods from $\geq 4$ food groups during the previous day <hr/> Children 6–23 months of age
6. <b>Minimum meal frequency:</b> Proportion of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more.	Breastfed children 6–23 months of age who received solid, semi-solid or soft foods the minimum number of times or more during the previous day <hr/> Breastfed children 6–23 months of age and Non-breastfed children 6–23 months of age who received solid, semi-solid or soft foods or milk feeds the minimum number of times or more during the previous day <hr/> Non-breastfed children 6–23 months of age
7. <b>Minimum acceptable diet (Summary)</b>	Breastfed children 6–23 months of age

<p><b>infant and young child feeding indicator):</b> Proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk).</p>	<p>who had at least the minimum dietary diversity and the minimum meal frequency during the previous day</p> <hr/> <p>Breastfed children 6–23 months of age and</p> <p>Non-breastfed children 6–23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day</p> <hr/> <p>Non-breastfed children 6–23 months of age</p>
<p>8. <b>Consumption of iron-rich or iron-fortified foods:</b> Proportion of children 6–23 months of age who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home.</p>	<p>Children 6–23 months of age who received an iron-rich food or a food that was specially designed for infants and young children and was fortified with iron, or a food that was fortified in the home with a product that included iron during the previous day</p> <hr/> <p>Children 6–23 months of age</p>

(Source: WHO, 2008)

It also included two questions on bottle feeding from the optional indicators. The questionnaire had to be administered time-efficiently, since the anthropometric measurements and interviews (including socio-demographic questionnaire, household food insecurity access scale, food frequency questionnaire, hunger questionnaire and a dietary diversity questionnaire for mothers and children) of the broader CNSP baseline survey took approximately two hours to complete.

All questions were based on recall of the previous day, except for “*breastfeeding initiation*” which was based on historic recall and “*does your baby receive any of the following (iron sources)*” which was based on usual practice. The age range for the questions was 0-23 months, divided into specific monthly intervals, as appropriate to capture information for the different indicators. All questions could be answered either by “yes” or “no”.

#### *Training of fieldworkers, pilot study and data collection*

Women were recruited from the two communities included in the study to act as fieldworkers. These fieldworkers were trained and standardised to administer the IYCF questionnaire, together with other questionnaires within the broader CNSP survey.

Height/length and weight measurements of children and the weight, height and waist circumference (WC) measurements of mothers/primary caregivers were taken by two dietitians aided by two trained assistants, according to standard procedures.<sup>[17,18]</sup>

A pilot study was conducted in March 2011 over a period of one week in order to test the face and content validity of all the questionnaires. Data collection took place between March and July, 2011. During data collection, questionnaires were checked for completeness and accuracy by CNSP research staff.

#### *Data analysis*

Data were captured in Microsoft Excel and analysed using SAS 9.3 (2002–2010), SAS Institute Inc. Cary, NC, USA.<sup>[19]</sup>

IYCF indicators were calculated as prescribed in the “Indicators for assessing infant and young child feeding practices: Part I” (Table 1; column 2) document.<sup>[9]</sup> Demographic data and indicators were described using means, standard deviations and percentages.

Children’s ages, weights and heights were used to calculate length/height-for-age Z-scores (HAZ), weight-for-age Z-scores (WAZ), weight-for-length/height Z-scores (WHZ) and BMI-for-age Z-scores (BAZ) using WHO Anthro (version 3.2.2) software (StatSoft. 2013).<sup>[20]</sup> Data were interpreted with WHO child growth standards and cut-off values<sup>[21]</sup> (Table 2; columns 1 and 2).

**Table 2: Description and prevalence of nutritional disorders in children 0-23 months old**

<b>Nutritional disorder</b>	<b>Description</b>	<b>Total children (n=312)<sup>†</sup></b>	<b>Percentage</b>
Stunting	Length/height for age Z-score (HAZ) of equal or less than –2 SD of the WHO child growth standard median	93	28.81
Underweight	Weight for age Z-score (WAZ) equal or less than –2 SD of the WHO child growth standard median	15	4.81
Wasting	Weight for length/height Z-score (WHZ) equal or less than –2 SD of the WHO child growth standard median	3	0.96
Overweight	Weight for length/height Z-score (WHZ) equal or more than +2 SD of the WHO child growth standard median	68	21.79

Source/Reference for column 2: Description of nutritional growth disorders in children (WHO Multicentre Growth Reference Study Group, 2006)

<sup>†</sup>Number of children (n=312) differs from total number of data for 0-23 month old babies (n=322), due to anthropometric measurements not being possible in 10 children.

Adult women’s body mass index [BMI = weight (in kg) / height (in m<sup>2</sup>)] were interpreted using the WHO Consultation on Obesity classification (1999) i.e.: underweight (BMI <18.5 kg/m<sup>2</sup>), normal weight (BMI = 18.5–24.99 kg/m<sup>2</sup>), overweight (BMI = 25–29.99 kg/m<sup>2</sup>) or obese (BMI ≥30 kg/m<sup>2</sup>) as well as waist circumferences with a cut-off point of 88 cm indicating a substantially increased risk of metabolic complications.<sup>[22]</sup> The cut-off used for maternal short stature is a height measurement of <1.45 m.<sup>[23]</sup>

*Ethics and Legal aspects*

Ethics approval was granted for the CNSP baseline survey from the Health Research Ethics Committee, Faculty of Medicine and Health Sciences, Stellenbosch University (Ref nr: N10/11/368). The consent form was explained and written informed consent was obtained from the mothers of the infants/young children. This document was available in the three official languages of the Western Cape, i.e.: English, Afrikaans and isiXhosa. Participants were ensured of the anonymous nature of the interviews. Confidentiality was ensured by not recording any personal identification on records and anonymity was ensured by referring only to the group as a whole and not to individuals or individual findings.

**Results***Selected demographic - and anthropometric data of mothers and children*

The average age of the mothers/caregivers of children aged 0-23 months was 29.5 years (9.67SD) and that of the children was 9.85 months (7.11SD). Of the mothers/caregivers, 89% (n=278/312) were the children's biological mothers and 11% were caregivers (grandmothers/day-mothers).

The mean BMI of mothers/caregivers was 28.52 kg/m<sup>2</sup> (SD 7.98). The prevalence of underweight was 4.17%; normal weight was 33.33%; overweight was 28.85% and obesity 33.65%. A mean waist circumference of 88.63 cm (SD 16.89) was measured in mothers/caregivers of children aged 0-23 months. Mean maternal/caregiver height was 1.56 m (SD 0.073).

The prevalence of stunting, underweight, wasting and overweight (Table 2) in children aged 0-23 months was 28.9%, 4.8%, 0.96% and 21.79% respectively.

*Infant and Young Child Feeding (IYCF) practices*

Breastfeeding initiation within one hour after birth was calculated as 75.2% (n=242/322) of the sample. Thirty eight and a half percent (38.5%; n=45/117) of the infant population younger than 6 months were recorded as being exclusively breastfed (EBF). Breastfeeding was continued in 32.5% (n=13/40) of babies 12 to 15 months of age.

Babies 0-6 months old who received exclusive bottle feeding were calculated as 19.4% (n=23/117). Babies aged 0 to 23 months who received bottle feeding in the preceding 24 hour period were calculated as 48.4% (n=156/322).

Eighty four percent (n=36/43) of infants 6 to 8 months of age received solid, semi-solid or soft foods. The proportion of children 6 to 23 months of age who received foods from 4 or more food groups was calculated at 44% (n=90/205). These food groups included: 1) grains, roots, tubers [e.g. bread, cereal, cooked porridge or potato]; 2) legumes and nuts; 3) dairy products, excluding breastmilk (milk, yoghurt, cheese); 4) meat, fish, poultry and liver/organ meat; 5) eggs; 6) Vitamin A rich fruit and vegetables [sweet potato, carrots, pumpkin, butternut, spinach, broccoli, apricot, peach, mango]; 7) other fruits and vegetables.

The proportion of breastfed and non-breastfed children 6 to 23 months of age who received solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more were calculated at 71% (n=145/205). The proportion of children 6 to 23 months of age who received a minimum acceptable diet (apart from



breastmilk) was determined to be 44.4% (n=91/205). Eighty nine percent (n=182/205) of children 6 to 23 months old received iron in a food or supplement form; with 56% (n=114/205) receiving iron-rich food/s, 42% (87/205) receiving a multi-vitamin containing iron and 53% (n=109/205) receiving baby cereal or foodstuffs manufactured for babies containing iron.

## Discussion

In this sub-section of a larger research project, sub-optimal IYCF practices and poor anthropometric profiles were found in mother/caregiver-child pairs in two vulnerable communities in the Breede Valley, Western Cape Province.

Early initiation of breastfeeding in three quarters of new born babies, was lower when compared to the national figure (88%)<sup>[15]</sup>, but corresponds with data derived from a sub-study of the CNSP, where 77% of mothers with babies aged 0-6 months reported initiating breastfeeding early.<sup>[24]</sup> Early initiation of breastfeeding holds many documented benefits<sup>[25]</sup> and should be a supported practice at various points of contact with pregnant and breastfeeding mothers, including in ante-natal and postnatal clinics and maternity wards.<sup>[26]</sup>

Considering the very low average EBF for SA (~8%)<sup>[15]</sup>, the reported EBF rate in this study, of more than a third of babies aged younger than six months, probably better reflects predominant and partial breastfeeding.<sup>[24]</sup> Similarly, when the data gathered from the IYCF questionnaire were checked for consistency against data derived from a dietary diversity questionnaire (DDQ), administered on mother/caregiver-child pairs within the broad CNSP baseline study, 35% of babies aged younger than six months were recorded as being exclusively breastfed. However, a more in-depth assessment of breastfeeding practices in the younger age group (0 to 6 months) in the same communities suggests significant over-reporting of EBF with both the DDQ and the WHO indicator.<sup>[24]</sup> Previous work in SA has shown that the term “EBF” was not well understood or practiced.<sup>[27,28]</sup> In this study area it is possible that the term was either not well understood or it was known and participants reported on what should be done rather than their own practices. Furthermore, it is acknowledged that the EBF indicator lacks sensitivity (i.e. it may commonly classify children as exclusively breastfed who may have received non-breastmilk liquids or foods prior to the survey) and therefore overestimates the proportion of exclusively breastfed infants.<sup>[9]</sup> This overestimation of EBF rates by 1-day recall measures has been observed previously.<sup>[29-31]</sup> In-depth questioning around this specific aspect of infant feeding should therefore be stressed in field research for calculation of this indicator.

Only about a third of babies were reported as still being breastfed at 12 to 15 months of age, falling far short of the WHO recommendation of “*continued breastfeeding up to two years of age and beyond*”.<sup>[32]</sup>

One in five babies received bottle feeding from birth and were never breastfed, and almost half of babies aged 0-23 months received bottle feeding during the previous 24 hours. Bottle feeding does not provide a safe alternative to breastfeeding in SA, mainly because of poor caregiver knowledge and education, as well as lack of resources that result in poor hygiene and suboptimal IYCF practices.<sup>[33]</sup> Furthermore, the development of undernutrition as well as overweight and obesity have also been linked to formula feeding, with practices of dilution and overconcentration/overfeeding, respectively.<sup>[34,35]</sup>

Infants between 6 to 8 months of age should be receiving solid, semi-solid or soft foods; however, about a third of babies in this study did not receive complementary foods in the preceding 24 hours. Almost half of the children 6 to 23 months of age received a diverse diet of minimum acceptability. The mean dietary diversity score (DDS) for children 6 to 35 months, calculated from the broader CNSP dataset was 4.16, indicating a diet of adequate diversity (Table 3).

**Table 3: Dietary diversity scores of children, reported for five age categories (N=307)**

<i>Age categories</i>	<i>6 – 35.9 months</i>	<i>6 – 12.9 months</i>	<i>13 – 23.9 months</i>	<i>23.9 – 35.9 months</i>	<i>6 – 23.9 months</i>
<i>Number of children (n)</i>	307	87	108	112	195
<i>Mean (SD) dietary diversity scores</i>	4.16 (1.61)	3.26 (1.35)	4.43 (1.53)	4.60 (1.62)	3.91 (1.56)

However, in the age group 6 to 12 months the dietary diversity score was 3.26, and in the age group 6 to 23 months the dietary diversity score was 3.91. Both these values are below a score of 4, indicating insufficient dietary diversity.<sup>[36]</sup> This corresponds with the low percentage of children aged 6-23 months, who received foods from 4 or more food groups, as calculated with the related WHO indicator.

A review of complementary feeding practices in SA highlighted the fact that the early introduction of liquids and solid foods are common practice in the country. Studies show that liquids and/or solids are introduced as early as the first few days after birth, with an average age of introduction between two to three months of age.<sup>[16]</sup> Similar findings were reported in qualitative sub-studies of the CNSP baseline survey.<sup>[37,38]</sup> This situation leads to poor breastfeeding practices and a resultant poor start to complementary feeding practices. Low dietary diversity and frequency of feeding lead to young children not receiving a minimum acceptable diet for their age. Data from the Breede Valley mirrors the assessment of complementary feeding practices in SA<sup>[16]</sup> and is of great concern, since the complementary feeding time period presents a critical window of opportunity to foster good eating habits and ensure better health outcomes in later life.<sup>[1-3]</sup> Furthermore, poor complementary feeding has been identified as a risk factor directly associated with stunting,<sup>[39]</sup> which makes the timing of introduction of solids as well as the diversity and frequency of feeding so much more important in the SA context.

Intake of iron rich food and/or supplements in the studied communities seems acceptable. This data corresponds with SANHANES-1 data; which has attributed this improvement at national level to the SA food fortification programme enacted in 2003.<sup>[14]</sup> However, the question in the IYCF questionnaire posed to mothers/caregivers in the Breede Valley communities specifically listed the following options for iron rich food and/or supplements: i) meat, fish, poultry and liver/organ meats; ii) baby cereal or other special baby food enriched with iron; iii) multi-vitamin syrup [containing iron] or iron drops; and did not include bread and maize meal, i.e. staple foods fortified by law in SA.<sup>[40]</sup> Children in the studied communities seem to have adequate dietary iron intake from the mentioned sources.

In the Breede-Valley sub-study, anthropometric indices indicated that maternal overnutrition and child undernutrition, particularly stunting, as well as child overnutrition co-existed. A high prevalence of overweight and obesity of mothers/primary caregivers coupled with a high mean waist circumference indicate an increased risk for non-communicable diseases. When the IYCF practices and child anthropometric profile are considered parallel to the maternal anthropometric profile, it is clear that nutritional practices in the first 1000 days of life places the future development, growth and health of children in the Breede Valley in serious jeopardy.

Studies conducted in other provinces of SA also indicated the co-existence of stunting and overweight/obesity in children younger than five years.<sup>[35,41,42]</sup> Furthermore, the co-existence of overweight and obesity in mothers/caregivers and undernutrition, particularly stunting, in children have also been reported<sup>[43-45]</sup> This presents evidence of a worrying double burden of malnutrition in SA communities undergoing a nutrition transition.<sup>[16]</sup>

The National *Department* of Health's (DOH) Integrated Nutrition Programme (INP) for SA has focussed on furthering the maternal and child nutrition agenda over the past two decades.<sup>[28]</sup> However, a recent independently prepared report on the "*Evaluation of Nutrition Interventions for Children from Conception to Age 5*" highlighted the limited progress SA has made in improving child nutrition over the past 20 years.<sup>[46]</sup>

The report goes on to state that, although the Departments of Health, Social Development (DSD), Agriculture, Forestry and Fisheries (DAFF) as well as the Department of Rural Development and Land Reform (DRDLR) each have sufficient policies, regulations, and strategies to guide their respective portfolios of nutrition interventions, evidence points to unequal commitment to nutrition across departments with varying levels of leadership, management, planning, budgeting, and staffing.<sup>[46]</sup>

Various recommendations are made in the report to address the current situation, including; elevating the status of the INP within the national and provincial government structures with a well-developed Nutrition Plan that includes nutrition output in a delivery agreement across all sectors. It is also recommended that common indicators should be developed for tracking food and nutrition across all sectors with measurable targets over the short, medium, and long-term, and a consolidated monitoring and evaluation framework for tracking delivery and the effects of nutrition interventions.<sup>[46]</sup>

These recommendations support the collection of data relevant to the construction of the WHO IYCF indicators which should be included in community-based research projects, larger scale population studies in SA, including the Demographic and Health Survey and follow-on SANHANES, as well as the country's District Health Information System (DHIS)<sup>[28]</sup> It has been proposed in the updated SA IYCF policy (2013) that the following indicators: 1) percentage of mothers initiating breastfeeding within one hour after birth; 2) percentage of babies exclusively breastfed at 14 weeks and 3) percentage of infants 0-6 months exclusively breastfed; should be calculated from information gathered in surveys and the 14 week data through the DHIS.<sup>[47]</sup> The potential to monitor more indicators should be investigated and supported,<sup>[28]</sup> especially in the light of the recommendations made in the evaluation report.<sup>[46]</sup>

### **Limitations of the study**

Although the WHO indicators used to assess IYCF are valid and reliable, the questionnaire used in this study was not validated. This limitation warrants a separate study and was beyond the scope of the current study.

### **Conclusion / Recommendations**

It is of utmost importance to optimize infant nutrition and growth, especially in the first 2 years of life. Although indicators have limitations, they provide a good starting point for decision makers to implement appropriate interventions.<sup>[47]</sup> IYCF indicators applied in a household survey, among children aged 0-23 months, in the Breede Valley indicated sub-optimal IYCF practices. Anthropometric indices indicated that maternal overnutrition and child under- and overnutrition co-exist. The combined anthropometric - and IYCF practices profile points to poor nutrition during the first 1000 days of life of infants and young children from these communities.

Valuable experience was gained working with the IYCF indicators at service delivery level. It is recommended that the National and Provincial Nutrition Directorates in collaboration with other government departments strengthen the use of at least some of the core set of WHO IYCF indicators in the DHIS, community-based research projects as well as larger scale population studies in SA.

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## **Chapter 4: Methodology**

## **4.1 Introduction**

IYCF indicators measured in the CNSP baseline survey among children aged 0-23 months in the Breede Valley indicated sub-optimal IYCF practices. Anthropometric indices indicated that maternal overnutrition and child under- and overnutrition co-exist. The combined anthropometric - and IYCF practices profile points to poor nutrition during the first 1000 days of life of infants and young children from these communities (Chapter 3).

The poor profile of selected aspects of nutrition during the first 1000 days of life in two vulnerable communities in the study area (Chapter 3), served as motivation to identify key stakeholders who can impact IYCN in the Breede Valley. Thereafter, stakeholders were engaged in initial stages of an MSP to explore their commitment and capacity to address IYCN at implementation level.

Stakeholder processes form part of a shared journey of understanding about how best to approach a specific issue in a given context. Stakeholder analysis draws on theories and methodologies in business management and policy studies and consists of participatory approaches for systematic stakeholder identification, differentiation and engagement (Reed *et al.*, 2009). These methods and practices have become progressively popular in various organisations in many different fields (Reed *et al.*, 2009). As mentioned in Chapter 2, in the global and national nutrition spheres', international stakeholders including donors, governments, and non-governmental organizations have also widely promoted MSPs (IFPRI, 2014a; Schiffer, 2007).

### **4.1.1 Purpose of stakeholder identification, analysis and engagement**

A stakeholder analysis identifies persons who can impact certain situations or can be impacted upon. It helps with unpacking power relationships and informs the following questions: "Whose opinion holds sway? Who can tell or contribute to the story of the community?" It also looks at interrelatedness issues, priorities and degrees of impact of different parties (DFID, 2002).

The purpose of a stakeholder analysis is to set the stage for engagement. It provides a stakeholder landscape and enables an analysis of relationships between stakeholders. It

offers a tool for preparation for engagement and can assist the scientist with reflection. It also provides assessment of perceptions versus realities (DFID, 2002; Reed *et al.*, 2009). For a stakeholder analysis to be useful, it should be focussed on a specific policy, programme or issue. Information gathered in this way can be valuable and accurate and it can be used to provide input into other analyses, to develop action plans or to guide participatory consensus-building processes (Schmeer, 1999).

Stakeholder identification and analysis are necessary steps at the beginning of any planning process, but it can also be useful as a management instrument. It can be used to monitor and manage change, assess the impacts of management on people, institutions and resources and to identify emerging issues (DFID, 2002; Renard, 2004) In particular, it provides an indication of the possible power struggles among groups and individuals, and helps identify potential strategies for negotiating with stakeholders who are in conflict (DFID, 2002).

The timing of a stakeholder analysis is important in order to ensure the usefulness of the results. In early stages of finalizing policies or programmes, a stakeholder analysis can assist in judging the probability of acceptance and sustainability of expected interventions. When instituted at an opportune time, a stakeholder analysis can inform task team strategies to overcome opposition, build partnerships and channel information and resources to promote and sustain proposed interventions (DFID, 2002).

To increase support or shape agreement for improvement, policy makers and managers must take additional steps following the stakeholder analysis. The information should be used to develop and implement strategic communication, advocacy, and negotiation plans or to hold consensus-building workshops (Schmeer, 1999). This will aid the development of enabling environments for intervention planning. The process of assessing commitment has also been described as a way of building awareness and commitment (Te Lintelo, 2014).

#### **4.1.2 Stakeholder processes from a Public Health Nutrition research and practice perspective**

The increased recognition of the importance of nutrition by different levels of society has expanded the frontiers of nutrition research at the population level. Pelletier and co-authors (2013b) drew from work by Nowohty *et al.* (2001) & Gibbons (1994) in describing these new frontiers in the difference between Mode 1 and Mode 2 research (cited in Pelletier *et al.*, 2013b). As discussed in Chapter 2, the two modes are not mutually exclusive. Mode 1 relates more to conventional research with the aim to generate theoretical or generalizable knowledge and fill gaps in scientific knowledge. Mode 2 involves action-oriented methods with the aim to develop knowledge that can help identify, characterize, and solve real-world problems. The subjects of study are multiple stakeholders and the methods include, among other, stakeholder analysis, social network analysis and influence mapping (Pelletier *et al.*, 2013b). Unfortunately, Mode 2 research still represents a small proportion of the articles published in nutrition journals. Thus there have been appeals recently to expand population nutrition research agendas to more effectively inform and guide the initiation, development, implementation, and governance of policies, programmes and interventions to address the wide-ranging causes of nutrition-related problems (Pham & Pellitier, 2015).

Hughes and Margetts (2012) propose a PHN bi-cyclic practice model to guide the systematic development, implementation and evaluation of nutrition interventions in practice. The model includes three distinct stages and integrates capacity building into a planning cycle approach (Figure 4.1). The first stage, referred to as the “Intelligence” phase is signified by the first wheel of this bi-cycle approach. This first phase includes a community and key stakeholder analysis and engagement process. This entails a needs assessment and analysing the structure and attributes of the community, including the community’s capacity for action in intervention management from the outset (nr 1-8). It emphasises the importance of understanding the attributes, nuances, and cultural and historical context within communities. The “action” phase, depicted as the link between the “intelligence” and “evaluation” phases, concentrates on planning and managing intervention implementation (nr 9-12). The second wheel of the practice bi-cycle includes different types and levels of

evaluation and accentuates the importance of reflective practice and sharing of scholarship (nr 13-17) (Hughes & Margetts, 2012).

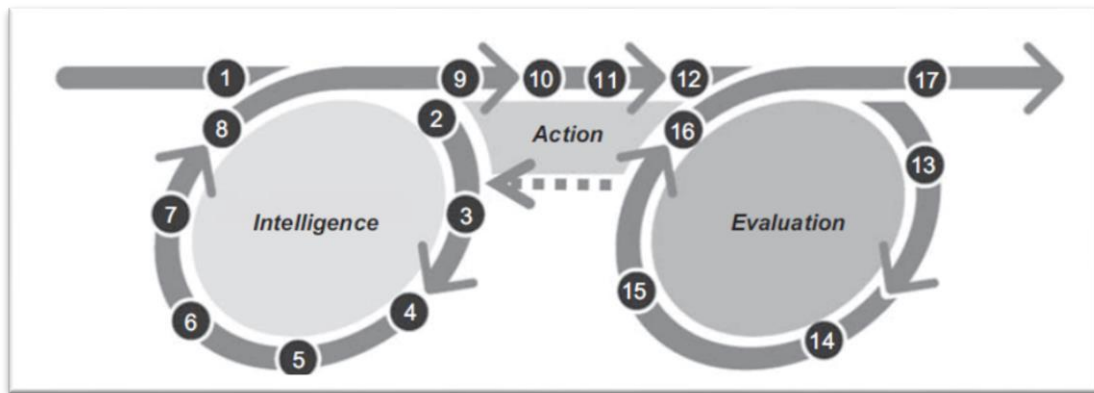


Figure 4.1: The Public Health Nutrition practice bi-cycle. Source: Hughes and Margetts (2012)

Understanding before acting is a key concept to apply in order to uncover “intelligence” in communities which is required to empower and motivate community members and ultimately develop appropriate and sustainable interventions. Undertaking a needs assessment and problem analysis in communities involves gathering and analysing a range of qualitative and quantitative data. Community analysis can also serve as an important foundational step in capacity building. Understanding the nuances in communities through community analysis further aids identification of key stakeholders and sets the scene for community and stakeholder engagement and the follow-on cycles of action and evaluation (Hughes & Margetts, 2012).

As mentioned in Chapter 1 (Introduction) the CNSP baseline project of the Division of Human Nutrition, investigated the community food and nutrition security situation in vulnerable communities (Avian Park and Zweletemba) in the town of Worcester, Breede Valley sub-district, Western Cape Province, South Africa. This project followed a similar approach to the PHN practice bi-cycle, by Hughes and Margetts (2012), which offered an opportunity for initiating an MSP following on from the baseline assessment to link the ensuing phases of intervention planning, implementation, monitoring and evaluation.

To refresh the reader's mind the research question, aim and objectives are repeated in the following section.

## **4.2 Research question, aim and objectives**

### **4.2.1 Research question**

Can a systematic approach to stakeholder identification, analysis and engagement support the development of commitment and capacity to address infant and young child nutrition in the Breede Valley?

### **4.2.2 Aim**

To develop and test an MSP using a stakeholder mapping tool (Net-Map) and other participatory tools, to identify, analyse and engage multiple stakeholders to explore whether such an approach can support the development of commitment and capacity to address IYCN in the Breede Valley sub-district.

### **4.2.3 Objectives**

1. To systematically identify and differentiate between stakeholders
2. To explore the perspectives, commitment and capacity of key stakeholders in relation to IYCN
3. To define relationships among key stakeholders as well as their priorities and powers
4. To critically reflect on the research process and explore local conditions conducive for action on IYCN (i.e. an "enabling environment")
5. To develop a conceptual framework to address IYCN governance at implementation level by initiating, exploring and documenting initial stages of a multi-stakeholder process

## **4.3 Methodology**

### **4.3.1 Research design**

There are various approaches and techniques that can be used for stakeholder analysis and engagement. The particular detail of the approach will depend, among other issues, on what

is to be addressed, the objectives of the process, the anticipated usefulness, cost and time available and expertise – with specific reference to facilitation (DFID, 2002; UNDP, 2006; Schiffer, 2007).

After considering the stakeholder analysis and engagement literature, the researcher decided to use the generally advocated phases in stakeholder analysis design (DFID, 2002; Reed *et al.*, 2009; Schmeer, 1999) as basis for the MSP. This general approach is recommended by development agencies, among other, DFID and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) to undertake development activities and interventions of any kind and size (DFID, 2002; GTZ, 2005). It is also used as a systematic process for collecting and analysing data about key stakeholders in health reform (Schmeer, 1999). Furthermore, it is proposed as a method to complement a specific participatory research tool, NetMap, developed by the International Food Policy Research Institute (IFPRI) (Schiffer, 2007) which was utilised in this research process (detailed in section 4.3.3.3.).

The design includes three steps, i.e.: 1) Identifying stakeholders, 2) Differentiating between and categorising stakeholders and 3) Investigating relationships between stakeholders. It is described by Reed *et al.* (2009) as a typology of suggested steps (Reed *et al.*, 2009) (Figure 4.2.).

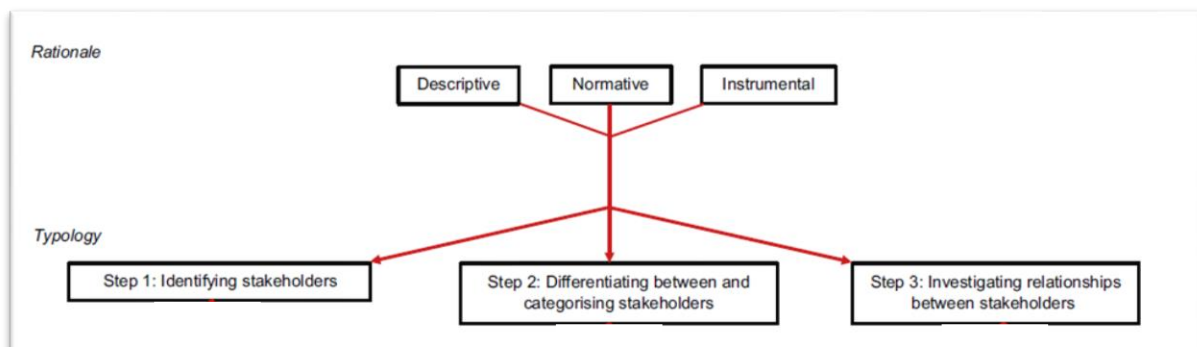


Figure 4.2: Schematic representation of rationale and typology for stakeholder analysis

Source: Reed *et al.* (2009)

During the research process, the researcher came to the conclusion that another step was needed, in addition to the stakeholder analysis steps, i.e. exploring local conditions to strengthen commitment and capacity (elements of an enabling environment) to support

IYCN. Due to the nature of qualitative research, it could not be anticipated from the outset how the research process would unfold; how stakeholders would respond; how much time would have to lapse between phases for meaningful engagement to take effect; and which questions would arise during the research that could still inform the data, without unnecessarily extending the boundaries of the PhD research project. This last added phase would allow for reflection on the entire research process, present a final opportunity to exchange perspectives on IYCN and possible ways of addressing it at implementation level, with a focus on what an enabling environment for IYCN should entail at this level. It was also deemed an appropriate way to do a proper closing of the PhD research process.

The additional step in the research process necessitated a change in the wording of one of the originally formulated objectives.

Objective 4 was previously worded as follows:

- To document how participation in initial stages of an MSP impacts on the perspectives, commitment and capacity of key stakeholders to address IYCN

This objective was consequently reworded, as stated in 4.2.3:

- To critically reflect on the research process and explore local conditions conducive for action on IYCN

A request was made to the Health Research Ethics Committee (HREC) for these amendments, and permission was dually granted (Detailed in section 4.5.2).

#### **4.3.2 Methods**

As mentioned in Section 4.3.1, the general stakeholder analysis design was chosen as basis for this project, with an additional last step: 1) Identifying stakeholders, 2) Differentiating between and categorising stakeholders and 3) Investigating relationships between stakeholders and 4) Reflection on the process and exploring local conditions (elements of an enabling environment) to support IYCN.



Individual interviews and focus group discussion are commonly used methods in the initial steps of the stakeholder process (DFID, 2002; Reed *et al.*, 2009; Schiffer, 2007) and “Importance / Influence or Interest / Influence matrixes” are frequently used to assess the importance and powers of the different stakeholders (DFID, 2002; Reed *et al.*, 2009). Workshops are often used for an initial engagement step, i.e. investigation of relationships between stakeholders (DFID, 2002; Reed *et al.*, 2009; Schiffer, 2007). There are also many other techniques, but the important deciding factor for the choice of method/s would be the usefulness of the technique/s (DFID, 2002) for the given context and the topic under investigation.

To ensure inclusiveness and active participation of all stakeholder groups, the underlying purpose of dialogue and networking is the main focus of stakeholder processes (UNDP, 2006). The various methods for the three step approach are depicted in Figure 4.3. (Reed *et al.*, 2009)

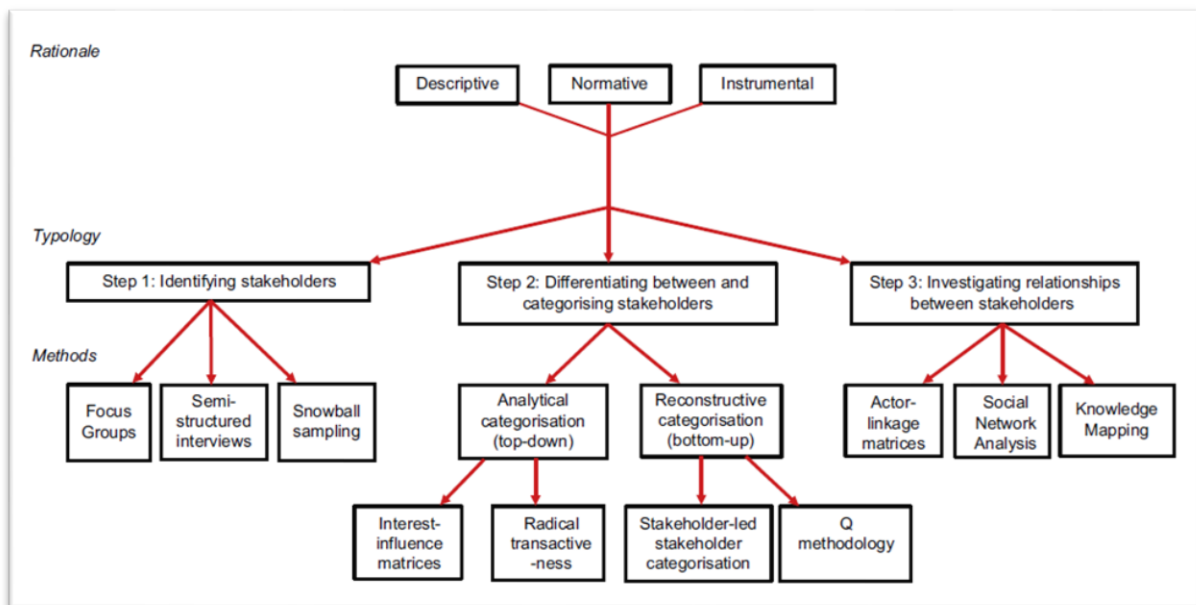


Figure 4.3: Schematic representation of rationale, typology and methods for stakeholder analysis. Source: Reed *et al.* (2009).

In this research study, the researcher wanted to obtain both individual and group perspectives from the different stakeholders about IYCN and how it could be addressed,

since these stakeholders at implementation level have diverse backgrounds with, among other, varied experiences, interests, and focus areas. It was therefore decided that the research process would follow an iterative sequence of focus groups, interviews and group work, with each process linking into the next. The researcher introduced each contact session with a recapping insert from the previous session to link the different phases. This would allow for reflection and time for stakeholders to learn from and about one another. This tactic corresponds with the first three phases of a “U-theory” approach (Figure 4.4), i.e.: Phase 0: Convening, Phase 1: Co-seeing and Phase 2: Co-understanding. These phases include putting available knowledge on the table; reflecting on one’s own understanding, knowledge and experience as it relates to a problem and its solution; learning and appreciating how others might relate to the problem and its solution; and through sharing knowledge and experiences, coming to a common perception of the problem and possible solutions (McLachlan & Garrett, 2008). This theory has been used successfully in the private and public sectors, applying management principles and approaches that can help different sectors work together more closely for planning and implementation (Harris *et al.*, 2014; IFPRI 2014a; McLachlan & Garrett, 2008; Scharmer, 2007).

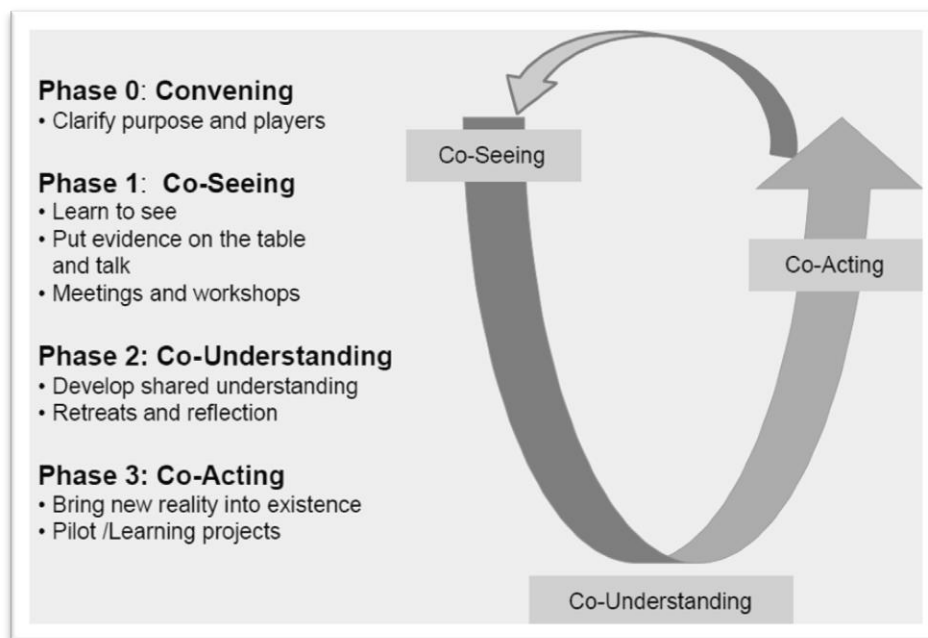


Figure 4.4: “Theory U” with explanation of the different phases of the approach. Source: IFPRI (2014); based on McLachlan & Garrett (2008), adapted from Senge et al. (2004).

Based on the research question, objectives and available methodologies, an approach was designed to guide the research. This is depicted in Figure 4.5, which illustrates the research design, methods applied in the research process as well as the objectives that would be addressed by each step and method or combination of methods.

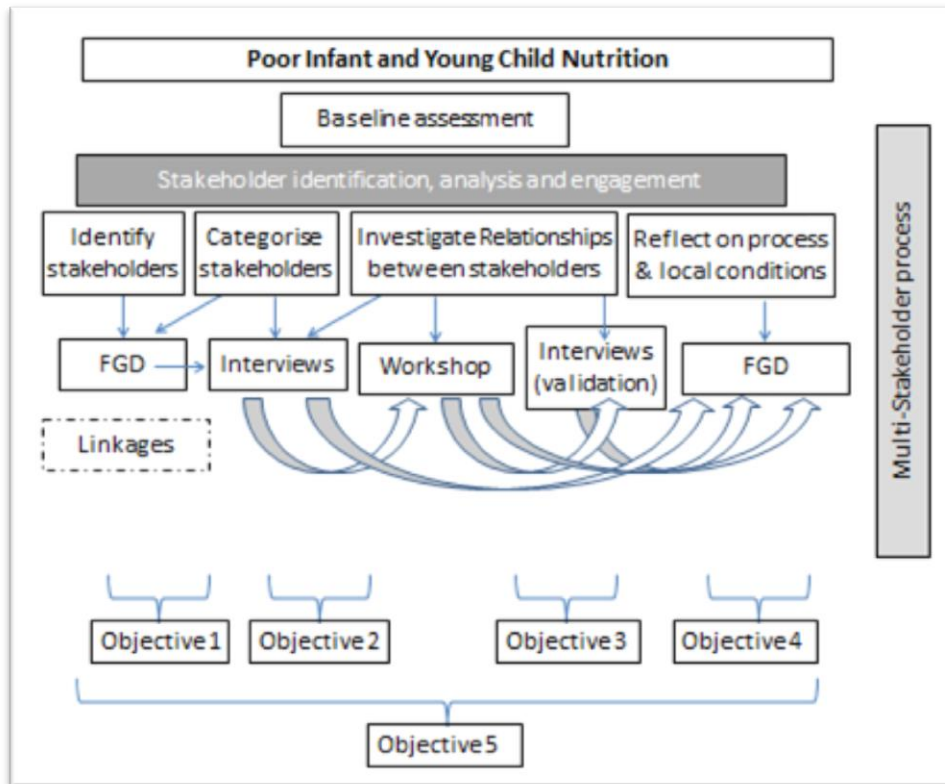


Figure 4.5: Research design and methods applied in the research process to address the objectives of the research study

FGD = Focus Group Discussion

The rationale for the choice of specific methods for the different steps in the research process will now be explained in more detail.

### 4.3.3 Rationale and description of selection of methods

#### 4.3.3.1 Stakeholder identification and differentiation

To ensure that stakeholders were systematically selected and not on an ad hoc basis, the researcher consulted with three senior officials from the sub-district who have extensive knowledge about the study area, including the government, business and community

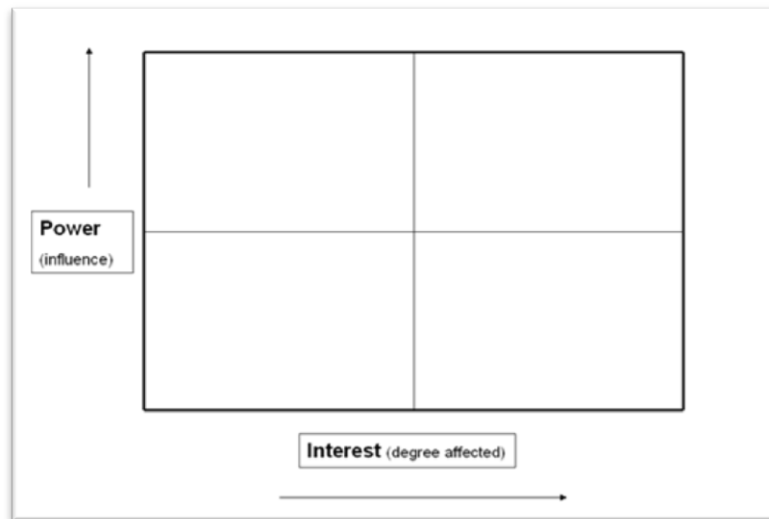
structures along with the nutrition problems of the sub-district. These officials made suggestions of potential people who could identify relevant stakeholders in IYCN at implementation level.

The researcher drew up a list and invited the suggested 9 people to a focus group discussion to identify key stakeholders in IYCN in the study area. The participants were selected based on their specific knowledge of the area, its actors, and the power of those actors to influence the issue at hand. The group who accepted the invitation consisted of 1 senior official from the health sector; 2 representatives from the local municipality, 1 investigator and 2 fieldworkers (community members) involved in the CNSP Phase 1 research as well as 2 key academics/researchers involved with the Worcester campus.

The FGD was organised at a convenient and suitable venue. The researcher welcomed everyone, explained the aim of the focus group discussion and provided background information on the planned research project. She did a short presentation on the importance of the first 1000 days of life and provided a snapshot from the baseline assessment described in Chapter 3. The researcher and facilitator (study leader) led the group discussion and asked that participants volunteer stakeholder groups or names of those who could influence IYCN in the area. One participant suggested that groups of stakeholders should be identified first and then individuals within each group. Ample time (one hour) was allowed for brainstorming and discussion.

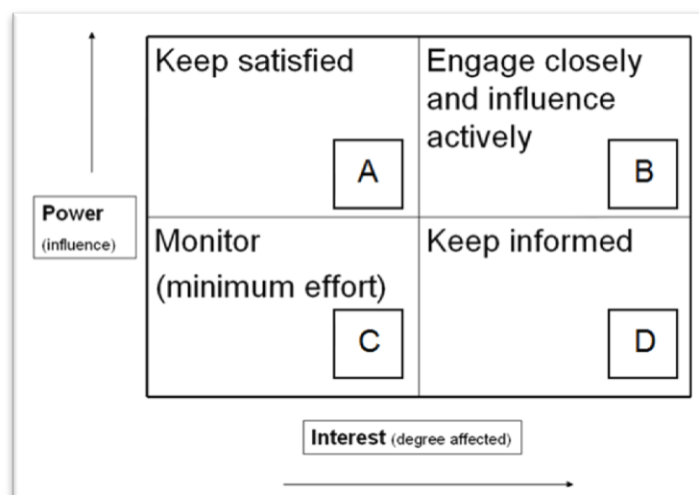
After participants agreed that the list was complete, a Power (Influence) / Interest (P/I) matrix (Table 4.1) was used to differentiate between and categorise stakeholders. The researcher explained the P/I matrix to the group as follows: in a P/I matrix, “Interest” measures to what degree stakeholders are likely to pay attention to IYCN and what degree of interest or concern they have in or about it; “Power” measures the influence they have over IYCN, and to what degree they can help achieve, or block, desired change of these practices (Start & Hovland, 2004) This method was chosen since it complements the social network analysis approach selected for step 3, i.e.: Investigate relationships among stakeholders, elaborated on in Section 4.3.3.3.

Table 4.1: Stakeholder Power/Interest Matrix. Source: Start & Hovland (2004).



Stakeholders with high power and interest are the people or organisations important to fully engage and bring on board (Quadrant B) (Table 4.2). If trying to create change, these people are the targets of any campaign. Stakeholders with high interest but low power (Quadrant D) need to be kept informed but, if organised, they may form the basis of an interest group or partnership which can lobby for change. Stakeholders with low power and low interest (Quadrant C) are unlikely to be a group who needs to be brought on board. Those with high power but low interest (Quadrant A) should be kept satisfied and ideally brought around as patrons or supporters for the proposed change (DFID, 2002; Start & Hovland, 2004).

Table 4.2: Stakeholder Power/Interest Matrix and explanation of quadrants. Source: DFID (2002) and Start & Hovland (2004).



All the stakeholders in box B with the highest power and interest, as well as those on the border of box B; i.e. those with highest power and medium interest, would be included in the sample for further engagement in the planned subsequent research phases.

The chosen methods (FGD and P/I matrix) identified the following stakeholder groups as those with highest power and highest to medium interest to address IYCN in the study area (Box 4.1).

Box 4.1: Stakeholder groups with highest power and highest to medium interest to address IYCN in the study area

- Community members – specifically: grandmothers, crèche owners, sport club organizers, community development workers, politicians, mothers and fathers, the youth, CNSP research fieldworkers
- Cape Winelands District Municipality (Community Development and Planning) and Cape Winelands District Government (Departments of Health, Education and Social Development)<sup>21</sup>
- Higher Education institutions (Stellenbosch University & Boland College)
- The local Business Forum (including private health care)
- Local Media (radio and newspaper)

The participants were thanked for their time and assistance in identifying the stakeholder groups with highest power and highest to medium interest to address IYCN in the study area.

#### *4.3.3.2 Initial stakeholder engagement to explore their perspectives, commitment and capacity in relation to IYCN*

There are various definitions and descriptions for commitment and capacity in the nutrition literature as well as assessments and indices to measure these at global and national levels, as reviewed in Chapter 2. In SA, the WHO LA was done at national and provincial levels, concentrating on the health sector. To the researcher's knowledge, no studies have been

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<sup>21</sup> The Constitution of South Africa sets the rules for how government works. There are three spheres of government in South Africa, i.e.: 1) national 2) provincial and 3) local government. The Department of Provincial and Local Government is responsible for national co-ordination of provinces and municipalities. Provincial departments employ directors and civil servants to do the work of government. Most of the civil servants in the country fall under provincial government, including those in service of DOH, DOE and DSD. Local government is the sphere of government closest to the people. Many basic services (e.g. water and sanitation, electricity, roads and transport, tourism) are delivered by local municipalities and local ward councillors are the politicians closest to communities (<http://www.etu.org.za/toolbox/docs/localgov/webundrstldocgov.html>)

published on the development of quantitative or qualitative methods for the assessment of commitment and capacity for nutrition in multiple sectors at implementation level.

A semi-structured interview guide (Addendum 1) was developed to explore stakeholders' perspectives on IYCN, their opinion on factors impacting on IYCN, their perception of themselves as stakeholders, barriers to fulfilling their roles as well as actions and resources needed to address issues relating to IYCN in the sub-district.

While developing the discussion guide, the researcher took some lead from a statement made by Heaver (2005) that, assessment of stakeholder commitment currently happens *“unsystematically and with more focus on formal policy, than the perspectives and behaviour of key stakeholders* (Heaver, 2005, p14). Since the focus of this study was on stakeholders who were diverse in many different ways, “commitment and capacity” were approached in their broadest terms; commitment being equated to “willingness” and capacity to “ability”. During the interviews, the researcher was mindful of the different forms commitment could take (to name a few: indications of interest and realisation of the importance of the topic; personal or managerial undertakings; existing projects/facilities in communities that have or could have a link with IYCN; nutrition policies and government budgets allocated to nutrition) and considered the numerous forms of capacity needed to successfully scale-up priority nutrition interventions i.e.: i) individual capacity, ii) organisational capacity and iii) systemic capacity), as described in Chapter 2, section 2.7.3. Follow-on questions were posed to explore these elements during the interviews, as the opportunity arose.

Twenty-seven stakeholders, representative of the different stakeholder categories with the highest power and highest to medium interest rating from the stakeholder analysis process, were approached to participate in semi-structured interviews. The researcher made notes during the FGD of some individuals who were already mentioned by name and the CNSP fieldworkers assisted in the identification of community members who fitted the profile as described in Box 4.1. For other key stakeholders, the person with the highest position and formal power in the organisation, or their immediate representative/deputy was approached; i.e. director; chief-director, deputy-director or chairperson. It was decided to include the programme manager of the Integrated Nutrition Programme (INP) in the district

as well, due to the focus of the study touching on one of the main focus areas of the INP, i.e.: IYCN. This person represents the highest level of management for the INP at district level in the Western Cape Province.

Each participant was also asked to plot themselves on the “Power/Interest” matrix (Table 4.1). This was done for cross-checking purposes in order to understand how stakeholders perceived their own power and interest on the topic of IYCN compared to the rating given by the group who identified the stakeholders (section 4.3.3.1). The two power matrixes that were produced (one from the stakeholder identification workshop and one from the individual interviews) were used to inform the stakeholder mapping process detailed in Section 4.3.3.3 and discussed in Chapter 6.

#### *4.3.3.3 Multi-stakeholder workshop to explore relationships and powers*

Following the interviews, a multi-stakeholder engagement workshop was held to investigate relationships between stakeholders as well as their powers to influence IYCN.

A participatory research method, Net-Map, developed by IFPRI could inform step 3 in the stakeholder analysis process (investigating relationships between stakeholders) and was chosen for this phase in the research process for four reasons. Firstly, the characteristics of this method, elaborated on below, made it appropriate for the purposes of this study, secondly the co-study leader has extensive experience in facilitating the Net-Map method; which is a very important deciding factor in the choice of method (DFID, 2002; UNDP, 2006; Schiffer, 2007); thirdly, the research process posed the opportunity to build the researcher’s capacity to learn and apply this method and fourthly, the developers of this tool encourage researchers and practitioners to use the tool and to adapt it to their needs ( Schiffer, 2007).

The Net-Map tool draws on social network analysis, combines it with power mapping and defines relationships among stakeholders as well as their priorities and power (Aberman *et al.*, 2012; Schiffer & Waale, 2008). In particular, Net-Map allows stakeholders to examine not only the formal interactions in the network, but also the informal interactions that cannot be understood by merely studying documents pertaining to specific stakeholders’ positions and constitutions. Apart from developing knowledge about these dynamics, the strength of the



process lies in its openness and the opportunities it creates to build trust among stakeholders through coming to a shared understanding. In this way the process itself is valuable for participants, as it could enable them to gain a more concrete understanding of the networks to which they belong. The visual and tangible methodology can enable concrete discussion of complex and even sensitive topics. Thus, the process generates in-depth qualitative information. Net-Map facilitates insight into the boundaries and structure of a stakeholder network, and distinguishes between influential and peripheral stakeholders. It identifies who has the power to influence what happens, how these parties interact, and based on this information how they might be able to work more effectively together (Schiffer, 2007). The underlying assumption of this method is that coordination will improve decision making by individual stakeholders and that increased collaboration could inspire partnerships and help bring conflict between stakeholders to light (Schiffer 2007).

Net-Map helps people understand, visualize, discuss, and improve situations in which many different actors influence outcomes. By creating maps, individuals and groups can clarify their own view of a situation, foster discussion, and develop a strategic approach to their networking activities. It can also help outsiders understand and monitor complex multi-stakeholder situations. While traditional survey-based approaches collect data about attributes of actors, network analysis focuses on gathering information about the network through which these actors connect (Schiffer & Waale, 2008).

For this step of the research project, the key stakeholders were invited to a stakeholder engagement workshop. Please see Table 4.3 for those who were invited and those who attended the workshop.

A convenient venue was selected for hosting the workshop on a date that suited most stakeholders. The researcher and two expert facilitators (study and co-study leaders) prepared beforehand to conduct the workshop in accordance with the Net-Map methodology. Fourteen stakeholders could attend the session. This was a manageable number according to Net-Map facilitation/practice guidelines which advises 15-20 participants (Aberman *et al.*, 2010).

Table 4.3: Names of stakeholder groups who were invited and who attended the stakeholder engagement workshop

<b>Representatives from the following groups were invited and were present at the meeting</b>
Community members; NGO's & CBO's (4 x Avian Park + 2 x Zweletemba); Political Party (1 x Avian Park) Department of Health (2) Department of Education (2) Department of Social Services (1) Business Forum (1) Higher Education Institutions - University (1 x Rural Clinical School)
<b>Representatives from the following groups were invited, but could not attend the meeting</b>
Community members (3 x Zweletemba; 1 x Avian Park); Political Party (1 x Zweletemba) Department of Social Services (1) Media (1) Community Development & Planning - Cape Winelands Municipality (2) Private Health care (1) Higher Education Institutions - University (1 x Rural Clinical School); Boland College (1 x Nursing)

To ensure that each participant entered the workshop with similar background information, the researcher sketched the IYCN situation to the stakeholders from data gathered during the baseline assessment of the CNSP-parent project (Chapter 3). A summary of the preliminary findings from the in-depth interviews was also presented to the group in order to set the scene for the workshop that followed. This presentation was deliberately used to provide participants with the opportunity to reflect on their own perspectives, but to also begin taking the perspective of others into account. The idea was also to expose them to the perspectives on elements of the broader, holistic and interconnected system that influence IYCN. Questions were taken for clarity.

The facilitator (co-study leader) explained the procedure and expectations of the workshop and indicated that stakeholder relationships, as well as their powers and priorities, would be explored (Schiffer, 2007). The facilitator initiated a discussion in order to determine different roles in relation to IYCN, including the stakeholders' own roles. The first question posed to the group was: *"Who has a role to play to ensure that babies and young children are well fed in this area?"*

Through brainstorming, the participants identified key stakeholders operating in the Breede Valley sub-district and beyond who have a role to play with regards to IYCN. The different stakeholders identified were assigned different colour codes as detailed in Table 4.4.

Table 4.4: Stakeholders who can impact infant and young child nutrition in the Breede Valley sub-district with an identifying colour code assigned to each stakeholder group

Stakeholder names	Colour code
National, Provincial and local Government [Health, Education, Social Services (grants), Treasury, State departments as employers, political parties]	Orange
Community structures [Religious organisations; Community Care workers, NGO's, CBO, crèche community]	Yellow
Employers & Private sector [Farmers, Retail (Worcester mall); Rainbow Chickens; Hextex, Municipality]	Blue
Other [Parents, grandparents, Stellenbosch University, media (national & regional) media (local radio & newspaper); peer groups, sport organisations, cultural practice, global fund]	Red

The facilitator explained how some of these actors could be connected: i.e.: through money/funds; command/authority; information and advocacy (Schiffer, 2007). Hereafter the facilitator and co-facilitator (study leader) invited the participants to form into two groups and to gather around two tables that were positioned at the back of the room.

On each table, a large sheet of empty, white paper was displayed, depicting an imaginary map of the Breede Valley sub-district. At each table there was a set of coloured cards representing all of the actors (Table 4.4), identified by the participants, who have a role to play to ensure that babies and young children are well fed in this area.

The task was to identify different actors on the map (large empty white sheets of paper) and to plot them out. The process was initiated by the group deciding on a particular stakeholder card, placing it on the map and showing where the actors play a role in terms of their influence on IYCN. They were encouraged to move the cards about and to consider how they were connected. Some of the connections/linkages between the actors had been identified during the brainstorming session. Different coloured markers were used to draw specific connecting lines (linkages) between actors (Table 4.5).

These linkages included: money/funds; command/authority; information and advocacy. These different linkages between stakeholders have previously been identified as the most important connections between stakeholders in processes involving a specific policy issue (Schiffer 2007), as in this case, with IYCN as the focus. For practical reasons, it is

recommended that the number of different links be limited to four or five, in order to keep the resulting diagrams manageable and meaningful (Schiffer 2007).

Table 4.5: Linkages between the different stakeholders in the Breede Valley sub-district and beyond with the identifying colour code assigned to each connecting line between stakeholders

Connecting lines indicating linkages between stakeholders	Colour code of connecting lines
Money/funds	Green
Command/authority/power	Red
Information	Blue
Advocacy	Orange

The lines / connections were drawn as one-way or two-way arrows between the different stakeholders indicating whether flow was only in a one-way direction from one stakeholder to another or whether it flowed between stakeholders and therefore in both directions. Through questioning, the two facilitators lead the groups to begin to understand where some of the barriers and breakages occur and possible reasons for sub-optimal IYCN in the Breede Valley. Participants were also asked to indicate the groups with most/least power by drawing the relationships from these groups with thicker or thinner lines. To reinforce the visualisation of where power was concentrated, the participants were encouraged to place “checker rounds” (small discs used in board games) next to the stakeholders they regarded as having the most power.

After about an hour of discussion and placing of cards and drawing of connections between stakeholders, the two groups were asked to report back to the larger group. In some Net-Map processes, computer generated maps are produced after a stakeholder workshop to capture the qualitative (drawing of links) and quantitative data (power/influence “towers”) gathered during the process. The researcher allowed for more interpretation and verbal sharing of the meaning of the connections as well as the most powerful actors on the maps, by the participants themselves. In this way detailed analysis from the participants were enabled. The participants were prompted to think about possible future linkages or existing structures that could be mobilised to include issues of IYCN on their agendas. In this manner

opportunities for strategic intervention were developed and discussed in a participatory way. These qualitative discussions were recorded and used in the final analysis of the maps.

After the workshop, the information from the two Net-Maps was combined to form one visual of the flow of funds, command, information and advocacy between stakeholders who can impact IYCN in the Breede Valley sub-district. Although the groups had different points of departure, all the different actors and the flows among and between them were similarly depicted on the two maps and it was therefore considered acceptable to combine the maps. A detailed analysis of the NetMap will be presented in Chapter 6.

After the workshop the researcher circulated a meeting report via e-mail or hard copy format, as preferred by stakeholders, to verify the content of the report as a factual representation of the workshop proceedings. Follow-up interviews were organised with at least one representative from each stakeholder group for those stakeholders who could not attend the workshop to ask them for their input and comments on the report and map. In this way the combined map was validated by presenting it to stakeholders and discussing it in the post-workshop interviews.

Four post-workshop reflection questions (please see below) were posed to stakeholders who attended the workshop and these questions were incorporated in the follow-up interviews with stakeholders who could not attend the workshop. Since Net-Map is a form of joint analysis, which can lead to thinking around potential solutions, these questions were intended to encourage stakeholders to think about possible solutions, while the Net-Map process was fresh in their minds.

- What did you get from this research process?
- What can you identify as the key levers (influences, powers, control) to try and shift or change this situation of poor IYCF/IYCN in this area?
- What do you think you could do, (short /medium / long term) based on these identified levers?
- What can you commit to doing at this point in time?

#### 4.3.3.4 Focus group discussions/interviews to reflect on research process and explore local conditions conducive for action on IYCN

The methods and discussion guide (Addendum 2) for this step of the research were developed after the stakeholder workshop, validation of the Net-Map and preliminary data analysis. The research team considered the preliminary data from the participatory research process up to this point and discussed one of the research gaps identified in the Lancet (2013) Series:

*“Operational research of delivery, implementation, and scale-up of interventions, and contextual analyses about how to shape and sustain enabling environments, is essential as the focus shifts toward action.” (Gillespie et al., 2013)*

The conceptual question and sub-questions the researcher set for this specific phase of the research, reported in Chapter 7, were:

- What does an enabling environment for IYCN look like at implementation level?
  - What types of issue framing approaches and narratives grab the attention for IYCN in different contexts?
  - Which elements are crucial for an enabling environment at implementation level to create momentum for change in IYCN?
  - Who should be leading the process of change for IYCN at implementation level?

Four focus group discussions and two interviews (in cases where key stakeholders were not available for the focus group discussions) were held with the following groups/individuals:

- Community groups:
  - one for Zweletemba (3 participants)
  - one for Avian Park (5 participants)
- University /Boland College/ Business Forum /DOH (4 participants)
- DOH and DSD (4 participants)
- Interview with DSD
- Interview with DoE (newly appointed person in senior management)

FGD was selected as the primary data collection method since it was felt that the concepts would be best discussed and unpacked in homogenous groups.

The introduction to the focus group discussions / interviews included a reflection about what is known about IYCN in the study area and how the research process had unfolded from the baseline assessment of IYCN (Chapter 3), the stakeholder identification and initial engagement (Chapter 5), a multi-stakeholder workshop as well as follow-up interviews (Chapter 6). This reflection set the scene for the opening question: *“How should we tell the story about IYCF in this area?”* to gauge possible ideas around framing of the narrative.

Following this discussion, the interviewer made the statement that literature indicates that an “enabling environment” is needed to advocate for nutrition. She provided the definition that has been developed for an enabling environment as follows:

*“political and policy processes that build and sustain momentum for the effective implementation of actions that reduce malnutrition”* (Gillespie et al., 2013)

The terms “political and policy” as well as “enabling environment” were discussed in simpler terms in cases where this terminology was not well understood by groups or individuals.

The groups / individuals were also informed that it is acknowledged in the literature that there is no definition for “enabling environment” at implementation level. The follow-on question was then explored: *“How would you describe an enabling/supportive environment to create momentum for change in IYCN in the Breede Valley?”*

The researcher listened carefully for vocabulary, descriptions or discussions involving the three linked elements identified that are pivotal in creating and sustaining an enabling environment, i.e.:

- *knowledge and evidence*
- *politics and governance*
- *capacity and resources*

(Gillespie et al., 2013)

The researcher did not refer to any of these elements, but probed discussion that involved these elements. She also paid specific attention to additional elements that were mentioned as critical at implementation level and probed to elicit a clear articulation of these elements. Only after a detailed discussion of this question did the interviewer reveal to the participants the three linked elements. If the elements had not been clearly expressed by the participants up to that point, the interviewer posed questions about the applicability of these elements at implementation level. The groups/individuals reflected on the discussion and referred to the elements as they were seen to be applicable at implementation level. Participants were also prompted to think of any key additional elements present or required at implementation level, if none or few had been mentioned up to this point.

A final question was explored: *“Who should be creating / shaping enabling environments to address IYCN at this level? Who should be leading the agenda for IYCN?”*

The researcher also encouraged any additional and last perspectives and opinions.

The researcher thanked the participants for their participation and time. She also informed them that this FGD/interview concluded the specific part of the larger research project, but that the parent project was still continuing.

#### **4.4 Reducing bias in qualitative research**

When conducting qualitative research, it is important to be aware that the researcher is the primary research instrument (Britten, 2006). This could lead to potential biases, including issues from personal background, previous experiences or motives for doing the research which could in turn cloud the interpretation of findings, data analysis and interpretation (Davies, 2007).

As mentioned in Chapter 1, the researcher worked for Department of Health as community dietitian before joining Stellenbosch University in a community nutrition lecturer’s position. While working in these positions the researcher crossed paths with at least four of the participants who were identified as “stakeholders” through the research process. They never worked together directly, but had engaged in trainings sessions, meetings or at shared



platforms (e.g. rural campus). In order to reduce biases, the researcher prepared in advance for each data collection encounter while being mindful of her roles as colleague, lecturer and researcher. Previous similar encounters where she had to move between roles (lecturer, colleague and postgraduate student) helped her in switching between roles and the training courses she attended also aided this process. Keeping a personal reflective journal and verbalising some of the initial concerns of switching between the different roles to her study leaders, helped her to stay focussed on the objectives of the research study.

The researcher experienced some fears about the research process. She realised that the fears were based on assumptions about the participants' possible feelings towards the importance of the research. She was expecting that people would be hesitant to offer their time for the various planned steps in the research process. Although there were instances when participants could not commit to certain meetings / engagements, they allowed her time for follow-up individual meetings. This exceeded her expectations of this diverse group of stakeholders' commitment to engage around the topic of IYCN and research in general.

## **4.5 Ethical and legal aspects**

### **4.5.1 Ethical considerations in research**

The primary duty of protecting the rights and welfare of research subjects and ensuring the scientific quality of research rest with the investigator/s. Ethical guidelines assist both investigators and ethical review committees in acting responsibly. Appropriate design and administration of research protocols, including the processes for obtaining consent, data collection and communicating research findings, should be guided by principles of research ethics (CIOMS, 2008). Principles of research ethics are summarised below.

#### **4.5.1.1 Respect for autonomy**

This principle refers to researchers' obligation to respect the decisions made by independent persons concerning their own lives. It further involves enabling individuals to make informed choices based on reason.

#### 4.5.1.2 Beneficence

Researchers have a responsibility to bring about good in all actions. This involves weighing risks and benefits of specific research actions and to always act in a way that would benefit participants.

#### 4.5.1.3 Non-maleficence

This principle refers to researchers' obligation not to harm others. When the principles of "beneficence and "non-maleficence" are combined, it means that each action must produce more good than harm.

#### 5.5.1.4 Justice

Researchers have a responsibility to treat all participants equally, fairly and impartially. This includes treating all participants in similar positions in a similar manner.

The principles of research ethics, mentioned above, were consciously applied throughout the research process during each engagement with individual participants as well as groups of participants. The only instance where participants were treated differently, were when taxi fare was paid for community members to travel to the interviews and workshop. This compensation was considered to be justified due to the low socio-economic status of the communities the participants resided in. Moreover, personal and professional ethics, including, among other, respect for individuals and groups, trustworthiness and honesty, confidentiality and avoiding potential or apparent conflict of interest were also practiced. To ensure accountability in research ethics, the administrative ethics processes as stipulated by the Human Research Ethics Committee (HREC), Faculty of Medicine and Health Sciences, Stellenbosch University, were also diligently followed, as elaborated in the sections to follow.

#### 4.5.2 Ethical approval of the project

Ethical approval for this research project was granted by the Human Research Ethics Committee (HREC), Faculty of Medicine and Health Sciences, Stellenbosch University (Reference nr: S13/03/043) in April 2013 (Addendum 3).

An application was submitted to the HREC in February 2014 for an amendment to the protocol. This was done to provide for the last step of data collection, as stated in section 4.3.3.4 and the inclusion of focus group discussions as research method. This application was approved (Addendum 4a) along with a change to the wording of the corresponding objective (Addendum 4b).

A final matter that required an amendment was the original title of the project. The original title was approved in an internal preliminary process before the protocol was finalised and stated:

“Exploring stakeholder commitment and capacity to address **infant and young child feeding practices** in the capital of the Breede Valley , Western Cape Province, South Africa”

Over the time-period the researcher was engaged with her PhD studies, some of the terminology inherent to the research was further developed and refined in the literature. One example pertains to “infant and young child feeding” (IYCF) practices. The term that subsequently grew into use to refer to the broader aspects of food, health and care is: “infant and young child nutrition” (IYCN). The researcher wrote an application letter to HREC to amend the original title to include the more comprehensive terminology as follows:

“Exploring stakeholder commitment and capacity to address **infant and young child nutrition** in the capital of the Breede Valley , Western Cape Province, South Africa.”

The application was approved by HREC (Addendum 5) as well as by the Postgraduate Committee of the Division of Human Nutrition.

#### 4.5.3 Language

The predominant languages that residents use in this area are Afrikaans, English and isiXhosa. Most residents speak and understand at least one or a combination of these languages. Participants indicated which language/s they were comfortable in, before commencement of the interviews and focus group discussions. The researcher is bilingual in Afrikaans and English and conducted all the interviews and focus group discussions in one of these two preferred language of the individuals or groups.

The workshop was conducted in English, but the researcher translated key concepts into Afrikaans. Only two participants in the room were Xhosa speaking, but it was established during the initial interviews already that they understood and spoke English and Afrikaans as well. They indicated that they were comfortable with the workshop being conducted in these two languages. Questions were addressed in the language the question was posed and translated into the alternative language to ensure that all participants followed the conversations. A translator, who could speak all three languages, assisted the researcher in one of the initial interviews in the first phase of data collection.

#### 4.5.4 Written informed consent

Written informed consent was requested from all participants and separate written consent was requested to record the focus group discussions, interviews and workshop proceedings. The reason for the recordings was explained and participants were ensured of the anonymous nature of the recordings. The consent form was explained and signed before each focus group discussion, interview and workshop (Addendum 6-8). Confidentiality was ensured by keeping transcriptions password protected, removing all personal identification from records and by keeping the list of interviewees separate from interview data. Anonymity was ensured by referring only to codes and themes in the results reporting. Recordings were destroyed at the end of the project.

#### 4.5.5 Permission for government officials to participate in research

Permission for employees of government to take part in the focus group discussions, interviews and workshop was requested and received from the applicable provincial and/or district departments / sectors / line-managers, including from the Departments of Health, Education, Social Development and Community Development and Planning. (Addendum 9-12)

Two of the government departments requested to be sent either a summary of the content, findings and recommendations of the research or the full dissertation and ensuing publications. The findings of the research will only be deemed final and in a format appropriate to circulate to the mentioned government departments, once the thesis has been accepted and approved. These requests will be honoured and copies of the

dissertation and ensuing publications will be sent to all four government departments whose personnel participated in the research.

## **4.6 Data handling and analysis**

### **4.6.1 Pilot project**

The researcher completed a Qualitative Research Module, Masters module in Clinical Epidemiology (M.Clin Epi), presented by the Centre for Research on Health and Society, Department of Interdisciplinary Health Sciences, Faculty of Medicine and Health Sciences, Stellenbosch University during the second semester of 2012. The research protocol was in an advanced draft format at the time and the researcher used the opportunity posed by the course objectives and assignments of the course, with permission from the course convenor, to refine the protocol and test and adapt the interviewer guide (Addendum 1). She conducted two pilot interviews, transcribed and analysed these and wrote a qualitative report on the findings. Furthermore, the co-study leader provided the researcher with theoretical and practical training in the Net-Map method, explained in section 4.3.3.3.

The M.Clin Epi course and the Net-Map training provided the necessary structure and support to plan and execute the data collection and analysis for the proposed PhD research.

### **4.6.2 Data capturing and analysis**

The audio recordings of the interviews and focus group discussions were sent to transcribing services which transcribed the recordings in English with simultaneous translation from the interview language, if necessary. A separate electronic file with unique name was created for each interview. After the interviews were transcribed, the researcher performed quality control on the data by listening to the recordings while reading the transcripts to ensure that information was captured accurately. She made notes of the main themes that could be established around the key concepts explored in the interviews and focus group discussions and added additional themes that emerged while she was repeatedly reading through the transcriptions. The analysis can therefore be described as deductive (pre-prepared structure), but also allowed for inductive analysis (build and develop with an open mind) (Hsieh & Shannon, 2005).

The general term used for the analytical process performed on transcribed data is “content analysis”, where people’s words are explored in detail for common themes which are then distilled into units of meaning or codes (Skinner, 2007). In this case the researcher intended to understand the world of human experience in practice and the analytical process can therefore be referred to as “interpretative content analysis”.

The transcriptions of each phase of data collection were separately entered into the “Atlas.ti” software programme (Atlas.ti Qualitative Data Analysis, 2015) and assigned to a unique hermeneutic unit (file) to enable labelling segments of text (quotes) with a string of words/phrases (codes). The researcher established these codes after careful reading and re-reading of the text.

Once all the transcriptions were coded, the codes were grouped into “families” (main themes) which are larger groups of codes for easier handling in reporting the data. The researcher was careful to remain true to the data and reflect on the participants’ words and phrasing.

The Net-Map report was a summary of the workshop proceedings and was validated by the stakeholders as a true reflection of the workshop accounts and outcomes. This report, together with the visuals produced and the detailed interpretation by the participants were seen as the basis of the analysis of this phase of data collection. It was complemented with the analysed post-workshop interviews as well as the answers to the post-workshop questions.

#### **4.7 Concluding remarks**

With the focus on building capacity and commitment to address IYCN at local level, the study design decided upon was an adapted stakeholder analysis with an additional last phase; i.e: 1) Identifying stakeholders, 2) Differentiating between and categorising stakeholders and 3) Investigating relationships between stakeholders and 4) Reflection on the process and exploring local conditions (elements of an enabling environment) to support IYCN. The rationale for the choice of the methods used during each phase was detailed in this chapter.

Stakeholders were identified during a FGD and differentiated between and categorised using a Power/Interest matrix. Hereafter stakeholders were interviewed to explore their perceptions on IYCN as well as their commitment and capacity to address this topic. Stakeholders were engaged in a multi-stakeholder workshop where relationships, networks and powers among them were mapped. The stakeholder map was validated through individual feedback and interviews. Lastly, focus group discussions were used for reflection on the stakeholder process and local conditions that can support IYCN were explored.

The combination of these qualitative methods provided a detailed profile of the key stakeholders who can impact IYCN in the Breede Valley sub-district.

The chapters to follow will describe the perspectives, commitment and capacity of key stakeholders in relation to IYCN; map the stakeholder landscape, with reference to stakeholder relationships, power and interests; reflect on the research and explore the elements of an enabling environment for IYCN in the Breede Valley sub-district.

**Chapter 5: Systematic stakeholder identification and engagement to  
explore commitment and capacity to address IYCN in the Breede  
Valley Sub-District**



## 5.1 Introduction

This chapter covers the results of the first two objectives set for the research study, i.e.

1. To systematically identify and differentiate between stakeholders
2. To explore the perspectives, commitment and capacity of key stakeholders in the Breede Valley sub-district in relation to IYCN

## 5.2 Summary of methods

The methodology followed for these two objectives was described in Chapter 4, sections 4.3.3.1 and 4.3.3.2, and is depicted in Figure 5.1. A focus group discussion (FGD) was conducted to identify the stakeholders who can impact IYCN in the Breede Valley district. To differentiate between the stakeholders, a Power/Interest matrix was completed. In this way, the stakeholders with the highest power and interest as well as those with the highest power and medium interest to address IYCN in the Breede Valley were identified. These stakeholders were approached and invited to take part in semi-structured interviews to explore their perceptions about IYCN as well as their commitment and capacity to address the situation (described in Chapter 3) in the Breede Valley.

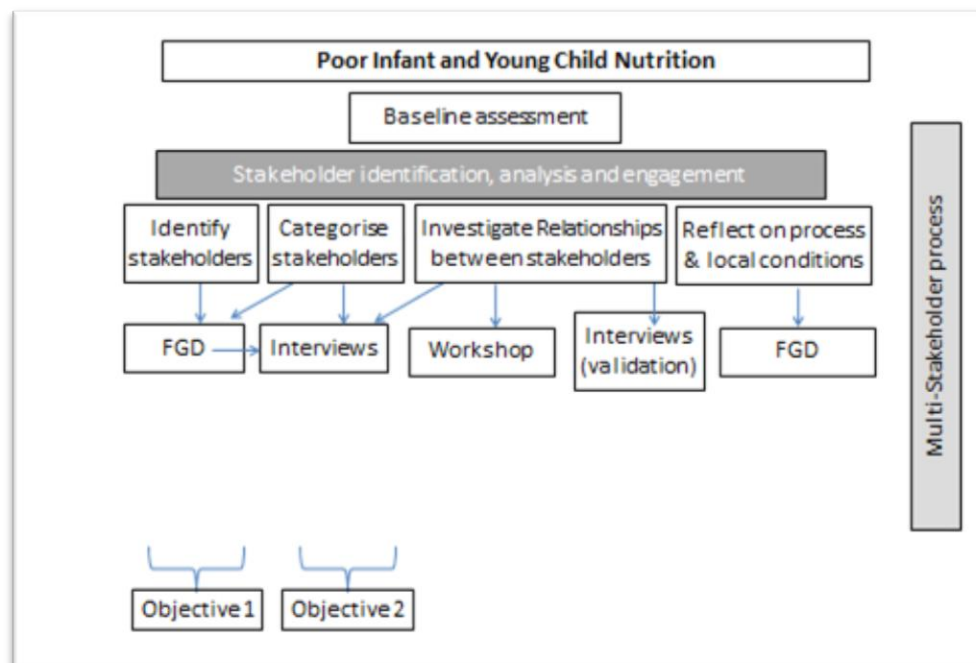


Figure 5.1: Methods and objectives indicated for stakeholder identification, categorisation and initial engagement.

### 5.3 Results

#### 5.3.1 Stakeholders in IYCN

Based on the focus group discussion, the stakeholder groups with highest power and highest to medium interest to address IYCN in the study area were identified and are shown in Table 5.1 and described in Box 5.1.

Table 5.1: Focus group discussion rating of stakeholder Power/Interest related to infant and young child nutrition in the Breede Valley sub-district

<div style="border: 1px solid black; padding: 2px; display: inline-block;">                 ↑ p o w e r             </div>	<p><b>Community members (Zweletemba x 1):</b> Political party youth league leader / teenager</p> <p><b>Community members (Avian Park x 1)</b> Political party ward councillor</p> <p><b>Business Forum</b></p> <p><b>Private Health care</b></p> <p><b>Government:</b> DoE Special Support Services</p> <p><b>Local Government:</b> CDP Manager / Social Services</p>	<p><b>Community members (Zweletemba x 4):</b> Grandmothers, crèche owner, CNSP fieldworker</p> <p><b>Community members (Avian Park x 5):</b> Grandmothers, crèche owner, CNSP fieldworker / CDW / mother</p> <p><b>Media (Radio x 1)</b></p> <p><b>Government:</b> CDP Director / DOH, INP Manager / DOH Deputy Director</p> <p><b>Community members:</b> Unemployed father; Sport organiser</p> <p><b>Training Institutions:</b> Stellenbosch University / Boland College</p>
	<div style="border: 1px solid black; padding: 2px; display: inline-block;">                 Interest →             </div>	

DOH = Department of Health; DOE = Department of Education; DSD = Department of Social Development; CDP = Community Development and Planning; CDW = Community development worker

Stakeholders with low interest and low power were not included, since they are considered unlikely to have influence on the issue at hand (DFID, 2002; Start & Hovland, 2004). Those with high interest but low power could form the basis of an interest group or partnership which can lobby for change (DFID, 2002; Start & Hovland, 2004) at some point in e.g. an

advocacy process. Although it is realised that power is not static, this category was not considered as key stakeholders for the purposes of the research process.

Box 5.1: Stakeholder groups with highest power and highest to medium interest to address infant and young child nutrition in the study area

- Community members – specifically: grandmothers, crèche owners, sport club organizers, community development workers, politicians, mothers and fathers, the youth, CNSP research fieldworkers
- Cape Winelands District Municipality (Community Development and Planning) and Cape Winelands District Government (Departments of Health, Education and Social Development)
- Higher Education institutions (Stellenbosch University & Boland College)
- The local Business Forum (including private health care)
- Local Media (radio and newspaper)

The researcher made notes of the details of some individual key stakeholders who were mentioned by name during the FGD. The CNSP fieldworkers assisted in the identification of community members who fitted the profile as described in Box 5.1. For other key stakeholders, the person with the highest position and formal power in the organisation, or their immediate representative/deputy was approached; i.e. director; chief-director, deputy-director or chairperson. It was decided to include the programme manager for the Integrated Nutrition Programme (INP) in the district as well, due to the focus of the study touching on one of the main focus areas of the INP, i.e. IYCN. This position represents the highest level of management for the INP at district level in the Western Cape Province.

Twenty-seven stakeholders, representative of the different stakeholder categories, were approached to participate in semi-structured interviews. During the time the researcher approached stakeholders to take part in the interviews, not everyone knew why she wanted to engage with them and referred to them as “stakeholders in IYCN”. Others made similar remarks while reading the participant informed consent form, where the purpose of the research project was stated. In most cases, stakeholders were accommodating in scheduling appointments and keen to participate in the interviews and to share their perspectives on the research topic.

### 5.3.2 Stakeholders' understanding of IYCF/IYCN

Most stakeholders were confident in their understanding of the meaning and importance of IYCF. It was generally described as good nutrition for babies; milk that babies drink and healthy food that babies should eat. They named breastfeeding, other milks and examples of complementary foods (specifically cereal, fruit and vegetables) as well as the timing of introduction of family foods into the baby's diet as important in the context of IYCF.

The link between IYCF and child health, growth and development along with the future health impact of IYCN; particularly on brain development, learning abilities, future prosperity and benefits to communities and government, were described by the majority of stakeholders when they were asked about their perspective on the meaning of IYCN.

"I want to see the children, all the children, having a good health and being clever in their minds, because if the child is hungry she can't think, you see." (Interview 02 to Du Plessis, 2013)

"We have to also remember that because the next time, the next five years after your child is born or the next 10 years, your teacher comes to you or call you at the school and say your child is a slow, slow learner and your child cannot understand anything. The problems start with you as a mother..." (Interview 03 to Du Plessis, 2013)

"So at the end of the day you will not only...the community of Avian Park benefit, but even the Government will pay less 'AllPay', less grant, because there'll be less overweight and blood pressure problems because now they eat healthy, they live healthily, they do the right things." (Interview 05 to Du Plessis, 2013)

"I listened to a radio programme last week to say that children that has not experienced stunting between the age of naught and 6...has 40% more to give economically" (Interview 19 to Du Plessis, 2013)

From the perspective of the Business Forum representative, the meaning of IYCN was described as the financial impact it might have on business.

“I think of maternity leave and having to pay people to go onto maternity leave and what that impacts; it places on a business.” (Interview 12 to Du Plessis, 2013)

In exploring stakeholders’ knowledge about IYCF, participants mentioned breastmilk as being important, the best milk and that it is economical. The cost of formula milk, its abundant availability and utilisation in lower socio-economic communities and the dangers associated with its use was also stated. Although there was expression of the importance of breastfeeding and complementary feeding, the correct IYCF practices were not well known by stakeholders. Misconceptions, misinformation, “old wives’ tales” and ignorance surfaced on the topic, particularly by community members.

“Because it's a sour type of milk (*formula*) and milk that comes out of your breasts is sort of sour” (*indicating formula milk and breastmilk is similar*)” (Interview 04 to Du Plessis, 2013)

“Some throw strange stuff in the children’s bottles. Like ‘ouma meelbol’<sup>22</sup> is very popular. Flour that is scorched; it’s very popular in Avian Park” (Interview 05 to Du Plessis, 2013)

“But I’m not with that...(referring to the complementary feeding guideline of starting solid foods at 6 months)...my grandchildren, if they’re a month I give them their first porridge, two, one spoon and at 3 months I start giving them their boiled potato, squash and so on, boiled fish and say from 3, 4 months I let them eat out of the pot.” (Interview 06 to Du Plessis, 2013)

Stakeholders representing the university, Community Development and Planning, and the Business Forum, stated upfront that they were not knowledgeable about the detail of IYCF.

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<sup>22</sup> “Ouma meelbol” is a traditional mixture of scorched flour and warm milk fed to babies as porridge. In poor communities the scorched flour is mixed with water and given to babies in bottles as a replacement for milk.

Officials from the Departments of Health (DOH) and Social Development (DSD), were knowledgeable and confident in their conviction about exclusive breastfeeding, continued breastfeeding and appropriate complementary feeding recommendations.

### **5.3.3 Stakeholders' view on factors that influence IYCN and barriers to its improvement**

There were overlaps in many instances between the factors perceived to influence IYCN and the barriers to its improvement mentioned by stakeholders. These issues will be reported together in this section.

The main issues raised in this regard at individual/community level were:

- poor knowledge/ignorance about the topic;
- poverty and unemployment and a lack of money for food;
- poor parenting skills and child neglect;
- the misuse of social security grants for the benefit of the parent/s and not necessarily the babies and children;
- teenage pregnancies leading to poor IYCF and child care;
- gangsterism and drug abuse and the impact it has on unborn babies and young children;
- HIV-status and the interpretation that HIV-positive mothers cannot breastfeed;
- employed women and the resultant lack of time for food preparation and child care;
- children not attending crèche due to limited funds and therefore missing out on care and at least some form of food during the day;
- absent or abusive father-figures who have financial and gender powers in households and who do not fulfil their responsibilities towards mothers and children.

“Our children get babies while they are still very young” (Interview 01 to Du Plessis, 2013)

“They (*mothers*) are taking the grant of the children and they are doing the hairstyles...” (Interview 02 to Du Plessis, 2013)

“Young ladies ‘tik’ (*use drugs*) and they have children and they don't worry”  
(Interview 04 to Du Plessis, 2013)

“Mothers have to go back to work 'cause like if they are farm workers, they've got seasonal work so if there's babies born within that...when the season starts, they immediately leave for work in order to support their families.” (Interview 15 to Du Plessis, 2013)

“We find that one generation follows the next. They are ignorant about many things and they are trapped in a cycle. They are poor, drink a lot, shout at the children. And the next generation is reared the same way.” (Interview 18 to Du Plessis, 2013)

“Many of our problems that we face, whether it is gangsterism, whether it is crime, thieving and all the way up to murders, have a source somewhere and it's that person, the perpetrator that is the gangster. If you go back in his life, you'll probably find there's no father. It's a broken household. There was a history of abuse and you go back until he's an infant and you'll find that that child has actually been disadvantaged from its very first breath.” (Interview 12 to Du Plessis, 2013)

Most often the grandparents have to care for babies born into these circumstances, putting extra strain on the resources they have to their disposal largely based on the old age grant (R1350.00 per month). Although support from grandparents could be to the benefit of the child, there was also a feeling that grandparents should reprimand their children to take up their responsibility and look after their own children.

“If they are on drugs, they leave the children by their parents. Maybe the parents are old people, you know, then the parents have to look after their babies while she's walking around at night looking for drugs, you understand?” (Interview 14 to Du Plessis, 2013)

“We (DSD) have addressed the grannies, because they allow the cycle to continue to such an extent that every time they accept the grandchild by taking care of the child and by giving the mother the opportunity to carry on with her ‘loose (*promiscuous*) life’. They are trying to be a support network, but many times it is because they do not call the mother or the father to take up responsibility” (Interview 25 to Du Plessis, 2013)

Ignorance concerning IYCF and poor practices was also reported in the higher socio-economic areas in communities. Misinformation and poor practices are passed down from one generation to the next and there seems to be an unwillingness to accept guidance from the health care workers employed in the private medical sector.

“They (*parents*) believe that it worked, nothing happened to them; why not do the same. If you turn around then they say: ‘they can tell me here now but when I get home I just do my own thing’.” Interview 21 to Du Plessis, 2013)

In the health system, a focus on treatment priorities, time constraints, understaffing and high work load of nurses and physical lay-out of clinics lead to health and nutrition education and behaviour change interventions not receiving enough attention. The lack of a caring ethos in nursing and outdated knowledge were also cited as reasons for the lack of good birthing practices and poor early infant feeding support which, together with health care workers not internalising the importance of IYCN, lead to mothers not being well prepared to care for and feed their babies.

The impact of the INP on the current nutrition problems was questioned, since the budget is mainly focussed on staff salaries and the Nutrition Therapeutic Programme (NTP – targeted supplementary feeding) and facility-based activities are receiving priority over community-based interventions.

“Some aspects within DOH have a tendency to take priority...and emergency, death, ambulances, doctors, resuscitation and machinery are miles ahead and get much more attention than nutrition; the prevention and feeding aspects.” (Interview 22 to Du Plessis, 2013)



“Department of Health’s abilities to address nutrition are...if you look at the programmes that have been around for so many years, the school feeding programme and the Integrated Nutrition Programme; those programmes are at the most probably relieving the problem. I don’t know if anyone knows to what extent it is relieving the problem, but it is not solving the problem.” (Interview 22 to Du Plessis, 2013)

According to respondents, the Department of Education (DOE) is overwhelmed by the magnitude of learners’ developmental delays and the learner support they have to offer is limited. Developmental delays are evident on all levels: physical (motor development), social and psychological, which is a reflection of the lack of optimal feeding and care they had been exposed to from an early age. A lack of human resources limits the DOE’s reach to the most-needy schools. Teachers are despondent since they have to cope with children with different levels of development in one classroom while they also had to master a new curriculum instituted in 2014.

“We are certainly supposed to work in all schools, but you can’t. It’s totally overwhelming. We definitely focus where the biggest problems are.” (Interview 18 to Du Plessis, 2013)

“The children arrive at the school totally underdeveloped. Those children, at age five don’t know colours, they can’t count, they don’t know shapes. They can’t have a simple conversation with you. They don’t have skills such as cutting. Their hand-eye coordination, their ability to copy; all test unbelievably low. They can, for example, at age 5 or 6 years old; they can’t yet draw a diagonal line. And you would think that the children would have developed well in terms of motor functions, but it seems as if that doesn’t develop properly either. Their trunks; bodies aren’t strong. It gives you an idea that the children don’t move enough. It might have to do with the safety issues and stuff. It’s so dangerous in the areas where they live that they are raised in an unnatural environment.” (Interview 18 to Du Plessis, 2013)

In the Community Development and Planning (CDP) department in local government, there has been a shift in focus from food aid to vulnerable groups (food parcels) to sustainable development initiatives. As this change was implemented without consultation with the community and before bridging measures were implemented, it may have led to the intensification of IYCF problems.

As DSD is responsible for sanctioning the Children's Act (Act nr. 38 of 2005), the Department has an enormous responsibility to act on issues of child care. The staff numbers are, however, not considered to be adequate in relation to the workload. Frontline staff's limited knowledge on IYCF/IYCN and its link to development was also highlighted as contributing to poor understanding of the problems encountered in this area.

Government departments being on the "receiving end of the problem" was raised as an issue that ultimately influences IYCN. The so-called "upstream factors" or the social determinants of health were quoted in the clarification of these statements.

"I think there is that realization that we're at the receiving end of whatever's gone wrong, so if we're at the receiving end, how can we fix things if we don't know what's needed in order for things, that have already gone wrong, not to be that way".  
(Interview 24 to Du Plessis, 2013)

"I think in our minds as managers, there are a lot of things that we do not have control of, like poverty and yes, substance abuse and upstream things which influence nutrition..." (Interview 27 to Du Plessis, 2013)

An example was offered, in similar terms by DOH, DSD and DOE officials, to explain the shortcomings in community support systems as well as in government systems, as described in the following vignette: a mother who arrives at the DOH ante-natal clinic is already pregnant and often a pregnant teenager. The mother is not optimally prepared and optimally supported to care for the baby, neither by the health system, nor the community and the child grows up in circumstances that cannot be remedied by either systems. If and when DSD becomes involved, the child is already a neglected and abused child. The child

who eventually enters the school system has developmental delays and could be on the spectrum of foetal alcohol disorder and will struggle in the school system, might drop out with low education, have low skills and either follow the path of unemployment or low paying employment (working on farms or as cashiers in retail) with the continuation of the poverty cycle into the next generation.

The overarching barriers in government departments, which hinder their abilities to address IYCN, stem from the many different focus areas and different mandates that they face. Nutrition is just one of the many programmes of DOH, with IYCN embedded within the INP's different priorities. Government departments function within a set organisation, have different power structures and reporting mechanisms and separate budgets which limit their capacities to work in an integrated way.

“I think every government department is focussed on delivering on its own business, its own objectives, its own agenda and not always looking at how does it overlap or how does it link or how is it aligned to the work the other department is supposed to be doing.

I think that we are so keen on delivering on our own mandates and our own powers and functions and legislative responsibilities that things such as the millennium development goals, which is supposed to be cross cutting, are not necessarily included in realising that: you know, we all serve the same communities and that we must combine our agendas in order to achieve common strategic objectives rather than individual performance orientated objectives.

So I don't think any government department will be able to comprehensively say that 'this is the collective package we provide for the first thousand days'." (Interview 19 to Du Plessis, 2013)

“This (*focus on IYCN*) is absolutely an admirable thing but it's not always feasible within the mandate for what you have to execute your work, if I can put it that way. This is where the relay baton is sometimes dropped” (Interview 23 to Du Plessis, 2013)

This fragmented way of working is inadequate for dealing with IYCN, specifically in the context of the first 1000 days of life. Furthermore, training institutions perpetuate this way of working and thinking through structuring healthcare training in a similar fragmented fashion. Some healthcare students and newly appointed staff are reportedly not well skilled to fulfil their basic roles and to act on the most burning problems in the district.

“We tend to work in silos but that is actually how we train our health professionals”  
(Interview 16 to Du Plessis, 2013)

“If we receive people from other universities and from the nursing colleges (*outside the sub-district*) they don't know how to do IMCI (*Integrated Management of Childhood Illnesses*); they don't know how to do BANC (*Better Ante-Natal Care*), they don't know the immunisation schedule, uhm...they don't know how to treat TB, and they are; they cannot treat HIV... I just think people need to be trained better to do what matter, genuinely” (Interview 27 to Du Plessis, 2013)

The complexity of the societal factors that influence IYCN and the barriers that hinder different stakeholders to act on IYCN, were verbalised and related to the fact that many citizens are not focused on nutrition or informed or interested in how food and nutrition influence their bodies. There was a realisation of the deep-rooted problems in society related to nutrition of which the outcomes are often invisible. Human behaviour, stemming from these social contexts, is intricate and it was felt that government departments, faculties and institutions do not address this aspect comprehensively.

“I think we need to recognise that many of the things we see are the tips of icebergs. They have roots that are much, much deeper and we might actually have lost generations already that we can't actually save” (Interview 12 to Du Plessis, 2013)

“The ability of the Department of Health or the government or the academic group, to address people's behavior is weak.” (Interview 22 to Du Plessis, 2013)

“A practical example in the poor communities of Cape Winelands is, although we are the richest or the best producers of quality wine, export wine, we’re also the areas that are hardest hit by foetal alcohol syndrome.” (Interview 19 to Du Plessis, 2013)

“If you look at the sexual crimes, rape and child trafficking and all this stuff, it is just as dangerous because ‘who do I trust in my community’? I so badly want to trust you and believe that you, that you have my child’s best interests at heart but now I trust you then you’re the wolf in sheep’s clothing. It’s sort of a grey area, you want to reach out as a community member but where and when do you reach out?” (Interview 08 to Du Plessis, 2013)

#### **5.3.4 Stakeholders’ opinions on actions needed to address IYCN**

The actions needed to address IYCN, as mentioned by stakeholders, included direct and indirect actions.

A stakeholder suggested the need for consistent IYCF messaging and training on these messages, particularly for staff and students in the health and social services departments. It was felt that DOH should appoint more dietitians and DSD should also consider appointing other therapists from categories with expertise in dealing with IYCF and child development, including dietitians and occupational therapists. It was further expressed that DSD needs to follow up on grant recipients to ensure that the money is spent to the benefit of the child and not the parent.

Health education, including topics of IYCF/N, in community venues e.g. town halls, clinics and schools, and targeted to teenagers, mothers, fathers and grandmothers could empower individuals and have a ripple effect to the broader community. A need for skills in budgeting and vegetable gardening; practical food preparation demonstrations; soup kitchens for children and constructive entertainment for the youth; and support from other community members or professionals for community volunteer work, were also mentioned as actions needed to ultimately improve IYCN.

Improving education, in general, was seen as a way of improving communities' social capital, which could have a spill-over into other levels in communities, with specific mention of prevention of unwanted life events (e.g. teenage pregnancies).

“So it's up to us now to make sure that South Africa becomes a better land by educating, by going for education, seeking for education and be successful, you see.”  
(Interview 09 to Du Plessis, 2013)

Empowering gangsters was mentioned as an unorthodox way of thinking, but could create some form of safety in communities to aid the establishment of a supportive environment for other actions in communities.

“So you can work upside down because it's a place where nobody wants to begin but they (*gangsters*) have a huge influence in our community in Avian Park” (Interview 05 to Du Plessis, 2013)

A statement was made that the National Development Plan 2030 (NDP) of the SA Government should be used as a guide to direct issues pertaining to IYCN in an integrated and “whole of society” approach. Further comments supported this notion, including, when communities unite it can lead to attitude changes, decisions to go the extra mile and to take collective responsibility for issues of child care. The same actions could aid intergovernmental cooperation. Partnerships and dialogue between communities and government; and government and the private sector can go a long way in strengthening the governance of IYCN.

“Do you know how badly I want to say it's the governments' responsibility, but I want to believe that it's every resident's responsibility, each and every one of us has a responsibility towards ourselves firstly and then towards, to people around me; my neighbours and their neighbours.” (Interview 08 to Du Plessis, 2013)

“It's not only governments responsibility to implement these initiatives but churches also and other civil society organisations should also get on board and tackle this thing because it's really not something that government or municipalities can address on their own.” (Interview 15 to Du Plessis, 2013)

“What I realise is that unless government form partnerships with civil society or with the private sector, it will not be able to deliver on the demand that there is on government.” (Interview 19)

A suggestion was made that a workshop should be held for all stakeholders in the Breede Valley to understand their roles as stakeholders in IYCN as a possible action to start this integrated process.

“I think first of all, all the stakeholders should be maybe have a workshop with all the stakeholders and giving like facts and stats and the whole holistic picture of what is happening in the district and what facilities are available or the ... what nutritional challenges are there within the district and let people just think about their roles and government departments and civil societies about what role they can play in that.” (Interview 15 to Du Plessis, 2013)

A need was expressed for preventive and promotive actions to be the focus of DOH and that the INP budget should specifically be restructured to allow for this change in focus. However, the change in the structure of the nutrition budget should come from a higher government level before the district would be able to reallocate the money to preventive actions, as opposed to the current main focus on treatment of severe acute malnutrition through targeted supplementary feeding.

“I think for myself first and foremost is that there should be this realization across the board that if we want to make a dent in...be it in malnutrition, be it infant mortality that we need to focus on the prevention side and then there should be this unpacking of what that entails and then money should be re-allocated. Look at what we can bring to the table to make sure that the prevention is in place. So, it (*budget*

*restructuring*) needs to come from much higher than that. And if I were to guess - at national level, filtering down to province, and then to district, and operational level from there. (Interview 24 to Du Plessis, 2013)

The need for trans-disciplinary skills transfer in DOH was expressed and a specific suggestion was made for a course on IYCN management for decision makers.

“There is no chance anymore to turn around and to say, just a dietitian should see them, or the ...or the DD should see them and I just wonder, because how much does a physio know about nutrition, how much do the doctors know about nutrition, what happens to the nursing staff around nutrition? We do not have enough resources, we do not have enough. I mean we will have to start doing trans-disciplinary things. (Interview 27 to Du Plessis, 2013)

A need for communication experts to frame the urgency of the IYCN problems and to formulate an advocacy strategy, including a communication plan and campaign around IYCN, was expressed. Community media are already on board and can continue to be a medium to help spread IYCN messages. However, a plea was made by the local media for support from local business to enable them to improve their service and coverage to the communities.

“This (*referring to IYCN*) is serious. This needs to be taken care of.” (Interview 03 to Du Plessis, 2013)

“Nutrition should be something that is in a person’s face; all of the day.” (Interview 15 to Du Plessis, 2013)

“In some way you must start with the mothers and you will have to start preventing so that it (*poor IYCF, care and development*) starts getting less; so that you can try and stop the stream.” (Interview 18 to Du Plessis, 2013)



“I think then if I had communications on board, to have it (*IYCN messages*) all across our media, on the radio, part of a soapy, TV ads and the like.” (Interview 24 to Du Plessis, 2013)

The success of the HIV/AIDS campaign in SA was cited as a model that should be followed and applied to IYCN as a priority scenario, with indication that DOH should be taking the lead in this regard.

“Why does the HIV programme work so well, same policies, why does it work so well? We have HIV treatment and we actually have it under control and the reason is that it is in all the departments. I mean, if you are there, you can get a grant if certain things are wrong with you, you can have food parcels at another department. In the schools we have it in the curriculum, you understand. Everyone actually knows about HIV. We have almost had enough of all the HIV messages and at one stage we said that everyone is punch-drunk with this, and everyone is that, but I think that the penny has dropped somewhere.” (Interview 27 to Du Plessis, 2013)

Branding of the first 1000 days in logo format and using it on products produced by local farmers and industries, similar to the Fair Trade/Heart and Stroke Foundation logo's, was thought to potentially have an impact on support of practices that impact this period, among other: occupational health support during pregnancy, maternity benefits, crèche facilities at work, breastfeeding and complementary feeding support and flexible work hours for mothers to attend to child health issues.

“So what I'm saying is that businesses have obviously cottoned on to this a long time ago, especially international ones and there will definitely be a positive spin off for products if we can put some type of catch phrase onto your product and say: 'buying this product you are giving life', you know, 'supporting life for the first thousand days'.” (Interview 12 to Du Plessis, 2013)

A comment was made about how far businesses need to go to respond to employees' well-being “beyond the pay cheque”. Some businesses are already responding to employee

health on a more holistic level, but not everyone feels it is their responsibility. A holistic approach to women in employment could be highlighted through training/sensitisation around breastfeeding and employment to managers. In this regard, the need to provide the business sectors with examples of interventions that work, when doing sensitization on issues pertaining to IYCN, was articulated.

“When you package the crisis you must also make sure you package the solution at the same time because people...there’s nothing worse and there’s nothing more demotivating for somebody who hears all the crisis, all the crisis, all the crisis and there is never a solution...because and it’s got to be a viable one that is looked, that is thought out.” (Interview 12 to Du Plessis, 2013)

It was mentioned that appropriate research can put nutrition on the development agenda and research should continue in this area. A need for practical and interdisciplinary research by the university as well as a good balance in the service-learning agreement between universities and government was another point raised.

“The research should be interdisciplinary because the sociologists and the anthropologists and economists and a host of disciplines will be needed to quantify all the different dimensions (of IYCN).” (Interview 22 to Du Plessis, 2013)

### **5.3.5 Stakeholders’ opinions about resources needed to address IYCN**

It was explained that government departments already work together to save on resource costs, but a need for capital funds was highlighted as a resource needed to firmly address IYCN as integral to the development agenda in this sub-district. Infrastructure in the form of a permanent clinic structure in Avian Park was mentioned as a resource that would bring primary health care, including baby and child health, within reach of this specific community. Currently Zweletemba has a fixed clinic, but residents from Avian Park need to travel to Worcester town for health care services. A need was also expressed for crèche facilities for children who are not currently attending a caring facility since they cannot afford the fees for these services.

Stakeholders were of the opinion that passionate people (including volunteers, community health workers, nurses, dietitians and other cadres of health and social services staff) who have received training and/or updates in IYCN and skills in trans-disciplinary work are needed to properly address IYCN education. They would need dedicated space in communities and clinics as well as the necessary stationary, equipment and support to fulfil this task. A need was also expressed for communication resources to accompany the advocacy campaign mentioned previously. A comprehensive and integrated package of services dedicated to child care was proposed as a strategy to pool resources and expertise. In so-doing it will ensure that there is not only a focus on treatment but also prevention.

“In government we should have a basket of services to say if a child is released from a public hospital this is the kind of basket of services and not wait for the child to come back sick to the hospital or sick to a clinic or to a child ending up at a police station because you know there’s some problem in the family” (Interview 19 to Du Plessis, 2013)

### **5.3.6 Stakeholders’ commitments to address IYCN (stakeholder roles)**

Stakeholders expressed their willingness to assist or fulfil their roles with actions directly and indirectly linked to IYCN at different levels and in many different ways.

Community members expressed their willingness to act in roles as community development workers (vegetable gardens), volunteers and community health workers (to spread IYCF messages) and role models (youth support from parents, grandparents and at sport clubs) to further the IYCN cause. Grandmothers already take care of their grandchildren and are willing to learn more about IYCN to improve their caring skills. The farmers in the Breede Valley support the work of DSD in crèches and DOH in the community-based services rendered on farms. Political parties can engage young people, pressurise government about poor service delivery and advocate for job creation. A personal commitment from a community member to support IYCN as a cause was worded as follows:

“There’s a change that’s going to take place and when change happens it happens in the mind before it goes to the heart and if the heart accepts it, then the hard work is

over, but it doesn't stop there because now you have to teach the people to do it. So, there's a lot of things needed but it just sounds a lot. We probably have to take it piece by piece but really if one looks, it's not just for now, it's long term but at least my child and her child and my grandchildren's children will be healthier than my mother and my grandmother and great grandmother. So if we start it today, then we are the most unselfish people on earth. (Interview 05 to Du Plessis, 2013)

The Business forum stated their willingness to engage with the university to support further nutrition research as well as engagement with the Worcester campus to strengthen relationships and explore future collaboration. The existing notion of a holistic view on employee health in some businesses could be explored as an avenue to broaden support for IYCN. The Business forum also showed interest in the university's research and extended an invitation to the researcher to present her research as guest speaker at one of the future Business Forum meetings.

"It's an hour 12:30 to 13:30 with a guest speaker and then we have lunch and we network a little bit and that's every month. It's a fixed date and it would be interesting to perhaps have you back as a guest speaker and you could come and present some of your findings. Even if you wanted to pilot some of these things with some of the companies. It would be interesting. It would be interesting to see if some companies would take it up." (Interview 12 to Du Plessis, 2013)

DOH, as one of the custodians of maternal and child health with an available Monitoring and Evaluation (M&E) meeting platform to raise priority issues, stated their responsibilities towards nutrition and health education with a focus on the first 1000 days of life. It was mentioned that the budget for the INP is decentralised and more flexible compared to in the past. Nutrition is also integrated into other platforms and programmes; targets form part of facility managers' performance appraisal (mainly for facilities to be accredited with mother-baby friendly [MBFI] status) and the topic has been put on the management agenda of DOH. The latter initially happened due to the realisation by the district management that malnutrition is responsible for child deaths in the area.

“We then went into a diarrhoea season and we had deaths and as we looked at it, because we do monitoring... If we do them, we have a look at every death, and many of them are linked to nutrition. We said to one another that we will rectify these things and it (*IYCN*) came on the agenda more and more. I very seldom attend a meeting where in a conversation, where nutrition is not part of the conversation and this excites me very much as a manager, who did not know much about nutrition and had learned, as we progressed and I think .. Yes, I must say as management, I can say that the whole management especially in the Cape Winelands is convinced that this is where our focus must be.” (Interview 27 to Du Plessis, 2013)

A concern was expressed that, although nutrition and *IYCN* have been put on the management agenda and there is an awareness of the issues that need to be addressed, that the real commitment in dealing with it is still to be seen in action where there is a sit-down and dedicated brainstorming session to ensure everyone is briefed and a real integrated approach to addressing *IYCN* is formulated.

“But I think in terms of, ja changing things around it needs to be that everyone involved needs to know where we stand and how we can change that around and that we need to brainstorm how we are best going to do this with everyone’s strengths that we can draw on to make a change.” (Interview 24 to Du Plessis, 2013)

DOH provides training to other departments, specifically DSD in issues pertaining to child health and breastfeeding. They also train cooks from ECD centres in economical and nutritious meal preparation and community development workers in basic health messages. DOE fulfils a role in adult education, parenting skills development and could relay nutrition information to parents and staff.

DSD provides subsidies to ECD centres to cover child feeding and they also fund training of ECD principals through Boland College. They work extensively on farms in the Breede Valley sub-district and have the platforms to reach parents for information sessions. They also support programmes for teenage pregnancies and child care.

CDP's involvement in the domain of IYCN presently lies in ECD centres by supporting training of staff in collaboration with DSD and DOH and providing food parcels to families in distress. The content of the food parcels were decided upon in collaboration with dietitians from DOH.

“That's why we are rather working closely with the Department of Health because they have the staff. They have the expertise and would rather support the programmes that they are implementing.” (Interview 15 to Du Plessis, 2013)

A unique forum called the “Liaison group” has been in existence in the Breede Valley since 2009 and is focussed on intergovernmental cooperation. This Liaison group comprises the directors and senior managers of DOH, DOE, DSD and CDP. They meet quarterly and discuss issues of transversal importance.

“I've engaged my partners at a very senior level, from the start of my starting year at Cape Winelands in 2009 to say, let's start the intergovernmental liaison committee comprising of myself, as the most senior person in local government in the Cape Winelands dealing with the aspects relating to rural and social development with, you know, regional directors of education, health and social development to say how do we at least, you know, share information about what kind of service to deliver. Where do we deliver it? Who is involved in that and what kind of resources are we pumping into that? And, I mean, this has really opened up a new sort of a window of opportunity for all of us because we've now begun to see transversal issues around the millennium development goals, issues of vulnerability, issues of hot spots within our communities. Issues of hot spots both in terms of malnutrition, in terms of poverty but also in terms of, you know, unemployment in terms of youth gangsterism, in terms of substance abuse and in terms of all those things affecting society without being, you know, seriously prioritised, transversally by government departments because if community safety and police look at, they look at the problem. They don't look at preventing the problem and I think this is what has gone wrong and what we've tried to do within this liaison committee, to say: if we do spend resources, where do we spend it?”

Community radio already works with DOH, DSD and the university and communicates messages in the domain of IYCN. They are willing to increase this focus as advocates for child health and work with local business in a reciprocal manner to further their community support initiatives. The private hospital promotes breastfeeding through their ante-natal and breastfeeding support service. The university has a committed institutional focus on community engagement and networking functions which is operational, but could be improved. Students at the Worcester campus are trained to address the current and important health issues in an interdisciplinary way.

“Eighty percent of the disciplines do, they fall in with the burden (*referring to the burden of disease in the district*) and with what we do, not 100%, I mean I do understand there's curriculum outcomes and things to which the students must comply to, but as we come up with something, they define it and they fit in and that for the students is a study opportunity.” (Interview 27 to Du Plessis, 2013)

Good relations and communication with DOH help to identify student placement for practicals and internships for maximum impact. The university is also committed to do relevant research and to communicate this research in the sub-district to ensure uptake of this evidence-base into practice.

Boland College trains nursing students in maternal and child health, including breastfeeding. They are committed to bringing the caring ethos back into nursing, in order, among other, to ensure that the birthing process is a good experience for mothers and that mothers and babies remain together to ensure a good start to bonding and breastfeeding. Furthermore, nursing students are exposed to interdisciplinary learning and teaching along with healthcare students from Stellenbosch University to encourage interdisciplinary work. Boland college also trains ECD principals in crèche management.

“We closely work with the management of the Cape Winelands District (Health) office that's responsible for the programmes etc. Because what we've heard, when we've started here is that registered nurses coming out, if they put them in the, in the services, there's some gaps. So we actually had sessions where we've sit with the

managers responsible for the operations and programs to actually hear from them what the problems are, and in a way we've adapted our programmes on the different programmes in Health to see how we can actually address it." (Interview 16 to Du Plessis, 2013)

### **5.3.7 Stakeholders' capacity to address IYCN**

Various forms of capacity were mentioned as being present and available in order to address IYCN in the Breede Valley sub-district. Community members have acted as volunteers before and it could therefore be assumed that they have developed capacity to do this kind of work. Some of the ECD staff have been trained to monitor children's weights and to refer children to the clinic if any signs of malnutrition are identified. Grandparents are seen to have experience in raising children and seem to be the care resource of choice when mothers have to work and a crisis resource to take care of grandchildren when parents experience traumatic events, or when children are abandoned.

"I listened one evening when the parents were giving feedback (*at a parenting skills workshop*) and there were really a few of them who I thought 'wow, these people should actually spread the message amongst their own people because they did it so well'. And they were so excited about it. We really hope that it is the start of something that could spread and which could continue and reach more schools." (Interview 18 to Du Plessis, 2013)

"The grandmothers, uh they take more care for the child because I think they have more experience." (Interview 9 to Du Plessis, 2013)

An example was cited where a father's involvement with a sport club, led to the son's involvement at the same club. Family involvement in community activities could in such a way have a ripple effect on skills development and positive activities to keep children occupied and off the streets.

"Yes, I started doing sports at school and so on. It's actually a passion and it's in our family. My father played sports, rugby and so on, now I just go on." (Interview 14)



The same young man is passionate about being a role model for other young people; to inspire them not to become involved in drugs, despite their hardships. He mentioned a resource that is often seen as a “soft” issue, but can be extremely powerful.

“I mean okay we all don’t have money. Everybody isn’t rich but we’re rich with love understand. We have love. I have love for them, (*young people*) understand? (Interview 14 to Du Plessis, 2013)

Many farms in the Breede Valley have crèche facilities on their properties and work with DSD to improve these facilities. The reason for some farmers establishing crèches was cited as compliance with regulations around occupational health and export of their products. In this way regulation paved the way to support child care on farms. The good relationships established between farmers and DSD staff has strengthened the capacity of these child care facilities to act on their mandate.

DOH trains health staff and community care workers and DSD personnel, among other, in topics with a focus on maternal and child health; DOH and Boland College are involved in training ECD staff while CDP and DSD fund this training. PHC clinics are seen as a resource for information on IYCN. DOH nutrition personnel are qualified dietitians and classified as professionals with scarce skills. The appointment of one more dietitian in the sub-district was attributed to “Healthcare 2010”, DOH’s comprehensive service plan that guided the health sector reform in recent years. The DD Comprehensive Health Services was cited as a manager who has the power to move specific funds within the INP budget and who can push the IYCN agenda within DOH management and possibly on other forums.

“But I think the Cape Winelands has gone a step ahead in challenging the Comprehensive Service Plan in saying that we need to put our money where our burden is. So we are making a few changes in that regard. (Interview 24 to Du Plessis, 2013)

The South African Social Security Agency (SASSA) grants were felt to hold potential to increase households’ purchasing power and capacity to care for children, if used

appropriately. Therapists from DOE reported having done parenting skills training in a specific area in the Breede Valley and are investigating possibilities to roll this programme out to more communities. CDP already have extensive links to other stakeholders and departments and focus on capacity building, including empowering women for employment. In the domain of IYCN their involvement lies in ECD's by supporting training of staff in collaboration with DSD and DOH.

The Liaison group forum was mentioned as a place where IYCN could be raised as an issue of cross-cutting importance to be put on the agenda at the highest level of government leadership in the sub-district. They have the capacity to unpack and act on the "whole of society approach" as envisioned in the NDP. This forum builds and nurtures relationships and ad hoc invitations are made to other stakeholders to attend these meetings, as deemed necessary and appropriate. The university and Boland College have both been invited to these meetings in the past.

"Now taking a shift from a sort of government approach to a 'whole of society approach', I think will help senior managers to break out of the mode of realising that government alone is supposed to deliver and disregarding the role of the private sector and civil society." (Interview 19 to du Plessis, 2013)

Public meetings where the local municipal council presents their 5-year plan to community members were mentioned as a space where community members can voice their concerns. This is an example of local government engaging with communities. It was expressed that ward councillors of political parties in communities should be putting pressure on service delivery and can potentially become advocates for IYCN.

Community radio uses DOH's Health Calendar and formulates programme focus topics around these themes. They have very good relations with some of the government departments, specifically DOH and DSD and some local businesses. The size of their listener audience is ranked 4<sup>th</sup> out the 27 radio stations in the Western Cape, during the week. They have had a constant growth in listener numbers and are ranked 2<sup>nd</sup> amongst 27 radio stations for audience size on Sundays.

The local Business Forum represents more than one hundred businesses in the area ranging from street vendors to large corporate companies. Peer pressure between businesses as well as company policies were mentioned as ways of potentially shifting issues for change in this specific sector.

“I think that type of underlined competition between different businesses might actually be more effective at bringing in changes of policy than a top down approach from government or a bottom up approach from community.” (Interview 12 to Du Plessis, 2013)

The university and Boland College have infrastructure and a mandate to train students. The university appoints very good facilitators to assist students in the rural rotations and expose them to interdisciplinary work and skills sharing. Furthermore, the research done by the university broadens the evidence-base of interventions that can be implemented at district and sub-district level.

The data gathered from semi-structured interviews with stakeholders in IYCN, in the Breede Valley sub-district, provided a rich description of the perceptions they hold about IYCN as well as the barriers they perceive to be curbing its improvement; ideas about actions and resources needed to address IYCN and commitments and capacity for IYCN at the implementation level. Before closing the interviews stakeholders were asked to rate themselves on the Power / Interest matrix.

### **5.3.8 Stakeholders' self-reported powers/interests in IYCN**

During the stakeholder identification meeting, the stakeholders were positioned in the upper right quadrant and upper left quadrant bordering on the upper right quadrant; i.e.: those with highest power and interest, as well as those with highest power and medium interest (Table 5.1). When stakeholders rated themselves, twelve stakeholders rated themselves in the upper right quadrant (high power and high interest) three stakeholders rated themselves in the upper left quadrant (high power, medium interest), three rated themselves in the lower left quadrant (medium power, medium interest) and four rated themselves in the right lower quadrant (high interest, medium power) (Table 5.3).

Table 5.3: Stakeholders' self-reported Powers/Interests related to IYCN in the Breede Valley sub-district

↑ P o w e r	<b>Training Institution:</b> Stellenbosch University x 1 <b>Business forum</b> <b>Private Healthcare</b>	<b>Community members (Zweletemba x 6):</b> Grandmothers, crèche owner, CNSP fieldworker / ANC youth league leader / teenager <b>Community members (Avian Park x 6):</b> Grandmothers, crèche owner, CNSP fieldworker / DA ward councillor/ CDW, mother <b>Media (Radio x 1)</b> <b>Government:</b> CDP Director / DOH, INP Manager / DOH, CS / DSD social worker/ DSD social worker supervisor
	<b>Government:</b> CDP x 2 DOE special support services x 2	<b>Community members:</b> Unemployed farther; Sport organiser <b>Training Institutions:</b> Stellenbosch University x 1/ Boland College Nursing

Interest →

#### 5.4 Discussion

The aim of this phase of the research study was to systematically identify key stakeholders in the Breede Valley and to qualitatively explore their perspectives, commitment and capacity to act on issues pertaining to IYCN.

Stakeholders who can impact IYCN in this sub-district were systematically identified by a strategically selected group of individuals who know the sub-district well. Interviews were conducted with 27 of these individuals who represented the community (crèche owners, grandmothers, community-development worker, mothers and fathers, sport club organiser, the youth, politicians and research fieldworkers), government sectors (DOH, DOE, DSD, CDP), training institutions (Stellenbosch University and Boland College), the business forum, private healthcare and the media.

The knowledge, attitudes and behaviours of mothers, fathers and caregivers regarding IYCN were extensively studied in the broader CNSP (Goosen *et al.*, 2014a; Goosen *et al.*, 2014b;

Mathhysen *et al.*, 2014). It was therefore not the intention to investigate these aspects in detail. Nonetheless, an opening question was posed about the meaning of IYCF and IYCN at the outset of the semi-structured interviews to initiate the discussions. In this case, stakeholders explained the importance of IYCN with specific reference to child growth and development. Although there was awareness of the importance of IYCN and its links to child growth and development, the correct knowledge and detail about IYCF/IYCN was not evident. This misunderstanding of nutrition issues by the many non-nutrition sectors that need to be engaged for multi-sectoral action is acknowledged in literature. It is also recognised that this lack of insight and confusion can lead to low attention or commitment to nutrition (Pelletier *et al.*, 2013a)

The factors impacting on IYCN and the barriers to addressing it was explored with the stakeholders. This was done to gauge their understanding of the complexity of problems experienced with IYCN in the sub-district. They explicitly identified some of the socioeconomic factors, as depicted in the WHO framework on the Social Determinants of Health (SDH), highlighted in Chapter 2. These included income (described as unemployment and poverty), (lack of/poor) education, (low skilled/poorly remunerating) occupations and gender (monetary and other power aspects in relationships as well as women in employment) as factors that impact IYCN in this area. Issues of race/ethnicity and social class were implicit in this identification, since the two communities engaged in the research were deeply impacted by their history, particularly the apartheid era. Participants also identified the intermediary determinants of health (material and psychosocial circumstances, behavioural and/or biological factors and access to health care) as impacting on IYCN.

The focus on the first 1000 days of life corresponds with a life course perspective on the impact of the social determinants of health (WHO, 2010b). This life course perspective channels attention to every level of development from early childhood to adulthood with a realisation of the immediate influences specific events have on health as well as the impact of these specific events on health and well-being in later life (Black *et al.*, 2013; Bhutta *et al.*, 2013; Martorell *et al.*, 2010; Victora *et al.*, 2008). Babies born into deprived conditions have a higher risk of dying young, becoming ill, not performing well in school and thereafter, not earning decent incomes and suffering from NCDs in later life (Black *et al.*, 2013; Bhutta *et al.*,

2013; Martorell *et al.*, 2010; Victora *et al.*, 2008). If they suffer developmental delays, it is likely to be those associated with intellectual disability, including speech impediments, cognitive impairments and behavioural problems (Jefferis *et al.*, 1999; Maughan *et al.*, 1999). Women with even mild intellectual impairments are at specific disadvantage and at higher risk of teenage pregnancies (Graham, 2004). Stakeholders reported a particular concern about high levels of teenage pregnancies in the study area in the Breede Valley. Teenagers are the “bearers and carers” of the next generation (Black *et al.*, 2013), but in this sub-district they were portrayed as ill prepared and poorly equipped to fulfil this task. A lack of role models and leaders, lead to poor knowledge and ignorance, poor human and social capacity and poor skills and job opportunities, and have the spin-off of dependence on grants and contributing to societal degradation. This description corresponds to the concept of the intergenerational cycle of poverty (Hoddinott *et al.*, 2011; Nisbett *et al.*, 2014a). This cycle draws attention to teenage pregnancies as a lead cause of IUGR resulting in low birth weight (LBW) babies. LBW babies give rise to undernourished children who enter the world as key expressions of poverty (Hoddinott *et al.*, 2011). Moreover, it draws attention to undernutrition as a significant driver by which poverty and its associated burdens are transferred to the next generation (Hoddinott *et al.*, 2011; Nisbett *et al.*, 2014a). In the case of the Breede Valley, the intergenerational cycle of poverty is playing out now as described above, but has its roots in, among other, the social injustice of the apartheid system, alluded to earlier.

Other pregnancies than those involving teenagers, are also of concern in this area since the majority of women of childbearing age in these communities were found to be overweight or obese (refer to manuscript in Chapter 3). Maternal overweight and obesity during pregnancy increase the risk of trans-generational transfer of obesity from childhood into adolescence and adulthood, escalating the danger of various adverse health conditions and diseases of lifestyle (Black *et al.*, 2013). This places an additional burden on the already overburdened health system and influences societal productivity (Black *et al.*, 2013).

The broad socioeconomic and political context of the social determinants of health (WHO, 2010b) impacting on IYCN was stated by the sectors positioned in this environment, including government department officials, the business forum and media. Societal values,

embedded in this context, were mentioned across participant groupings. Although all the different factors and aspects were not identified or expressed in an interlinked manner as portrayed in the social determinants of health framework, by all stakeholders, they could identify the different constituents of these determinants impacting on IYCN in this area. It can therefore be said that there is insight in the determinants of poor IYCN by stakeholders in the Breede Valley sub-district. Addressing these problems are however, hampered by, among other, being overwhelmed with the complexity of the problems as well as reactive positions taken on issues impacting on IYCN, which some sectors described as “being on the receiving-end of the problems”. Silo thinking in the government sectors as well as departmental-bound management and budgeting were highlighted as barriers to addressing IYCN in a comprehensive, integrated way. Sector-bound organizational structures, including a lack of targeted nutrition communication and/or advocacy campaigns were further offered in explanation as barriers to addressing IYCN. The DOH’s INP would be the natural champion for this task, but experience from other lower and middle-income countries indicates that the institutional position of nutrition often jeopardises its voice and actions. (Benson, 2004; Garrett & Natalicchio, 2011) Nutrition overlaps with many spheres and sectors, but it often becomes trapped in one of government’s vertical departments or programmes; e.g. health, agriculture or social development, each with its own specific strategic and performance focus which results in vertical flows of budgets, resources and reporting lines (Harris & Drimie, 2012; Garrett & Natalicchio, 2011). In the Breede Valley sub-district the INP was described as being integrated into other health platforms and programmes, which has reportedly promoted awareness around the programme. This positioning of nutrition could, however, result in being “everyone’s business but no-one’s responsibility”, as described by Berg (1973, quoted by Nisbett *et al.*, 2014 p 423). Such an integrated approach could create the illusion of effective implementation when impact might in actual fact be sub-optimal.

Benson (2004) argued that advocacy groups should generate a perception of crisis related to malnutrition to ensure significant, urgent and high-profile action by governments. One of the stakeholders voiced this notion as follows when asked what actions were needed to address IYCF in the district:

“I tend to think that it’s always a crisis that shifts the mind, you see...because the mind is always comfortable in a certain place” (Interview 12 to Du Plessis, 2013)

Indeed, in this district, nutrition, with a specific focus on the first 1000 days, was elevated on the management agenda of DOH due to a crisis with children dying during the diarrhoea season. Although this is a step in the right direction for nutrition to be highlighted as important, the danger is that nutrition is still seen as treatment of malnutrition and not prevention of it.

In SA, advances have been made to curb child mortality, mainly via the world’s largest programme of antiretroviral therapy that was rolled-out in the country (Mayosi *et al.*, 2012). The massive success of this HIV/AIDS programme was supported by an extensive advocacy campaign led by the Treatment Action Campaign (TAC). It was visible in all spheres of society, including in all government departments, schools and public places (Hayward, 2008). SA has a wealth of experience in this regard which could be utilised to the advantage of advocating for IYCN (DPME, 2014).

Commitment to addressing IYCN was verbalised in the identification of various roles stakeholders currently play or which they could potentially play with regard to addressing IYCN. Training professionals and community health workers as well as other cadres of staff to undertake nutrition education on IYCN was expressed as a priority action. Although human resources were seen as problematic across government sectors, solutions involving resources and expertise sharing, interdisciplinary work, promotion of trans-disciplinary skills transfer and building good relationships were offered. Some respondents suggested or alluded to a “whole of society approach”, which has been advocated by the NDP 2030 (NPC, 2012). This includes actions needed for improved outcomes on many levels, including economic growth and health care. Reference to a “whole of society approach” show insight in the direction suggested from a national level, but also illustrates the principle of human



kindness, expressed in the Southern African term “uBuntu”<sup>23</sup>. This “can do” attitude and embracing of soft skills could strengthen capacity to act at implementation level.

Among the numerous forms of capacity needed to successfully scale-up priority nutrition interventions, are: i) individual ii) organisational and iii) systemic capacity (Gillespie *et al.*, 2013). Individual capacity focusses on the availability of resources as well as the appropriately skilled staff to perform the tasks at hand (Gillespie *et al.*, 2013). In this sub-district resources are described as scarce, but the energy and positive attitudes from many stakeholders could bridge some of the resource and staff barriers. There are currently two staff members professionally trained in nutrition working for the INP. This is an obvious shortfall, as recognised by some stakeholders. An option to increase this capacity is the training of others both inside and outside of government: community care workers, nursing staff, students of healthcare professions and other government personnel. This training should emphasise communicating basic IYCF messages.

Organisational capacity relates to sufficient staff with the appropriate skill mix functioning within an environment with suitable monitoring and reporting systems that ensures accountability as well as incentives and sanctions. This also includes the availability of proper training and support facilities (Gillespie *et al.*, 2013). The government structures in this sub-district do not have sufficient staff to deal with the general workload, including work related to IYCN. Staff also lack trans-disciplinary skills and specific monitoring on current targets. The only nutrition-related issue linked to performance appraisal in the health sector was for attaining MBFI status in facilities, but this is for facility managers only. Training facilities in government sectors are available, but support (specifically resources) is not optimal. On the other hand, a reciprocal relationship exists between Boland College, Stellenbosch University’s Rural Campus, and specifically the Health Department through a service-learning agreement. Students from the afore-mentioned tertiary education institutions are placed in health facilities and the broader community for practical rotations and internships and render a service while learning from the experience. There is also potential for broadening

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<sup>23</sup> uBuntu is a Southern Africa term roughly translated to mean “human kindness” or humanity towards others. When used in a more philosophical sense it means “the belief in a universal bond of sharing that connects all humanity” ([http://en.wikipedia.org/wiki/Ubuntu\\_\(philosophy\)](http://en.wikipedia.org/wiki/Ubuntu_(philosophy))).

this agreement beyond the Health sector and for expanding the sharing of training resources and platforms.

Systemic capacity concentrates on accessibility and utilisation of executive forums or multi-stakeholder platforms for discussing, debating and deciding on nutrition issues. Furthermore, this type of capacity allows for information, funds and command flow in a timely and effective manner and advances links with private sector, the community and NGOs. This happens when individuals, teams and committees are empowered to make joint decisions for effective performance. (Gillespie *et al.*, 2013) The potential for this type of capacity exists in the unique Liaison group that is operational in this sub-district. The forum presents a platform for the directors of the different government sectors to discuss issues of transversal concern. Examples cited were HIV and teenage pregnancies that have been prioritised as agenda items of this forum. IYCN was not an agenda item at the time of the stakeholder interviews, but this forum offers an ideal platform to further a cause of cross-cutting importance, such as IYCN.

The power / interest self-rating by stakeholders looked slightly different from the rating done by the group selected to identify these stakeholders. This is not unexpected since some groups do not have an institutional focus on nutrition and/or infants and young children, specifically DOE and CDP as well as the young men in communities. The training institutions rated themselves lower in power and interest, which could probably be explained by the broad training focus of these institutions.

The stakeholders with high power and interest are the people or organisations most influential to create change and those who should be fully engaged. Bringing these stakeholders into a shared space to learn from and about one another could forge stronger linkages between them. Furthermore, it would be important to strategize about ways of moving the “high power” business forum, private health care as well as CDP and DOE to a place where they have “high interest” as well. Literature suggests these stakeholders could play supporting roles in a change process (DFID, 2002; Start & Hovland, 2004). Well planned communication and advocacy to these groups about the evidence of the importance of the first 1000 days (Pelletier *et al.*, 2013) and the impact it exerts in the development spheres

(CDP), including increased earning potential and economic growth (business), health and well-being (private healthcare), cognitive development and schooling attainment (DOE) (Bhutta *et al.*, 2008; Dewey & Huffman 2009; Fall *et al.*, 2011; Martorell *et al.*, 2010; Victora *et al.*, 2008) could motivate these stakeholders to work collectively to address child nutrition.

## 5.5 Conclusion

Stakeholders in IYCN in the Breede Valley sub-district recognised the importance of IYCN, with a specific focus on child growth and development. This reflected both short and long term implications of poor IYCF. They were able to identify, assess and discuss the social determinants of health, in the context of IYCN in the Breede Valley.

In the initial stages of engagement, some stakeholders did not know why they were referred to as stakeholders in IYCN. During the interviews there was a progressive realisation that everyone can do something to change the current situation. This realisation hinged on recognising actions in their own homes and families and extended to the work place and other spheres of influence in communities. To this extent, the envisaged action for IYCN exemplifies the “whole of society approach” promoted by the NDP (NPC, 2012). The realisation that “everyone can do something” was also revealed in the Power/Interest matrix, where most stakeholders plotted themselves in the upper right quadrant with other stakeholders falling near the borders of this quadrant.

In this regard, the research methodology assisted in building an understanding of IYCN and what to do about it through role identification and stock-taking of available or existing resources. This could be interpreted as strengthening of commitment and capacity building.

Although many barriers exist to addressing IYCN, especially scarce human and financial resources, commitment was displayed in the identification of specific roles that are or could be fulfilled in addressing IYCN. Good relationships and sharing of expertise already exist between government departments. Furthermore, different forms of capacity, including individual, organisational and systemic capacity, needed to address IYCN issues are present in the sub-district. Some sharing of these capacities among government sectors is evident.

There is, however, no clear and cohesive approach across government sectors including inputs from community members and the private sector to comprehensively address IYCN in the Breede Valley sub-district yet.

**Chapter 6: Mapping the IYCN stakeholder landscape in the Breede  
Valley sub-district**

## 6.1 Introduction

In Chapter 5, the first and second of a three-step approach to stakeholder analysis were documented, namely: a systematic method of 1) identifying and 2) differentiating between stakeholders who can impact IYCN, as well as an initial exploration of their perspectives, commitment and capacity to address IYCN in the Breede Valley sub-district. The follow-on objective was to bring these stakeholders together, define relationships among them and outline their priorities and powers as it relates to IYCN in the Breede Valley sub-district.

## 6.2 Summary of methods

Twenty six key stakeholders who were identified and interviewed were invited to a stakeholder engagement workshop.<sup>24</sup> A social network analysis method known as Net-Map was applied in this phase of the research, as described in Chapter 4, section 4.3.3.3 and depicted in Figure 6.1.

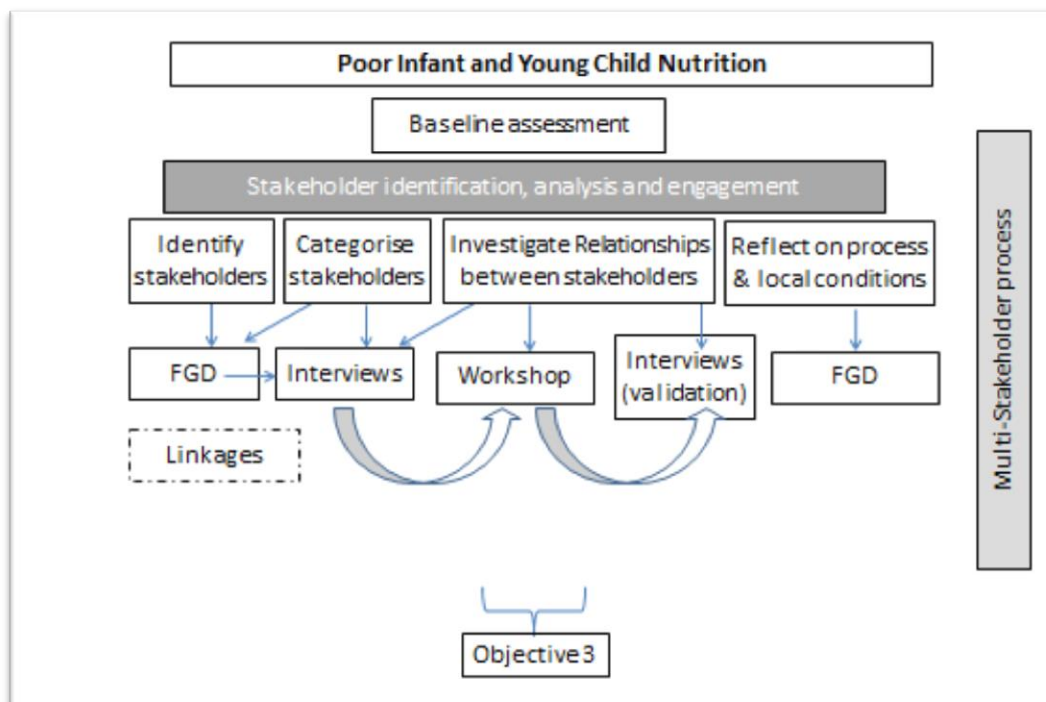


Figure 6.1: Methods and objective indicated for the investigation of relationships between stakeholders

<sup>24</sup> One community representative from Zweletemba withdrew after the initial interview. The organisation the person is involved with was originally thought to include vulnerable infants and young children, but it transpired that they cater for the needs of children 7 years and older. The researcher went on to conduct the interview, since the appointment had been made and invited her to the workshop on account of her knowledge of the community, but she humbly declined the invitation.

The stakeholders who were invited and who attended the workshop are listed in Table 6.1.

Table 6.1: Names of stakeholder groups who were invited and who attended the stakeholder engagement workshop

<b>Representatives from the following groups were invited and were present at the meeting</b>
Community members; NGO's & CBO's (4 x Avian Park + 2 x Zweletemba); Political Party (1 x Avian Park) Department of Health (2) Department of Education (2) Department of Social Services (1) Business Forum (1) Higher Education Institutions - University (1 x Rural Clinical School)
<b>Representatives from the following groups were invited, but could not attend the meeting</b>
Community members (3 x Zweletemba; 1 x Avian Park); Political Party (1 x Zweletemba) Department of Social Services (1) Media (1) Community Development & Planning - Cape Winelands Municipality (2) Private Health care (1) Higher Education Institutions - University (1 x Rural Clinical School); Boland College (1 x Nursing)

The facilitator (co-study leader) explained the procedure and expectations of the workshop and indicated that stakeholder relationships, as well as their powers and priorities, would be explored. The facilitator initiated a discussion in order to determine different roles in relation to IYCN, including the stakeholders' own roles. The first question posed to the group was: *"Who has a role to play to ensure that babies and young children are well fed in this area?"*

Through brainstorming, the participants identified key stakeholders operating in the Breede Valley sub-district and beyond who have a role to play with regards to IYCN. The different stakeholders identified were assigned different colour codes as detailed in Table 6.2.

## 6.2 Stakeholders who can impact infant and young child nutrition in the Breede Valley sub-district with an identifying colour code assigned to each stakeholder group

<b>Stakeholder names</b>	<b>Colour code</b>
National, Provincial and local Government [Health, Education, Social Services (grants), Treasury, State departments as employers, political parties]	Orange
Community structures [Religious organisations; Community Care workers, NGO's, CBO, crèche community]	Yellow
Employers & Private sector [Farmers, Retail (Worcester mall); Rainbow Chickens; Hextex, Municipality]	Blue
Other [Parents, grandparents, Stellenbosch University, media (national & regional) media (local radio & newspaper); peer groups, sport organisations, cultural practice, global fund]	Red

The facilitators explained the task at hand to the stakeholders, which was to identify different actors in IYCN and to plot them out on large empty white sheets of paper. By mapping different actors in this way, the linkages between them could be identified and analysed. The groups initiated the process by placing a particular stakeholder name on the map and indicating where the actors play a role in terms of their influence on IYCN.

They were encouraged to move the cards about and to consider how they were connected. The connections/linkages between the actors had been established during the introduction-overview and brainstorming session. Different coloured markers were used to draw specific connecting lines (linkages) between actors (Table 6.3). The thickness of the line indicated the level of its power (e.g. thicker lines = higher power). “Checker rounds” were also placed next to stakeholder name cards of those considered to hold the most power.

Table 6.3: Linkages between the different stakeholders in the Breede Valley sub-district and beyond with the identifying colour code assigned to each connecting line between stakeholders

Connecting lines indicating linkages between stakeholders	Colour code of connecting lines
Money/funds	Green
Command/authority/power	Red
Information	Blue
Advocacy	Orange

One group worked in Afrikaans and one in English. Participants could choose where they wanted to work and in the language they felt most comfortable. After a period of discussion and placing of cards and drawing of connections between stakeholders, the two groups were asked to report back to the larger group.

## 6.3 Results

### 6.3.1 Feedback from the “Afrikaans” NetMap group

This group depicted the parents as the main stakeholders in IYCN (Figure 6.2). Fathers were placed separately, since they were seen as not always being present or fulfilling their roles. Grandparents were also shown to play an important role in IYCN. There was a strong feeling



that the information children and families needed about IYCN should start in the home. The group argued that parents have to take responsibility, but they are often poor and illiterate; and alcohol and drug abuse were cited as barriers to fulfilling their roles. It was also stated that children are very aware of their rights and this leaves poorly skilled or unemployed parents powerless to communicate with their own children.

Unemployment was identified as an important problem in the area and the resultant lack of funds leave parents with very little money to buy sufficient and nutritious food. Unemployment, however, is exacerbated by the fact that young adults do not have the qualifications to take up available jobs, since they often do not complete school or do not perform well at school. This leads to reinforcement of the poverty cycle, explained in a similar way as in the first phase of interviews (Chapter 5): children are born into poverty; they do not complete school; they therefore have poor work opportunities; teenage girls often fall pregnant and bring another child into the poverty trap. When children do attend school, an issue was raised about young high school children falling pregnant and Department of Education (DOE) having to deal with the consequences.

Communication lines between government departments were seen as very important. These lines of communication potentially translate to strong lines of information to communities. A problem highlighted was that young adults are no longer being taught about child care and family planning. This is due to time constraints and staff shortages, including in ante-natal clinics, where staff are described as overburdened with many work priorities. It was mentioned that a good place for Department of Health (DOH) to intervene to address this situation would be in schools. The sentiment was expressed that comprehensive School Health services should be re-established and strengthened to fulfil this role.

It was stated that all government departments should provide information to the media, since the community radio and newspapers have a broad reach in this area and in this way the right information will reach the target group. A comment was made that it is clear from this map that participants regarded education as very important. An explanation was offered to substantiate the comment, in that, if education is in place, mothers will have the right information to feed their children well; a situation that can eventually benefit the

community and the country's economic growth. Teaching children life skills in schools, who in turn can pass on this information to their parents (Health Promoting School<sup>25</sup>, [WHO, 2015] “child-to-parent concept”), was mentioned as a powerful initiative to channel information to communities.

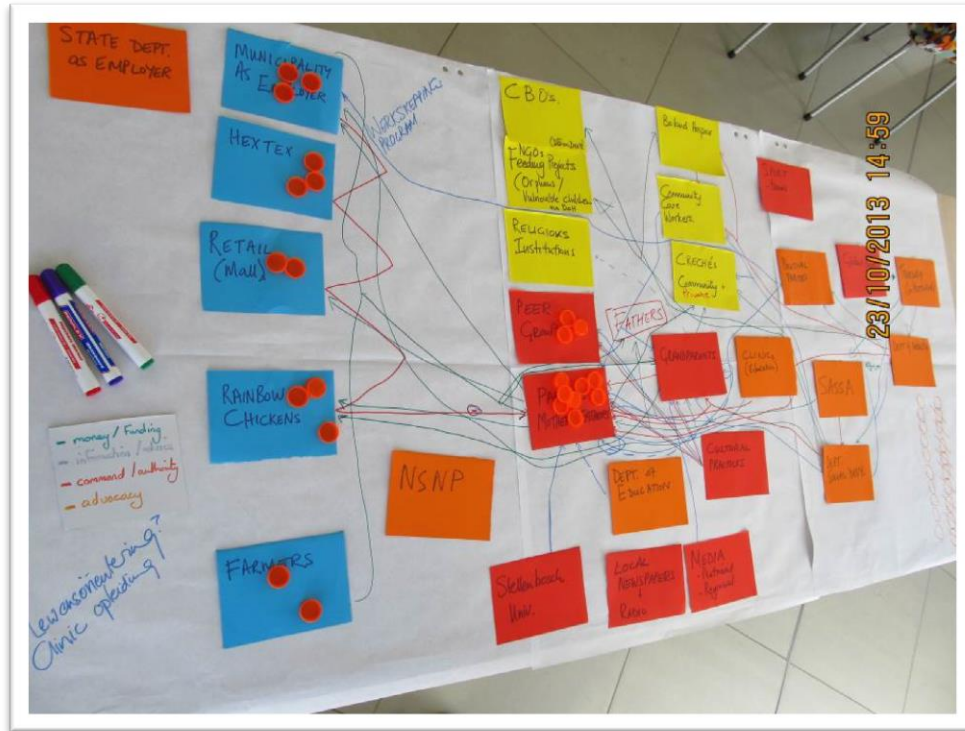


Figure 6.2: Visual of “Afrikaans” NetMap

### 6.3.2 Feedback from the “English” NetMap group

The governing national political party, the African National Congress (ANC), was prominent on this map and identified as possessing the power to influence many issues around IYCN. (See Figure 6.3) They were seen to govern and their rules and regulations and budget decisions have a ripple effect all the way down to parents and children. It was mentioned that if power was not managed well at the top, poor management in turn would filter down to sub-districts. In relation to this statement, reference was made to the local political party councillors who do not have the political will or mandate to influence many issues in the Breede Valley sub-district.

<sup>25</sup> A Health Promoting School (HPS) is defined as a school that is constantly strengthening its capacity as a healthy setting for learning, living and working (WHO, 2015).

A strong link was pointed out between government, farmers and parents. An example was provided as follows: government is instilling fear in farmers through pressure about minimum wages for their workers. Fewer farm workers are employed due to the response from farmers, i.e. mechanisation. People have less money for food; children are taken out of crèche and are often neglected. Furthermore, if government allows over-importation of e.g. clothes, then the local textile companies suffer. There are also fewer jobs because of the influx of foreigners, since the farmers prefer the cheap labour they can access from foreigners. A major problem is that resources are not increasing for the local people and the foreigners are draining the same resources.

The subsidies from government for crèches were highlighted as an important resource, because unemployed parents can make use of the crèches and the children can benefit from the subsidies in this way. Furthermore, the SASSA grants were said to increase parents' purchasing power, but they were also seen by some in the group as being problematic. Young mothers are allegedly not using the grant money to feed their children. Instead they use it to their own benefit by doing their hair and buying material things. This issue ties back in with labour; highlighted as a contentious issue in this area. Grants are said to offer too little money to provide in children's needs, therefore, parents still need to work, but the job opportunities in the Breede Valley are scarce and low in compensation.

The break-down of relationships between children and parents in the study area was identified as a sad reality. The Children's Act (Childrens Act, No 38 of 2005) was perceived as limiting parents' rights to discipline their children (with specific reference to protection from corporal punishment); children are leaving school early and the parents feel powerless to do anything about it. A comment was made that something clearly went wrong with family cohesion. The group perceived a need for role models. Sport teams and religious institutions were cited as important in this regard. The local and global media was also mentioned as important for role model messaging. Parents' need for information was reiterated as important. It was felt that if they had the correct information and education, they would be able to make informed choices. Children would thus stand a better chance of being cared for and fed correctly. It was felt that issues pertaining to information and education needed to

be taken further in discussion between DOH, DOE, DSD and the media, since these stakeholders were seen as the custodians of specific bodies of knowledge.

The presence of Stellenbosch University's rural campus, as well as Boland College, in Worcester was highlighted as being important for the training of professional people as well as skills enhancement. If targeted effectively to healthcare workers, community carers and ECD staff, it was felt that IYCN would be positively impacted in local communities through the close contact these workers had with community members.

One of the stakeholders made the statement that, "if we want to see a change in 5-10 years' time, there are probably 3 things that should happen." (Multi-stakeholder engagement meeting, Participant 14 to Du Plessis, 2013)

The following three points were raised to substantiate the statement:

"Nr 1) The State must regulate this matter (IYCN). We should not wait for them to do that, but that will be the quickest way of moving forward; Nr 2) Behaviour change. We should work towards empowering the mother as final decision maker about IYCN; and Nr 3) Advocacy. This is possibly the most important place we can make an impact" (Multi-stakeholder engagement meeting, Participant 14 to Du Plessis, 2013)

It was mentioned that the district has three platforms that other sub-districts do not necessarily have, including: i) the Liaison group forum, ii) higher education settings and iii) a Business forum. Worcester town is a regional hub with four government directors from DOH, DOE, DSD and the local municipality CDP department, who meet quarterly and have direct communication lines in an established forum, referred to as the Liaison group (also mentioned in Chapter 5). It was acknowledged that inter-sectorial collaboration is extremely difficult and the directors are constrained by policies and prioritised actions. Nonetheless, an advocacy strategy devised by these four directors could help to address behaviour change, information and knowledge which are clearly needed within communities. Secondly, there is a Stellenbosch University satellite campus and Boland College in the town. These higher education institutions can act as vehicles for advocacy and knowledge generation and - translation. Another forum in the town is the Business forum. It was stated that it is a very

busy forum and it is going to be difficult to get the “first 1000 days” as one of their priorities, but they do have a membership of more than 100 businesses and collaboration is worthwhile exploring.



Figure 6.3: Visual of “English” NetMap

One of the stakeholders offered the last words:

“It is not going to be easy, but let’s try...it’s not a short term conclusion and we must not think we’ll get some help or advice or be heard in a short period, but let’s try. Start small...make some talk...a meeting; sit down a bit with all these people and try something. We start somewhere and we’ll go a long way.” (Multi-stakeholder engagement meeting, Participant 1 to Du Plessis, 2013)

The participants were thanked for their input and the workshop was closed.

### 6.3.3 Consolidating and interpreting the maps and feedback

The information from the two Net-Maps was combined to form one visual (Figure 6.4). This was used to depict the flow of funds, command, information and advocacy between stakeholders who can impact IYCN in the Breede Valley sub-district. Although the groups had different points of departure, the different actors and the flows among and between them were similarly depicted on the two maps and it was therefore considered acceptable to combine the maps.

After the workshop, the researcher circulated a meeting report via e-mail and/or hard copy format to participants to verify the content of the report as a factual representation of the workshop proceedings. Follow-up interviews were organised with at least one representative from a stakeholder group, for those stakeholders who could not attend the workshop, to ask them for their input and comments on the report and map.

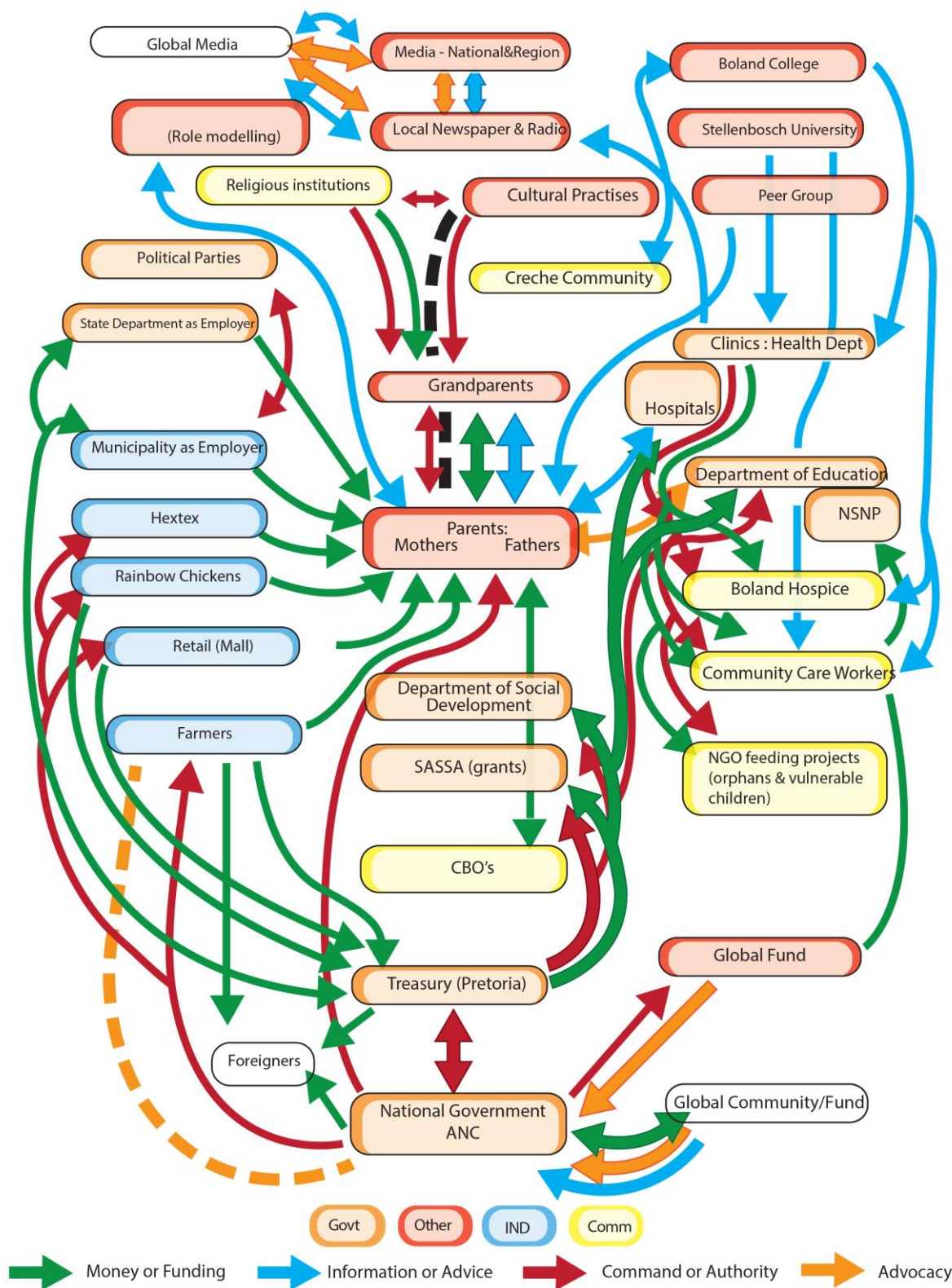


Figure 6.4: Combined Net-Map indicating flow of funds, command, information and advocacy between stakeholders who can impact infant and young child nutrition in the Breede Valley sub-district

(Thicker and thinner lines indicate the degree of power. Thicker lines indicate more power and thinner lines less power. The black hashed line indicates the breakdown in relationships and family cohesion)

#### 6.3.4 Supplementary information

Post-workshop reflection questions were posed to participants who attended the workshop and the questions were incorporated in the follow-up interviews with stakeholders who could not attend the workshop. The questions were as follows:

1. What did you get from this stakeholder engagement process?
2. What can you identify as the key levers (influences, powers, control) to try and shift or change this situation of poor infant and young child nutrition in this area?
3. What do you think you could do, (short /medium / long term) based on these identified levers?
4. What can you commit to doing at this point in time?

Responses about what stakeholder gathered from the stakeholder engagement process included:

“I was made aware of the magnitude of the problem and the difficulty of finding immediate solutions” (NetMap follow-up e-mail nr 02 to Du Plessis, 2013)

“I think it was an amazing opportunity where community leaders, politicians and government departments could come together and to see how to address a very complex problem. It provided me with the opportunity to see the whole picture and other role players’ opinions on everyone’s responsibilities” (NetMap follow-up e-mail nr 03 to Du Plessis, 2013)

“Getting a clear message about the logic of the importance of the first 1000 days; and realising that the state must regulate if progress is to be made, and how difficult that would be”. (NetMap follow-up e-mail nr 01 to Du Plessis, 2013)



One of the community members described her journey through the research process:

“The process has opened my eyes to see the danger we are sitting with. And I don’t know how to speed it up so that all the information that I have can go to other people as well. My worry is in future we won’t have intelligent children if we go on like this. Because the more time goes I see a terrible thing coming up if we are not going to do anything as soon as possible.

Babies are being neglected terribly, so the whole project up to now has given me...I worry, I can now see the picture.” (NetMap follow-up interview nr 03; to Du Plessis, 2013)

A number of responses emerged concerning the key levers that can shift or change the IYCN situation. These included: information and education sessions at clinics and other institutions with a specific focus on mothers and grandmothers; awareness and communication campaigns; poverty alleviation programmes - with a focus on budgeting skills, awareness around general healthy living; parenting skills; political will (from higher government levels) to support the full implementation of the SA IYCF policy; interdepartmental cooperation; mobilisation of the Liaison group to address the social determinants of health and to advocate for IYCN; and using the university as a knowledge partner and driver of change for IYCN.

Different commitments proposed for the short term were sector-specific. Community members and DSD felt they could have informal and formal discussions with friends/family/neighbours/colleagues in their homes/school/work/church to raise awareness for IYCN. DOH undertook to focus on training and monitoring of the better ante-natal care (BANC) initiative as well as implementation of the SA IYCF policy. CDP proposed that IYCN should be put on the Liaison group’s agenda and offered an invitation to the researcher to do a presentation to this effect at the forum’s following meeting.

For the medium term, DSD and CDP proposed workshops to be held with different stakeholders to plan and implement an advocacy strategy for IYCN. DOH proposed a 10-point plan for the department with a focus on the “1000 days” concept.

### Box 6.1 Department of Health, Breede Valley sub-district: 10-point plan for the first 1000 days

1. "Book" (*i.e. register*) every pregnant women before 14 weeks of pregnancy at a clinic
2. Measure mid-upper arm circumference (MUAC) and body mass index (BMI) of pregnant mothers (for anthropometric screening). Refer to the nutrition therapeutic programme (NTP), as appropriate and monitor.
3. Do active screening of every pregnant mother for TB and HIV
4. Polymerase Chain Reaction (PCR) test (follow-up test for HIV status) for babies will be done at 6 weeks and 9 months
5. Retrain all clinic personnel in observation rooms to weigh, measure and plot babies on growth charts as well as to act appropriately if needed
6. Monitor and audit immunisations up to 18 months of age
7. Better monitor and evaluate the NTP and to incorporate this point on monthly sub-district meetings
8. Train community based support (CBS) workers and other role players in the "1000 days" concept
9. Actively monitor severe acute malnutrition (SAM) management in hospitals for children under 5 years
10. Focus on family planning

Source: E-mail communication from DOH participant to Du Plessis, 2014

In the long term, an interdisciplinary and trans-disciplinary approach to nutrition was stated by DOH as a solution to addressing IYCN going forward. One of the CNSP fieldworkers has a dream of establishing groups/classes for IYCN support in communities. Community members expressed their willingness to assist in addressing IYCN in volunteering to act as advocates; to implement nutrition education sessions at ECD centres, and to act on short and medium term proposals, as stated above.

#### 6.4 Discussion

After initial exploratory interviews with key identified stakeholders (Chapter 5) to gauge their perspectives about IYCN as well as their commitment and capacity to address the situation in the Breede Valley sub-district, a multi-stakeholder engagement workshop was undertaken. The aim of this workshop was to explore relationships among key stakeholders and their priorities and power pertaining to IYCN in this area. A participatory research method, Net-Map, was used during this event since it was designed to address the mentioned aim, with a specific focus on implementation issues (Aberman *et al.*, 2012; Schiffer 2007).

The IYCN stakeholder influence map of the Breede Valley, collectively drawn by the stakeholders in this sub-district, had wide boundaries. It included the nuclear and extended family (consisting of mothers, fathers, children and grandparents), the broader community

(including employees, religious institutions, crèches, political ward councillors, peer groups, CBOs and NGOs; local radio and newspaper), higher education institutions; employers; municipal and local government; provincial and national government; external influences, including the national and international media; global community as well as the Global Fund<sup>26</sup>. It was clear from the maps that the story told about IYCN was complex and characterised by many local issues being connected to external influences created elsewhere. The discussions and maps portrayed the influences from different proximities and revealed how it affected local people, organisations, plans and actions in a powerful way.

Both NetMap groups emphasised the strong reliance of family members on each other for finances and information. A breakdown in relationships and family cohesion is, however, evident. Actions were discussed that could be coordinated by religious institutions, the media, sports clubs and crèches for the community from the community to rekindle family values; support behaviour change; and share information and knowledge. These influential structures mentioned could be supported by government departments, who were portrayed to be in positions to impart information and knowledge and facilitate behaviour change. In order for these community and government actions to work in synergy, government departments will need to ensure good service provision as well as communication and information via the different service points to community members. The media, which was portrayed as a stakeholder with wide reach to the community and already partnering with government, could be used successfully as a communication medium. In turn, community members need to be empowered by community structures to fulfil their responsibilities and improve their uptake of government, NGO and CBO initiatives. Government programmes and community-based initiatives as described here, aimed at the immediate and underlying cause levels of childhood malnutrition as portrayed in the UNICEF Conceptual framework, have been documented to hold potential to make substantial impact in addressing IYCN at local levels (Bhutta *et al.*, 2008).

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<sup>26</sup> The Global Fund, founded in 2002, is an organisation that supports countries to fight AIDS, tuberculosis and malaria. It is a partnership between governments, civil society, the private sector and people affected by the diseases. The Fund raises and invests nearly US\$4 billion a year to support programmes run by local experts, countries and communities in most need (Global Fund, 2015).

The strong flow of money from treasury, coupled with the simultaneous flow of command, was very clear on the “English” NetMap. Although funds are an asset and hugely needed resource in this area, concerns were raised about the impact of these funds and whether it is reaching the intended target groups. The command that runs parallel with the finances is understandable in the context of monitoring, but this top-down flow does create a “silo” approach to dealing with the problems at implementation level. This present structure-bound nature of government budgets does not allow for transversal utilisation of funds to support intergovernmental strategies for IYCN.

Another explicit flow of command from government, indicated on the “English” Net-Map, was linked to employment issues. It was stated that jobs are under pressure, because of labour legislation decisions (minimum wages in particular) made at a national level as well as external threats. In this case, the external threats referred to were labour unrests experienced in the recent past linked to minimum wage issues and fuelled by the opposition political party in the province. The “Afrikaans” Net-Map group had a more nuanced analysis of the labour and jobs situation. They felt that the quality of the jobs was problematic when viewed through the lens of IYCN, since available jobs were often low skilled and low paying. This scenario of politics and economics playing out in the Breede Valley and impacting on IYCN underscores the argument by Nisbett *et al.*, (2014a) for a more politically aware approach to IYCN. This implies more attention to the political economy of childhood malnutrition.

The non-appearance of advocacy in general, for IYCN in particular, was an important gap in both maps. Advocacy should be flowing from government and NGOs to the district and back to top management in government, but in the Breede Valley for the case of IYCN, it is lacking. It was clear from discussions that nobody placed IYCN on the broader development agenda in this sub-district. In a follow-up interview one of the stakeholders pinpointed this issue as follows:

“The obvious challenge for malnutrition is, sometimes it’s disregarded because our societal problems have become so difficult and so intense, you know, issues around family violence; issues around HIV/Aids; issues around TB; issues around foetal

alcohol syndrome and those kinds of things...that malnutrition has been put on the back.

If you put in a topic “violence against women and children” (*in a stakeholder map*) then the arrows (*referring to the orange coloured advocacy arrows*) would have been much more because it’s a topic that everybody talks about; everybody mobilise around, you know, whether it’s a community forum, whether it’s a church, whether it’s a community organisation, whether it’s Department of Health, what is this program...justice that they have; the centre that they have at the hospital, “child rape” (*referring to “Rape Crisis”*) and those kind -- so there would have been a lot of orange arrows.

The reason why there’s a lot of orange arrows when it’s “violence against women” is because advocacy...there’s a lot of money in advocacy. There’s a lot of support from government, I mean, coming to nutrition - you do not get such support.” (Interview 3 post NetMap to Du Plessis, 2013)

The dilemma for nutrition described in this quote corresponds with experience from other African countries (Benson, 2008; Harris & Drimie, 2012; Mejia Acosta & Fanzo, 2012) where a lack of urgency for nutrition is apparent and linked to, among other, competition for existing resources; no inter-sectoral mandate for nutrition; lack of engagement with communities; and poor use of nutrition capacity. This begs for better communication about nutrition by nutritionists and everyone involved in advocacy for nutrition (Gillespie *et al.*, 2013; Heaver, 2005). Indeed, capturing the critically window of opportunity for highest nutritional impact in the catch phrase: “*the importance of nutrition during the first thousand days of life*” has been very successful in creating a focal point for advocacy on the topic at global level and in some countries (IFPRI, 2014a; Nisbett *et al.*, 2014a; Pelletier *et al.*, 2013). However, in countries with a decentralised government system, including in SA, commitment and capacity building for specific priorities are required at various political and bureaucratic levels (Gillespie *et al.*, 2013), which is a timeous process. It was clear that advocacy on nutrition during the first 1000 days concept had not reached all the different sectors at implementation level of the Breede Valley sub-district. The research process started to address this gap to some extent, but further concerted efforts to advocate for IYCN should be prioritised in this sub-district as a matter of urgency.

Stakeholders described the multi-stakeholder workshop as being valuable, since they gained knowledge about the importance of IYCN with specific reference to the first 1000 days of life; they developed insight about the different roles of different stakeholders; their connections to one another as well as possible actions for IYCN going forward.

## **6.5 Conclusion**

The mapping exercise revealed local and external stakeholders for IYCN as well as the relationships among them. These were illustrated through flow of funds, command, information and advocacy, the latter being strikingly absent in the Breede Valley visual.

Factors that impact IYCN at the district level were portrayed as complex. A range of issues are connected in a network that transcends time and scale. Active participation in creating a graphic representation of the stakeholder map and the discussions that followed shed some light on the current IYCN governance situation at implementation level in the Breede Valley.

Community stakeholders displayed eagerness to engage in activities which hold potential for change from within the community. Stakeholders realised, that although resources were scarce, they possessed capacity, particularly in established forums (strategic capacity), that could be mobilised to address IYCN as a developmental priority. It was felt that joint solutions could be developed in the existing Liaison group comprising senior management from DOH, DOE, DSD and CDP. The local Business forum also holds promise as a discussion forum for possible future research and knowledge sharing. The University, Boland College and the media were seen as a partners for advocacy, knowledge generation and – translation.

**Chapter 7: What does an enabling environment for IYCN look like at implementation level? Perspectives from initial stages of a multi-stakeholder process in the Breede Valley Sub-District**

## 7.1 Introduction

In Chapters 5 and 6, the perspectives, commitment and capacity of stakeholders to address IYCN as well as the relationships and powers among them, as it relates to IYCN in the Breede Valley sub-district, were deliberated.

The last step of this research (Objective 4) aimed to critically reflect on the research process and explore local conditions conducive for action aimed at IYCN. Specific attention was paid to how stakeholders thought the “IYCN story” should be told; how an enabling environment could be defined for IYCN at implementation level; and who should be driving the IYCN agenda in this sub-district.

## 7.2 Summary of methods

The detailed methodology for this phase of data collection is described in Chapter 4 section 4.3.3.4. In summary, and as depicted in Figure 7.1, four focus group discussions and two interviews (in cases where stakeholders were not available for the focus group discussions) were held with the following groups/individuals:

- Community groups:
  - one for Zweletemba (3 participants)
  - one for Avian Park (5 participants)
- University /Boland College/ Business Forum /DOH (4 participants)
- DOH and DSD (4 participants)
- Interview DSD
- Interview DoE (newly appointed senior manager)

The introduction to the focus group discussions and interviews included a reflection about what is known about IYCN in the Breede Valley and how the research process had unfolded from the baseline assessment (Chapter 3), the stakeholder identification and initial engagement (Chapter 5), a multi-stakeholder workshop and follow-up interviews (Chapter 6). This reflection set the scene for the opening question: “*How should we tell the story about IYCN in the Breede Valley?*” to gauge possible ideas around framing of the narrative.



Following this discussion, elements of an enabling environment, other than knowledge and evidence about the IYCN situation at sub-district level, were explored.

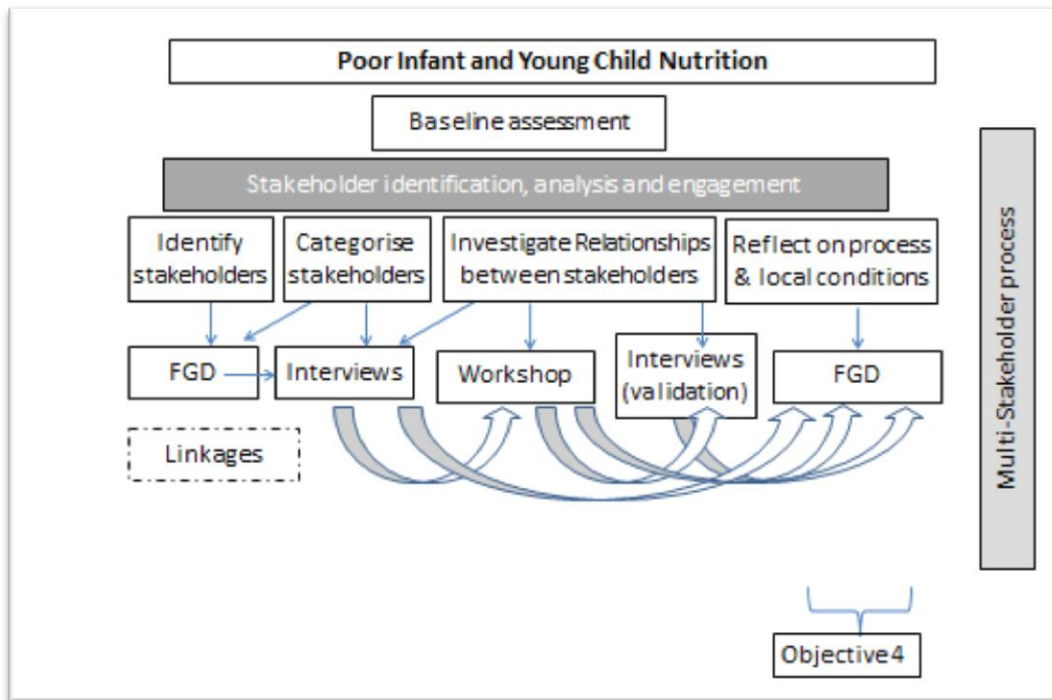


Figure 7.1: Methods and objective indicated for the reflection on the research process and exploration of local conditions conducive for infant and young child nutrition action

### 7.3 Results

The dialogues in the FGDs and interviews were structured around three broad themes: i) telling the story of IYCN; ii) elements that describe an enabling environment and iii) stakeholder/s to lead the IYCN agenda. These themes will be reported in relation to the three linked elements included in the definition of an enabling environment: 1) *knowledge and evidence*; 2) *politics and governance* and 3) *capacity and resources* (Gillespie et al., 2013) to gain insight about the “look and feel” of such an environment for IYCN at implementation level.

#### 7.3.1 Knowledge and evidence

Reflecting on the research process, it was acknowledged that local research by Stellenbosch University in the sub-district has contributed to building the knowledge-base of, among other, the profile of selected facets of the first 1000 days of life in the Breede Valley.

Knowing about the local situation was described as a starting point to finding collective solutions for the problems faced in IYCN. The University's social responsibility to do relevant research and to disseminate this knowledge in understandable language to communities who participate in research was mentioned.

"...there's an authenticity about locally based research that I think, we underplay"  
(Interview 2 to Du Plessis, 2014)

"...the researchers bring the evidence to the table in our area, so we have that privilege." (FGD 3: Participant 03 to du Plessis, 2014)

Applying "the importance of the first 1000 days" catch phrase seemed to be an efficient way of approaching the story of IYCN in the Breede Valley. For this framing, alongside the knowledge of the problems and the need for evidence-based interventions, the realisation was expressed that this package would have to be fed back into the training of professionals in the sub-district.

"I think the way you are telling the story is interesting, it grabs your attention. Even I understand the 1000 day story after hearing you. So I think there are many professional people who must receive retraining." (FGD 3: Participant 03 to Du Plessis, 2014)

Although there has been progress on growing the local information and research base, comments about the absence of advocacy as well as limited communication on the topic and the huge need for IYCN information was reiterated. Concern was expressed that the full impact of poor nutrition within the first 1000 days of life is not widely known, specifically referring to developmental delays and poor schooling outcomes which are not explicitly connected back to nutrition.

"...if we ask each other: is there enough awareness around nutrition? We know that our current exclusive breastfeeding rates are still ridiculously under ten percent of mothers!" (FGD 3: Participant 02 to du Plessis, 2014)

“You know what...we are facing...tiny, tiny, little babies coming in this clinic, and in five or ten years, we don't have any intelligent child in this country. They (*community*) need to know that!” (FGD 2: Participant 02 to Du Plessis, 2014)

Deliberating the various factors in a mother's immediate environment as well as her distant environment which influence her ability and choices to feed her children highlighted the need and importance of cross-cutting and standardised, focussed messages on the first 1000 days of life. The audience for IYCN was considered to be extensive and it was mentioned that “everyone” is in need of the messages to work towards the solutions.

“The clinic sisters and the doctors and mommy and those who help me and so, everyone, even the employer or those who provide jobs to them, they should be part of the solution.” (FGD 1: Participant 02 to du Plessis, 2014)

It was acknowledged that interventions take time to be successful and should therefore be paced, but should remain focussed in order to clear the many misconceptions that are still evident in communities around the topic of IYCN.

“...one of the enablers is sharing information in a very nugget, focussed way” (Interview 02 to Du Plessis, 2014)

“We talk about too many things – people are confused. They are totally confused. We must talk about one thing” (FGD 3: Participant 01 to du Plessis, 2014)

Apart from a focus on cognitive development and schooling performance, not much more was offered in terms of content of “the story” or messages to complement the story. This was considered to be left to experts in communication. Rather, the discussions steered towards who should be communicating the story and on which platforms.

All the different government departments, including DOH, DOE, DSD and CDP were cited as stakeholders who should be telling the story of IYCN. Telling the story would include providing information and education on the importance of nutrition within the first 1000

days of life and how good IYCN during this time-period impacts the life course. Conversely, there was recognition of the overburdened government system with its multiple focus areas and the realisation that it will take time to consolidate agendas and actions for IYCN. Nonetheless, this would have to be addressed as it was a priority to establish multi-sector collaboration. Therefore, a designated organisation/NGO, which receives funding from government, with a focus to promote optimal IYCF practices and care, was proposed as means of communicating messages and dealing with the problem of IYCN in a holistic manner. The NGO “FASFacts” (*FASFacts*, 2015), has done work in the sub-district and was cited as a model which could be copied for IYCN. “FASFacts” aims to educate the general public on the effect of alcohol consumption during pregnancy on the unborn baby, as well as the influence that people with FAS have on each individual in particular and the broader community in general. FASfacts uses experiential learning to convey the FAS message in local communities and nationally throughout South Africa. In order to reach these communities they establish satellite operational offices in communities (*FASFacts*, 2015).

The use of NGOs to assist in IYCN advocacy with a non-judgemental approach was deemed important in order to ensure buy-in from community members in particular.

“Someone, who’s hired privately, to deal with that problem and have a concern of those young children. So, they can listen to each and every problem that they have, and with a smile and not take them (*community members*) as, like they are stupid, or they are poor.” (FGD 2: Participant 01 to Du Plessis, 2014)

Bearing in mind the time it takes to do advocacy and for a campaign to reach its target, it was suggested that follow-up “reminders” should be built in at different points of contact with mothers / caregivers and children and between government sectors. In this way the message about the importance of the IYCN can be developed and built into people’s frames of reference. Although it was felt that IYCN should be strongly emphasised within a consolidated campaign, it was stated that even small beginnings can ripple out positively to the community.

“...we should make sure that as the kid moves along, which ever channel that is, that there's a message reminder or a message carrier at every point. We need to enable people at all levels to carry the message. If we've agreed that this (*a focus on IYCN*) is the universal message that needs to go into the system, then we must mature the messages all over the place.” (Interview 02 to Du Plessis, 2014)

It was stated that training curricula of students from healthcare professions needed to address IYCN in the context of prevention of disease and promotion of good health. Students were mentioned as partners who could spread the messages. The media were also included as a partner who should be communicating the messages. Further, the business sector was identified as having a social responsibility to assist in telling the IYCN story.

A number of diverse and sometimes unusual places and spaces were suggested for “telling the IYCN story”. It was stated that the story could be told anywhere in venues where people meet; including clinics, or venues close to clinics; churches; occupational health services in the workplaces; crèches and in the home. For fathers, more unorthodox venues were listed, including at shebeens<sup>27</sup>, in prison, and at sports events. Special gatherings could also be organised specifically to address IYCN. Breastfeeding week on the international and national health calendars was seen to provide a good focus on IYCF. A limitation was its one week duration. It was felt that special information days and classes should be organised for pregnant and lactating mothers.

IYCN was perceived as a topic that lends itself to visual stimulation. Traditional material including pamphlets; posters; and billboards would be supplemented by electronic media, including cellular telephones; the internet; and Facebook, were mentioned as information carriers for IYCN. It was, however, acknowledged that literacy is problematic for both written and electronic material as is access to technology. An innovative suggestion was made that taxis can be used as vehicles, literally and figuratively, to carry IYCN messages in communities.

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<sup>27</sup> A shebeen is a pub or bar located in a township that provides alcohol, music and dancing as well as a meeting place for local community members. <https://en.m.wikipedia.org/wiki/Shebeen>.

For discussion on aspects of knowledge and evidence, it can be summarised that stakeholders in the Breede Valley felt it was very important to know and have evidence about the IYCN for finding solutions. Concern that IYCN and the link to the development agenda are not yet fully realised highlighted the urgent need for communication and advocacy on the topic in the sub-district. A government-funded NGO model was proposed to drive such an initiative and various platforms and avenues were suggested as message holders and carriers for IYCN.

### *7.3.2 Politics and governance*

Politics at community level were described as more than just political parties, but also included the “political atmosphere in the community”, referring to issues people perceive to be important in their communities and their needs for the space where they live and work, which ultimately implicate the involvement of people.

“So politics, to me isn’t about a party, it’s about the arena, the playing field, of what is on the order of the day in the community...the political atmosphere within the community, that will at the end of the day exist of people. (Interview 1: Participant 02 to Du Plessis, 2014)

There was acknowledgement that distant political decisions impact the local/implementation level. Although this is the case, it was also felt that politicians in communities, the ward councillors, should be using their power to create jobs to make a real impact in local communities.

Government was said to have a responsibility towards its citizens and therefore the community should have a voice. It was also felt that government should, in particular instances, use their power to take action in the form of policy and legislation and enforce certain issues, including those pertaining to IYCN. ECD centres were mentioned as one such specific case where government should enforce crèche attendance to ensure improved nutrition and care for infants and young children.

“So I think what the councillor said, if they can design a policy where they say: ‘okay, ...(name omitted) and ...(name omitted) and ...(name omitted) and ...(name omitted) are incompetent to feed the children from six months...; so much we (*government*) tell you now, not ask, we tell you that the children go to a crèche.” (FGD 1: Participant 2 to du Plessis, 2014)

“If there is a policy in place, then - take for example all the children from six months to five years old, they should be in a crèche or else the ‘Allpay’ (*government grant to unemployed parents*) will be taken away.” (FGD 1: Participant 01 to du Plessis, 2014)

These tough measures mentioned to enforce crèche attendance, with the aim of improving IYCN, in part highlight the level of intervention needed. It also implies that government should dramatically increase the focus on IYCN.

The role of policy and legislation in addressing maternity leave in the formal and informal sectors was also highlighted as an avenue that can be used to support IYCN.

“What does the Tshwane declaration tell us? How do we make it possible with maternity leave to speak exclusive breastfeeding for six months, what does our maternity leave policy say?” (FGD 3: Participant 2 to du Plessis, 2014)

“I think that most farm workers get maternity leave but they are not paid. But the question obviously is who must pay? If generally the farm is under pressure and receive little subsidy from the government, it is perhaps the State that must pay the maternity leave.” (FGD 3: Participant 03 to du Plessis, 2014)

“So we need enabling legislation.” (FGD 3: Participant 03 to du Plessis, 2014)

Furthermore, it was stated that if government enforces certain issues in a responsible manner, they will benefit from it and so will the country in the long term.

“The government can have the advantage, there will be less prisons necessary to build, less hospitals, because granny won’t have a heart attack anymore..., locations will be there, because they will: ‘now look, this is my responsibility, number one to have one partner, it's my responsibility to look after my child and my wife or my husband and my children and not granny's”. Because mommy carries bags of medication from hospital just to lie there, because she can't drink it because there's not enough food. So we take it, as if a person can stay healthy for those thousand days, then you take a large financial responsibility from Government.” (FGD 1: Participant 02 to du Plessis, 2014)

“If the DSD, that government, that is issuing grants for the children, can have the monitoring and evaluation of these grants; that they are going straight to those children, that they are given and they can make a check-up in either in six months’ time.” (FGD 2: Participant 02 to du Plessis, 2014)

A specific example of government’s good intentions, with questionable impact, arose from an opinion from DOE, in that school feeding is a response to a crisis and an attempt to remedy the situation.

“It's obviously a response to a crisis and I think, a crisis is a good definition of the challenge as well, that kids come to school underdeveloped and by extension they are underfed and so, our way of addressing it is obviously to feed them.” (Interview 02 to Du Plessis, 2014)

The National School Nutrition programme was instituted in SA as a presidential lead project after the country became a democracy in 1994. Reflecting on the impact of nutrition interventions during the first 1000 days of life, however, led to a question about government’s continuing funding strategies, 20 years on. The following perspective was consequently communicated by the same participant:



“We’re (DOE) probably feeding them four years too late! The world is not a savvy place. I think we're all trying to find out what, what's best for the next generation and keeping this country competitive on all levels.” (Interview 02 to Du Plessis, 2014)

The lack of conversations on issues of mutual importance, in general, between government departments was expressed as a reason why there is difficulty in successfully addressing cross-cutting issues.

“...we don’t have common conversations; we have silo conversations and that’s part of why we struggle in my view, anyway.” (Interview 02 to Du Plessis, 2014)

Government departments explained the difficulty of their work by referring to the fact that they do not have control over the social determinants of health, as was mentioned in Chapter 5. Nonetheless, certain solutions were posed, with one specific opportunity, created by law, in the Intergovernmental Relations (IGR) Framework Act (Act No. 13 of 2007), where decision makers can engage around important issues at a local level.

“But here’s a constitutional opportunity for the province to legislate on the roles of the municipalities. For example, the province would be able to legislate that every municipality must appoint an occupational therapist to check the childcare facilities. Why not?” (FGD 3: Participant 03 to du Plessis, 2014)

“...the district health council can speak to any issue in health and must be consulted before you can sign off the district health plans. So there is a local political, legal mechanism that can be used. (FGD 3: Participant 03 to du Plessis, 2014)

Although the Liaison group (mentioned in Chapters 5 & 6) is not a legally constituted body, a link exists between the Liaison group and the local IGR forum via the CDP Director of the Cape Winelands Municipality who serves on both forums. He could potentially influence the IGR forum in this area to guide the issue of nutrition during the first 1000 days of life in this sub-district. This might pose a real opportunity to broaden support for the liaison group and to extend the reach and power of planned interventions.

There was a strong feeling that funds for IYCN initiatives should be dedicated from national and provincial government, and not from other smaller entities, to ensure sustainability of interventions. Also, it was said that the decisions on dedicated budget changes to support IYCN interventions should be made at a higher level i.e. provincial and national.

“So I mean it’s only money from the state that can sustain any initiative of this nature. You’re not going to get it in the business forum. You’re not going to get it out of NGO’s. You’re not going to get it out of volunteers. It can only be state money, because the underlying issue is unsustainability.” (FGD 3: Participant 3 to du Plessis, 2014)

“But it must come from there (*government*). Because funding must also be aligned for that. Because I mean if our NGO’s start getting funding to do things; they (*DSD*) fund NGO’s, we (*DOH*) fund NGO’s then we must – then the stuff must come in alignment for those things, the call for proposals. That isn’t happening now. (FGD 3: Participant 01 to du Plessis, 2014)

“...we have the expertise to be able to do it (*interventions*). That is a fact. But it (*budget shifting*) will have to be decided from high, it will have to be led from a ministerial level, with all directors. (FGD 4: Participant 01 to du Plessis, 2014)

Elevating the Integrated Nutrition Programme in the hierarchy of Department of Health, from an integrated programme to a more prominent programme, could raise the profile of nutrition and support budget shifting, among other and as mentioned above, in order to have an impact on IYCN.

“Unfortunately nutrition is just added to that and for years my argument has been that nutrition needs its own platform. Not only as an add-on to child health.” (FGD 3: Participant 01 to du Plessis, 2014)

Comments were also made in relation to accountability structures for decisions and interventions either directed through a mandate or as an issue that needs careful integration with performance management.

“But somewhere the decision must be made that we have the mandate that we can go back if it doesn’t work and say: ‘listen they are dragging their feet’ or they must say: ‘no, where is Education, where is Health?’” (FGD 4: Participant 01 to du Plessis, 2014)

“What I found when I want something to happen – let’s say my lecturer or my mentors at the campus, I must physically build it into their performance plan and specifically measure it. (FGD 3: Participant 04 to du Plessis, 2014)

Conversations about politics and governance in the Breede Valley elicited strong opinions about what could or should be done by government through direct intervention, policy formulation and legislation to impact on IYCN. Elevating the profile of nutrition could assist in channelling dedicated funds toward the cause. Investing in the first 1000 days of life, will lead to a reciprocal situation where communities and government will be benefitting, which should provide ample motivation to act quickly. A particular legal forum, the local IGR forum, was highlighted as an opportunity to scale up actions for IYCN at local level in SA. This broadens the scope for creating an enabling environment for IYCN actions at implementation level in SA.

### *7.3.3 Capacity and resources*

In the domain of capacity and resources, strong impressions of government officials being overwhelmed with high workloads arose as they faced many different focus areas as well as a lack of resources. It was therefore felt that the organisational capacity to tell the story of IYCN was weak in the Breede Valley. This partly explained the lack of advocacy, information and communication for IYCN. A further explanation was that the curative focus on the burden of chronic diseases, overshadow health promotion and prevention activities in terms of emphasis and resources. There was reluctance to take up an issue that was not aligned with different stakeholder departments’ budgets, targets and objectives and thus a

difference in priority setting. This was offered as an explanation of why there may be no clear lead for IYCN.

“I know that, if the Department did not budget for something...that if it is not aligned for what their goals are for or what is on the strategic goals, they will not, there won't be funding allocated. That's why I feel that it must be clearly decided, who should take the lead, even though there will be equal inputs and participation. But someone must take control and hold the reins otherwise, five years later when you come here, you'll have a problem. The knowledge was here, but what now?” (FGD 4: Participant 04 to du Plessis, 2014)

A need for champions to fly the flag for IYCN was expressed and it was acknowledged that “champions for a cause” can make a big impact. In the same interview, however, it was also mentioned that champions are overburdened with many pressing issues since they are often the same people involved in many different causes.

“But the champions; if you develop a group of 20 champions in Worcester, various people; somebody from the business forum, the directors of the Department of Health, head of the college, etc. they will only be able to do what they can do because they have thousands of other tasks.” (FGD 3: Participant 03 to du Plessis, 2014)

A dedicated post for a champion to drive such a process was not seen to be viable from DOH's point of view, due to the integrated way in which implementation is operationalized. Pooling of resources from all the departments to fund such a post was also not seen as feasible since no structure currently exists to bring such a suggestion to fruition. Therefore, the model which was proposed (see previous comment on “FASFacts”) of an outside partner (NGO) to focus specifically on IYCN with dedicated funds from government was restated as a possible bridging measure. It was thought, however, that an NGO should not be the sole driver of the cause, since a government department will still need to be the link back to the funding entity.

Perspectives about who, with specific reference to a government department, should be leading the IYCN agenda were varied. There was reference made to the fact that IYCN should be strongly linked to behaviour change, and since there is no custodian for behaviour change, it is difficult to say who should actually be leading the agenda. DOH was highlighted by DSD and DOE as the department who has IYCN as part of its core business and who should be taking the lead on advocating for IYCN. But DOH felt that the problems are already manifested by the time it reaches them. The other departments felt the same about their situations, in that it is “too late” for them to intervene when the problem presents itself at their door, confirming the prevailing curative as opposed to preventative approach followed by government departments.

There was general consensus that the Liaison group should be the driving committee where departments can deliberate work together on IYCN issues. The Liaison group is regarded as a hub of strategic capacity where issues of importance can be tabled, decisions can be made and accountability exerted. The directors represented at this group were described as leaders with passion who want to do the right thing. They believe in their workforce and inspire them through their leadership. Therefore, they know they can make decisions and their personnel will keep working on the momentum for actions since their sense of purpose fuels dedication. It was acknowledged that relationship building is difficult to do, but trust, partnerships and relationships were seen as important forms of capacity within the government sector in particular, that could bridge the lack of other resources.

“Look I feel, as we said in the workshop (*Chapter 5*), it should be referred to an Inter-departmental Committee. Otherwise, we will again have the danger of one Department or one roleplayer, who will have the expectation to drive the process.”  
(FGD 4: Participant 04 to du Plessis, 2014)

Resources in communities were said to be very scarce and families rely on one another for daily living and support and parents often have to make difficult decisions about the care of their young children.

“If I work on a farm and I am called; the lorry stops – this is what happens in Avian Park and De Doorns. ‘You can harvest today’. Then I leave that child with anybody because I can bring home R150 tonight. That’s the reality.” (FGD 4: Participant 01 to du Plessis, 2014)

Unfortunately it was said that there are some who do not care about their children’s wellbeing, tying in with comments about a breakdown in family values.

“There are few people, they are so concerned, they want their babies to be healthier and they want the information, but some, they just don't care. After all the interviews that I have and focus group and with the questionnaires (*in the broader CNSP*), I found out that people they just don't care, what happens.” (FGD 2: Participant 01 to du Plessis, 2014)

A need for incentives in communities were therefore expressed, e.g. for mothers to breastfeed and to change their current behaviour. Since family and community values were felt to be jeopardised and family units have disintegrated, religious institutions were mentioned as a resource in communities which could rekindle these values.

In summary there are many competing agendas and focus areas in the Breede Valley that are spreading resources thinly; leaving limited scope for promotion and prevention activities. Other ‘soft’ resources were, however, mentioned as important in the absence of physical resources. Champions and leaders are felt to be important, but in the case of IYCN, there is no consensus on who should be driving the agenda. There was realisation that IYCN is a multi-causal entity and in need of multi-sectoral input and it was therefore deemed best that the issue should be taken to the Liaison group to deliberate the issue of leading the agenda.

#### *7.3.4 Additional perspectives on the enabling environment at implementation level*

In response to the question about possible elements lacking from the definition of an enabling environment, as applicable to the implementation level, important responses emerged. Some participants responded that “policy to practice” was seen as difficult, especially since the reality of problems in society is in competition with IYCN, including the

social determinants of health. Besides, not all stakeholders see a direct alignment with the first 1000 days concept. There are also different environments impacting this level, including: the immediate environment (households, communities and service providers), but also the distant environment (provincial, national and global).

“Communities” and “people” were components absent from the global definition and this result in elements of “human behaviour” and “behaviour change” also being vague. These elements were felt to be of particular importance at implementation level, since people and communities need to respond to policies, legislation and interventions differently compared to, among other, policy makers, legislators and researchers in other levels in the hierarchy of a decentralised system.

“It is people who let the things happen.” (FGD 4: Participant 01 to du Plessis, 2014)

“I mean behaviour change takes a long time, because even the issues you're raising, if we were to effectively turn the tide, behaviour must change in the mother and the mother in her environment, the behaviour in the environment must change and in her immediate environment sits another environment, called community and so, you'll build it out...” (Interview 02 to du Plessis, 2014)

“So, we feed, just like we give ARVs, that will fix it, but we don't realize behaviour change for instance. We are trying to change behaviour in pockets. We are not pulling the lines through and we are not dealing with it on multiple platforms at the same time.” (Interview 02 to du Plessis, 2014)

“Partnerships” and “relationships” might be implicit to the global definition, but it was felt that these two elements were so important at implementation level, it warrants explicit citation. Motivation for the highlighting of these elements was mentioned in the fact that building partnerships and relationships, as well as sustaining it, is difficult, but necessary. A good working environment and retention of staff was seen as one means of sustaining relationships and partnerships. Furthermore, it was communicated that people at implementation level adapt to limited resources by working with what is available by taking

up an enduring attitude and believing that, although challenges persists, solutions are possible.

“I'm big about relationships; I think it's the one area we underestimate its power and influence we want to make...” (Interview 02 to du Plessis, 2014)

“So I just want to say that that is an enabler if people don't change all the time (*referring to staff turn-over*). It can make you despondent when your dietitians change all the time. Then you have to start building relationships from scratch and you have to teach them those skills; those soft skills every time” (FGD 4: Participant 01 to du Plessis, 2014)

Shared values, especially trust, were seen as essential elements in relationship building. Relationships in itself were seen as a resource, which could bridge the shortfall in resources which is often experienced at implementation level. In turn, a good working environment that includes incentives was seen as an enabler for fostering loyalty and a positive attitude towards the work that needs to be done.

#### **7.4 Discussion**

Initial exploratory interviews with key identified stakeholders (Chapter 5) were followed by a multi-stakeholder engagement workshop (Chapter 6). Insights were gathered on their perspectives about IYCN, their commitment and capacity to address the situation in the Breede Valley sub-district as well as relationships and powers among stakeholders in the domain of IYCN. The last phase of this research set out to critically reflect on the research process and explore local conditions conducive for action aimed at IYCN at implementation level.

Gillespie et al (2013) systematically reviewed the nutrition-relevant policy process and governance literature to define an enabling environment for improved nutrition (Gillespie *et al.*, 2013). The authors propose that a trio of interlinked elements; *knowledge and evidence, politics and governance, and capacity and resources*; are needed to shape and maintain



momentum for addressing malnutrition and for translation of this momentum into outcomes (Gillespie *et al.*, 2013).

The discourse around the importance of the first 1000 days of life, and the knowledge about the effective interventions during this very specific time period in the lifecycle, have been communicated powerfully on a global level (Black *et al.*, 2013; Pelletier *et al.*, 2013; Nisbett *et al.*, 2014a) This serves as confirmation of how well-packaged research can bring focus and create momentum for a cause (Gillespie *et al.*, 2013). To this effect the SUN movement has been very successful in advocacy and mobilisation on childhood undernutrition at global and country-levels encouraging countries, country partners, United Nations partners, academia and civil society organisations to pledge commitment to addressing IYCN (Mokoro, 2014).

Framing of the first 1000 days of life within a well-defined focus area has been said to be of specific importance (Pelletier *et al.*, 2013) Countries have approached capturing their own IYCN storyline from different angles, including an emphasis on hunger elimination in Guatemala and Bolivia; undernutrition reduction as an election strategy in Peru; lack of economic growth in India; and agriculture as a means of economic growth and reduction of poverty in Ghana (Gillespie *et al.*, 2013; IFPRI, 2014a). During discussions in the Breede Valley, stakeholders strongly related to cognitive development and scholastic achievement and the resultant increase in human capital that could be achieved through investment in the 1000 days' time period. The story of IYCN in the Breede Valley could therefore be framed to address this development concern.

The Lancet 2008 Series highlighted the lack of cohesion in messages, priorities and funding for the international nutrition community. Five years later there was consensus that there is much more consistency and harmonizing in the way different actors and organizations interact at a global level (Haddad, 2014), but it should not be a surprise that there was a lack of advocacy at the local level. The need for a well-planned communication and advocacy strategy was highlighted throughout the stakeholder engagement process (Chapters 5-7) in the Breede Valley. A similar point has recently been expressed in a SA evaluation report (DPME, 2014) where an explicit recommendation was made that DOH should create a specific, well-defined, and dedicated promotion and communication strategy on nutrition for

under 5s (including the first 1000 days of life). It was further stated that this strategy should borrow from experience gained from the HIV/AIDS campaign for the country (DPME, 2014).

A unique entity in the Breede Valley is the presence of the university's satellite campus. With the community's participation, the university can build evidence, assist in translating the evidence into understandable messages, and also apply evidence through evidence-based interventions. With the right knowledge, information and interventions, the enabling environment can be strengthened.

In order to pull forces together and address IYCN in a comprehensive and integrated way, there is a need for a supportive environment allowing for facilitation of various multi-stakeholder interventions (Gillespie *et al.*, 2013). Different sectors need to be able to see reciprocal advantages of and for their involvement. This in turn could galvanise the political will needed for action (Harris & Drimie, 2012). Participants in focus group discussions in the Breede Valley offered information, explanations and vocabulary that corresponded with the three linked elements needed for an enabling environment. It can therefore be said that these elements are important and applicable at the local level as well. Important additional components, not explicit in the international definition, were proposed to be "people", "community" and "behaviour". This could collectively be worded as "people-centeredness". People and not the structures they work in, are said to be most important and need to be appropriately directed through participatory leadership (Garrett *et al.*, 2014).

Furthermore, elements of specific importance at implementation level, warranting stronger emphasis within the three linked elements, and often referred to as "soft issues" were highlighted as: relationships; partnerships; trust; sustainability of organisational structures; and retention of staff. Relationships and partnerships between government departments, the university, business sector, media and the community were discussed. Trust building between all levels was seen as necessary to keep relationships and partnerships strong. Sustainability in structures and staff was also seen as enablers for cultivating an enabling environment. According to literature, these value-based collaborations consistently lead to successful partnerships (Garrett *et al.*, 2014).

A definition of the enabling environment at implementation level could therefore expand on the international definition, as follows:

*“political, policy and people-centred processes that build and sustain momentum for the effective implementation of actions that reduce ~~mal~~(under)nutrition”*

Much confidence was expressed in the Liaison group as a forum to collectively take up the IYCN agenda. The Liaison group in the Breede Valley seems to be unique in its existence at sub-district level in the Western Cape Province and possibly the country. In the absence of such forums, a way of taking nutrition issues forward faster at implementation level in SA, could be through creating a broader enabling environment based on the Intergovernmental Relations (IGR) Framework Act (Act No. 13 of 2005) in SA. The Act legislates the establishment of appropriate IGR forums at the three spheres of government, in particular the provincial sphere, vertically tied to the premier’s IGR forum, which must engage actively with various district IGR forums convened by district mayors. District Intergovernmental forums are consultative forums to facilitate intergovernmental relations between districts and locals. The primary role of this forum is to discuss national and provincial directives affecting municipalities. This offers a potential infrastructure for multi-sectoral engagement on malnutrition and other issues, as stipulated in the NDP 2030. Since ad hoc invitations may be made on the discretion of the chairperson (local mayor), this is an opportunity that warrants investigation for advocacy and action for IYCN.

One unresolved issue for the participants in this study was the question on organisational leadership for IYCN at implementation level. The Integrated Nutrition Programme, embedded within Comprehensive health services of Department of Health could be seen as a natural champion for IYCN. However, the low profile, limited resources and therapeutic-focused budget of the INP seemingly limits its current capacity to step up to this challenge. Evidence from other countries reveal that it is not uncommon to question the Nutrition component’s capacity to lead issues of importance for the advancement of nutrition, regardless of the Ministry in which they are positioned (Heaver, 2005; Natalicchio *et al.*, 2009). An inconspicuous position, multi-sectoral action required, lack of funds and capacity are cited for the poor ability to lead (Natalicchio *et al.*, 2009; Haddad *et al.*, 2014). Lessons

learnt from global and national level research indicate that nutrition champions and strong leadership are key in developing and sustaining political commitment and capacity to ensure action (Bryce *et al.*, 2008). Strong leadership is also needed at various levels along the continuum of multi-sectoral collaboration (Garrett *et al.*, 2014). Lack of such capacity as well as training and support for such individuals are barriers to effective and sustained commitment for nutrition (Bryce *et al.*, 2008; Nisbett *et al.*, 2014). This form of strategic capacity is also fundamental for advancing commitment building, agenda setting, policy formulation and capacity building for operations in nutrition (Pelletier *et al.*, 2011b). With only one nutrition leadership course on the African continent (African Leadership Programme), there is a certain need for training institutions, the private sector and government to collaborate on investing in leadership capacity for nutrition in the country as a whole. In the case of the Breede Valley, referring the IYCN issue to the Liaison group might unlock inter-sectoral ownership, leadership and governance as a key strategy in taking the IYCN agenda forward in this sub-district. These, however, remain questions that will have to be tested in additional empirical research in follow-on processes to the reported research.

## **7.5 Conclusion**

Knowledge and evidence about the first 1000 days of life was seen as important in finding solutions for addressing the problems at implementation level. A good frame for the storyline of IYCN in the Breede Valley points to intellectual development and scholastic achievement resulting in better income and healthier children and adults. In order to tell this story, a well-structured advocacy and communication campaign was seen as a priority action.

The international definition of an enabling environment to address childhood malnutrition encapsulates the elements of a supportive setting for such actions at local level. The importance of a people-centred approach was however emphasised and could be added to the definition to make it applicable at implementation level.

There was no clear lead institution identified for taking the IYCN agenda forward and it was therefore proposed that the issue should be referred to the Liaison group in the Breede Valley. In other sub-districts in the province, in the absence of such a group where directors

and their senior managers meet to address issues of transversal importance, the IGR forums, vertically tied via DIF, which are legally constituted entities, could be approached to take up childhood malnutrition as a directive stipulated in the NDP 2030.

Experience from the Breede Valley indicates that advocacy and dialogue about the importance of the first 1000 days could increase the prospects of these forums taking up the challenge of tabling the issue of childhood malnutrition on their agendas. Furthermore, there is early indication that national plans are aligning for nutrition within a development context (NPC, 2012). The Breede Valley directors are using the NDP as a guide towards action with a “whole of society approach” perspective. This is an example of a guiding document which could be used as a brokering tool for other forums to follow suite.

## **Chapter 8: Conclusions, limitations and recommendations**

## **8.1 Introduction**

The purpose of this chapter is to reflect on the research issue and process and to synthesize the main findings in order to answer the research question. The main conceptual conclusions, as well as the scientific and practical contributions to stakeholder engagement in the field of IYCN are offered, in the context of the scope and limitations of the research. Recommendations for further research are suggested in the final sections of this chapter.

In this research, a qualitative study design and selected participatory research methods were applied to explore a diversity of perceptions, willingness, abilities, relationships and powers of key stakeholders to address IYCN at sub-district level. Local conditions conducive for action to improve IYCN were considered to establish elements of an enabling environment for IYCN applicable at implementation level.

The results provide insight into the elusive concepts of commitment and capacity. In this instance, the concepts relate to IYCN governance at local level, where action is required by different stakeholders to address the common goal of improved IYCN. The personal and professional perspectives of key stakeholders involved at this level offered distinctive information about the unique challenges they experience as well as practical responses required to ensure action. In anchoring these findings in the growing body of literature on the underlying and basic causal factors of childhood malnutrition (UNICEF, 1990), this research sheds light on conceptual thinking around initial stages of engagement with multiple stakeholders to advance IYCN governance at local level.

## **8.2 Reflection on the main research findings**

The main themes that emerged from the overall research findings are displayed in Box 8.1.

### Box 8.1: Main themes from the overall research findings

The value of local knowledge and information;

The appeal of the 1000 days message and its link to development;

The urgent need for IYCN advocacy;

The value of stakeholder engagement and seeing the broad IYCN stakeholder landscape;

The need for multi-sectoral work for IYCN, while recognising the difficulty in functioning across sectors;

Realising the capacity inherent in “people” as a resource;

The need of a whole of society approach in taking forward the IYCN agenda

The importance of strategic capacity (especially in local forums and legislation) to advance action for IYCN.

These themes are highlighted by short corresponding quotes from the data and findings are synthesized in the following paragraphs. In addition, the expansion of the “enabling environment” definition as well as the use of a participatory community-based research approach, are also deliberated.

#### 8.2.1 The value of local knowledge and information

*“...there's an authenticity about locally based research that I think, we underplay”*

*(Interview 02 to Du Plessis, 2014)*

The baseline research undertaken with the Community Nutrition Security Project (CNSP) contributed to building the local knowledge-base on the profile of selected facets of the first 1000 days of life in the Breede Valley. This research study further built on the established knowledge-base by inviting local stakeholders into the research-practice-connect and engaged them around a locally identified nutrition problem. This was in order to initiate a process of finding collective solutions for improved IYCN. In this way the researcher responded to an identified call from literature to conduct action-orientated research. Action-oriented research is required to direct the advancement and application of successful policies, programmes and interventions for nutrition (Pham & Pelletier, 2015), through greater interaction with communities, government stakeholders, NGOs, and/or private-sectors stakeholders.

The research also contributed to the University’s social responsibility to undertake relevant research and to disseminate this knowledge in understandable language (knowledge-



translation) to those who participate in the research. In this way, the stakeholders were provided the opportunity to become owners of the research and co-owners of initial stages of the problem solving process, within the scope of the research project. This being said, the deduction should be interpreted with modesty within the study limitations and the challenges in doing community-based-participatory-research (CBPR), reported later in this chapter.

The recommendation made in Chapter 3 (submitted manuscript) about the collection of local data relevant to the construction of the WHO IYCF indicators should be communicated to the NDOH: Nutrition Directorate. The only indicator currently calculated from the District Health Information System (DHIS) is: “percentage of babies exclusively breastfed at 14 weeks”. The potential to monitor more indicators should be investigated in order to ensure the availability of timeous and relevant data for appropriate action and accountability for IYCN.

#### 8.2.2 The appeal of the 1000 days message and its link to development

*“This is serious. This needs to be taken care of.” (Interview 03 to Du Plessis, 2013)*

The message about the importance of nutrition during the first 1000 days struck a chord with the stakeholders as they recognised the cross-cutting importance of the issue and its link to development. In the case of Breede Valley, stakeholders’ interest in the topic primarily revolved around cognitive development and improved school grades with a resultant increase in earning potential.

The interest in the link between IYCN and development made an impression on the Breede Valley stakeholders due to the social difficulties (including poverty, teenage pregnancies, school attrition, poor education; poor skills; low remunerating job opportunities) experienced in the vulnerable communities in the study area. The intergenerational transmission of poverty is playing out in the Breede Valley, due to, among other issues, the legacy of social isolation and exclusion compounded by the apartheid era. Currently this cycle undermines progress on improved IYCN. However, focussing on improved nutrition within the first 1000 days of life can make a substantial investment in the future of these

communities. Nutrition specific interventions, mainly delivered through DOH should therefore be scaled-up as a priority action in this sub-district. The nutrition sensitive interventions should now be advanced in the follow-on planning and implementation phases of the broader CNSP, after the groundwork has been initiated through a baseline study and initial stages of an MSP in the sub-district.

### 8.2.3 The urgent need for IYCN advocacy

*“Nutrition should be something that is in a person’s face; all of the day.” (Interview 15 to Du Plessis, 2013)*

It was evident from conversations in the Breede Valley sub-district that a clear focus and advocacy for IYCN was lacking. The research identified this gap and the research process began to address it by raising awareness on the local status of IYCN and the need for multi-stakeholder processes to address the problem at implementation level.

Incidentally, the researcher was invited to do a presentation on the importance of the first 1000 days and the preliminary research findings at the local Business forum in April 2014. The Business forum invitation for this meeting included the following heading: *“The health and welfare of our community affects the productivity of your business.”* This insight and engagement with the forum could potentially be mobilized for research on investments in workplace practices that support the first 1000 days of life. The Department of Social Development invited the researcher do a training session on the importance of the first 1000 days of life for the social workers in the area (August 2014). During the introduction and closing, the coordinator of the session articulated the importance of embedding a focus on IYCN in DSD’s everyday work. This is because DSD is the custodian of the Children’s Act (Act No. 38 of 2005) which embodies an holistic approach to child well-being. The local radio station interviewed the researcher during National Breastfeeding week (2014) and highlighted the IYCN situation in the sub-district as well as the interventions needed to address the situation. The researcher also presented the research at the annual Sustainable Rural Health Research Day (*“From practice to research; from research to practice”*) at the Worcester Rural School campus on 31 May 2014. The Director: Health opened the research

day and commended the researcher for actively engaging local stakeholders in local research and presenting the research timeously to those involved with the research.

These invitations and presentation opportunities indicated the need for information on IYCN from the stakeholders and provided knowledge translation opportunities for the researcher. It is however, not adequate as the urgent need for a focussed and well-planned advocacy and communication drive, resonating with the experience of the successful DOH-driven HIV/AIDS campaign, was articulated during the research process. This finding supports one of the conclusions from a national evaluation study, which points to a countrywide lack of IYCN advocacy (DMPE, 2014). A lack of targeted communication and/or advocacy campaigns is cited in the literature as a barrier to successful scaling up of nutrition actions (Morris, 2008; Bryce *et al.*, 2008; Pelletier *et al.*, 2011; Haddad *et al.*, 2014). The national plans and broad development strategies will take time to reach implementation level. Instead of waiting for a national advocacy campaign to reach the local level and fill the identified gap, there should be preparation at this level to rise to the challenge of comprehensive action for IYCN. The commitments and capacity of stakeholders, unlocked and advanced during the research and deliberated in the following sections, should be embraced and strengthened for improved IYCN governance in the follow-on planning and implementation phases.

#### 8.2.4 The value of stakeholder engagement and seeing the broad IYCN stakeholder landscape

*"...come together and to see how to address a very complex problem". (NetMap follow-up e-mail nr 03 to Du Plessis, 2013)*

To begin seeing and understanding the vast, complex and far-reaching influences of IYCN at implementation level was an important experience for stakeholders. The social determinants of health as well as a range of power dynamics that impacts IYCN and that transcends time and scale were voiced and visually displayed in a diagram of a complex network. Stakeholders at implementation level displayed insight into issues that affect IYCN within close proximity, but also identified issues further away. This led to the realisation that certain decisions and actions for interventions to address IYCN cannot be taken at

implementation level, since it involves system issues that will require decisions on a higher authoritative level.

Positioning nutrition within this wider political and economic milieu opens up the “black box”<sup>28</sup> of wider structural issues that have relevance to nutrition and IYCN in particular (Nisbett *et al.*, 2014). Nisbett *et al.* (2014) reason that the central scope of this black box relates to political economies and resultant inequalities. These inequalities arise from competing interests, incentives, and ideologies of a range of different stakeholders with direct and indirect interests in nutrition. Some of these constraining factors evident in the Breede Valley are provided in the following paragraph.

#### 8.2.5 The need for multi-sectoral work for IYCN, while recognising the difficulty in functioning across sectors

*“This is where the relay baton is sometimes dropped” (Interview 23 to Du Plessis, 2013)*

In the case of the Breede Valley, good relationships and some sharing of expertise already exist between government departments. Different forms of capacity, including individual, organisational and systemic capacity, needed to address IYCN are developed in part or are present in the sub-district. There is, however, no clear and cohesive approach across government sectors, including inputs from community members and the private sector, to comprehensively address IYCN in the Breede Valley sub-district. Thus, there is insight in the causes of the problem and how it could be addressed; there is also potential that can be unlocked to comprehensively approach the issue of IYCN, but several barriers are currently hampering an optimal multi-sectoral approach.

The barriers to multi-sectoral work experienced at the sub-district level, hinged on department specific focus areas, mandates and budgets leading to poor integration around the social determinants of health. A lack of resources and absence of targeted advocacy were also identified as barriers. These barriers correspond with the identified broad barriers

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<sup>28</sup> Nisbett *et al.* (2014) refers to this wider context as a “black box” of nutrition, since it has been underspecified in research compared to the underlying and immediate levels of the causes of malnutrition. (Nisbett *et al.*, 2014)

to working multi-sectorally in the literature (Bryce *et al.*, 2008; Haddad *et al.*, 2014; Morris, 2012; Pelletier *et al.*, 2011a).

In articulating these barriers, one of the outcomes of the MSP process was that participants started to reflect on the quality of their current sectoral relationships and offered suggestions in this regard, which is discussed in the subsequent sections.

#### 8.2.6 Realising the capacity inherent in “people” as a resource

*“...to see the whole picture and other role players’ opinions on everyone’s responsibilities” (NetMap follow-up e-mail nr 03 to Du Plessis, 2013)*

During early engagement with key stakeholders in the Breede Valley sub-district, some stakeholders did not know why they were referred to as stakeholders in IYCN and why they were selected to take part in the research. Initial stages of an MSP created awareness of the local IYCN issues; it made stakeholders think about their roles and resources in addressing the problem; it made them aware of other stakeholders and their roles and resources, powers and influences and how these impact on the complex stakeholder landscape for IYCN. It also made them consider the elements needed for an enabling environment to address IYCN at implementation level.

Lifting the lid from the “black box” of nutrition governance in the Breede Valley during engagements made stakeholder realise that although resources were scarce and budgets sector-bound, they possessed strategic capacity, particularly in established forums, that could be mobilised to address IYCN as a developmental priority. In realising their existing capacity, stakeholders did not only view the IYCN situation from a deficit-based perspective, in other words, they did not define their resources and capacity only in terms of what they lacked. They viewed it from an asset-based perspective as well; i.e.: looking at their strengths and resources and considering what is available (Morgan & Ziglio, 2007).

*“It is people who let the things happen.” (FGD 4: Participant 01 to du Plessis, 2014)*

Stakeholders felt that finding joint solutions was imperative and that it can best be accomplished in the existing Liaison group comprising directors and their senior managers

from DOH, DOE, DSD and CDP. Especially since no strong lead was identified in the sub-district to take the IYCN agenda forward, it was felt that this forum holds the most promise, at the moment, to do so.

The question might arise if this forum was a good start to address IYCN collaboratively or just an easy entity to delegate to. Stakeholders displayed much confidence in the Liaison group as a forum to collectively take up the IYCN agenda and described the directors and senior managers as passionate, inspiring leaders. Te Lintelo commented in a review concerning accountability for International Nutrition Commitment, that it depends to a great extent on the willingness of the stakeholders who make commitments to deliver on them (Institute for Development Studies, 2014). Similarly Garrett stated that “*ultimately, it is not the structures but the people in them that are most important*” (Garrett *et al.*, 2014, p 4). Incidentally, in the absence of some resources, stakeholders in the Breede Valley identified the need for a people-centered approach and mentioned soft power skills (relationships, partnerships and leadership) as essential components for working multi-sectorally. This approach corresponds with the thrust of the NDP, which points to rekindling principles and valuing all people to prosper in an inclusive society (NPC, 2030), emphasizing the need for making explicit these concepts in planning for interventions.

Subsequent to the stakeholder workshop and follow-on interviews, the researcher was invited to do a presentation at a Liaison group meeting on the importance of the first 1000 days of life and the preliminary research findings. Following the presentation, a collective commitment was displayed when there was a unanimous decision to put IYCN on the agenda as a cross-cutting issue of importance for this group. This commitment signals a step in the right direction for addressing IYCN at implementation level, but key is that IYCN should be kept on this important agenda. There is a danger that IYCN can fall off the agenda when other issues of importance compete for attention in such forums (Garrett *et al.*, 2014). The literature states that continuing advocacy of the significance of nutrition, and in this case, IYCN, to such forums will be essential to keep the momentum going (Garrett *et al.*, 2014; Pelletier *et al.*, 2011).

### 8.2.7 The need of a whole of society approach in taking forward the IYCN agenda

*“...it’s every resident’s responsibility...” (Interview 08 to Du Plessis, 2013)*

The strong call for community engagement, partnerships and empowerment from the NDP 2030 was echoed in the narrative that emerged from the Breede Valley. During interviews with the Liaison group members, they mentioned the guidance they seek and take from the NDP and that the vocabulary of a “whole of society approach”, entrenched in the NDP, was familiar and embraced by the directors and senior government managers, as well as by the other stakeholders in the sub-district. Likewise, the development link of the importance of the first 1000 days of life in relation to improved schooling outcomes and a better standard of living, made a lasting impression on the Breede Valley stakeholders. This focus could be framed and branded as part of an advocacy campaign in the sub-district, and possibly linked to the anticipated national advocacy campaign in the province and country as a whole.

### 8.2.8 The importance of strategic capacity (especially in local forums and legislation) to advance action for IYCN

*“So we need enabling legislation.” (FGD 3: Participant 03 to du Plessis, 2014)*

There is potential in unique forums and legal frameworks to enhance the supportive environment for IYCN at implementation level. The Breede Valley Liaison group is not a legally constituted forum and its deliberations are not binding on the departments included in the group, but it has a link to a legally constituted entity, in the Intergovernmental District Forum (IDF). The primary role of the IDF is to discuss national and provincial directives affecting municipalities. This offers a potential infrastructure for multi-sectoral engagement on malnutrition and other issues, as stipulated in the NDP 2030, and might be a way of taking the IYCN agenda forward faster at implementation level in SA. In the Breede Valley, one shortfall of the Liaison group, i.e. lacking a strong connection with the community it serves, reflected in the closed membership of this group, could be bridged through the IDF, since community service and engagement is a core mandate of these forums (Intergovernmental Relations Framework Act, No. 13 of 2005). The potential for further research in this regard is stipulated in the recommendations section (3.4).

### 8.2.9 Expansion of the “enabling environment” definition

*“I’m big about relationships” (Interview 02 to du Plessis, 2014)*

Stakeholders were facilitated to think about the elements needed for an enabling environment at implementation level. The proposed elements for an enabling environment at implementation level resonated with the elements of an enabling environment defined at global and national levels. Stakeholders mentioned elements in addition to those in the international definition that they felt should feature in a definition for implementation level, including: relationship building, trust, partnerships (between communities and government; the private sector and government; private sector and CBOs; and communities and NGOs) and people at the core of the planning and implementation of interventions.

### 8.2.10 A participatory community-based research approach

*“Start small...make some talk...a meeting; sit down a bit with all these people and try something.” (Multi-stakeholder engagement meeting, Participant 01 to Du Plessis, 2013)*

Stakeholder identification and analysis research methods, with its origin in business management and policy studies (Reed *et al.*, 2009; DFID, 2002), were used in this research. The selection of a specific social network analysis, participatory stakeholder mapping tool, NetMap, was applied to develop and test initial stages of a multi-stakeholder process. This process identified, analysed and engaged multiple stakeholders in the context of their commitment and capacity to impact IYCN at implementation level in the Breede Valley sub-district.

In this research project in the Breede Valley, the research methods were not only participatory, but can be described as laying the groundwork for community-based participatory research (CBPR) within a context of community-university research partnerships. Employing these methods and building these partnerships are labour and time intensive. In these kinds of research endeavours both researcher/s and the community have to see a clear benefit in the project, be willing to build relationships and learn from each other. Building capacity as part of social responsibility is a central principle of CBPR.



Therefore, such an approach should not be attempted without a commitment to community capacity building, knowledge translation and dedicated time for education and action as part of the research process (Leung *et al.*, 2004; King *et al.*, 2009). Through the research-action process, communities and universities can construct learning spaces that need and support social action for transformation (Alvarez & Gutierrez, 2001) corresponding with the spirit of a whole of society approach. Considering these issues was particularly important in the context of a research project exploring issues of commitment and capacity. In this regard, the Division of Human Nutrition made an undertaking before commencement of the CNSP (described in more detail in Chapters 1 and 3) to address these important components of CBPR in follow-on research in phase 3 as well as through the service-learning agreement for undergraduate student training via the Rural School.

Universities and other research organizations are said to have, by and large, failed to work on, among other, the practical application of commitment and capacity to address malnutrition (Heaver, 2005). Considering the results and outcomes of this research in the Breede Valley, using a participatory community-based research approach to narrow the information gap on MSP at implementation level, proved to be helpful in also bridging the gap between research and deliberating possible action.

#### 8.2.11 Summary

*"It is not going to be easy, but let's try..." (Multi-stakeholder engagement meeting, Participant 01 to Du Plessis, 2013)*

In summary, the research process (*systematic approach to stakeholder identification, analysis and engagement*) was valuable in assisting with role identification and stock-taking of available, existing and required resources (*capacity*). There was a progressive realisation of what can be done individually and collectively (*multi-sectorally*) with expressed and displayed willingness (*development of commitment*) to address IYCN at implementation level.

### 8.3 Addressing the final objective

The fifth objective remains to be addressed, based on the research findings.

- 5) To develop a conceptual framework to address IYCN governance at implementation level by initiating, exploring and documenting initial stages of a multi-stakeholder process

When reviewing existing frameworks for understanding matters pertaining to IYCN, the UNICEF conceptual framework on malnutrition comes to mind, since it remains the key framework widely cited to understand the causes of childhood malnutrition (Nisbett *et al.*, 2014; Pelletier *et al.*, 2013 ). This framework was updated for the 2013 Lancet Series and includes the potential responses to malnutrition through nutrition specific and nutrition sensitive interventions at the immediate and underlying cause levels. The basic cause layer consists of the social, economic, political and environmental context, both at a national and global level. This should be maintained by an enabling environment that build and sustain momentum for the effective implementation of actions that reduce malnutrition (Black *et al.*, 2013).

This adapted version of the UNICEF Conceptual framework does not indicate HOW and by WHOM this enabling environment should be developed, shaped and maintained.

The “Nutrition Governance Framework” (Haddad *et al.*, 2012), mentioned in Chapter 2 section 2.8, proposes that improved inter-sectoral cooperation, strong vertical coordination, sustainable funding allocations, transparent monitoring mechanisms and advocacy will contribute to improved nutrition outcomes.

Considering the results from the Breede Valley stakeholder process and other research in this field (Garrett *et al.*, 2014), this framework underemphasises the importance of the “people” element to nutrition governance. Systematic stakeholder identification, analysis and engagement are demanding processes. Time, effort and resources are needed to nurture the people, relationships and partnerships at this level and are required for diverse

actors and sectors to move from different and often-conflicting viewpoints to co-seeing, co-understanding and eventually co-acting.

Although the accompanying text to the Nutrition Governance framework mentions the importance of data and indicators (Mejia Acosta & Fanzo, 2012), it does not indicate explicitly in the framework that knowledge and evidence should be informing the four dimensions of nutrition governance. Furthermore, legal frameworks together with policy and institutional frameworks are important in this context and should be indicated.

Gillespie and co-workers (2014) stated that political momentum can be created and followed through by deliberate action instead of waiting for it to develop accidentally. Likewise, conversion of political momentum into action does not happen automatically. It requires a thoughtful and focussed arrangement of numerous factors and processes. The three linked elements which have been identified to be of utmost importance for creating and following through on momentum and translating momentum into outcomes, are those that complement the enabling environment i.e.: knowledge and evidence; politics and governance; and capacity and resources (Gillespie *et al.*, 2014). These elements of an enabling environment could be explicitly indicated in the framework to highlight the importance of creating a supportive environment within which the required co-ordination for nutrition outcomes happens.

Instead of constructing a new framework to address Objective 5, the nutrition governance framework could be expanded to include findings from initial stages of an MSP on the left, combined with research on nutrition governance on the right (Mejia Acosta & Fanzo, 2012), and more clearly indicate the elements of an enabling environment, shown in Figure 8.1.

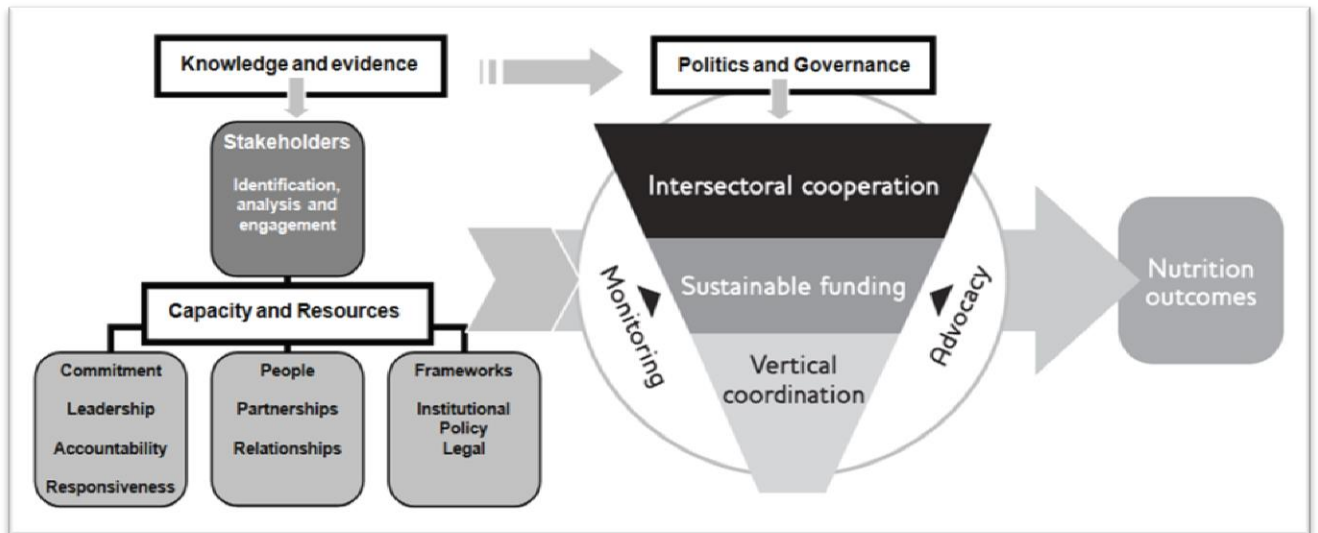


Figure 8.1: Proposed adaptation of the Nutrition Governance Framework, with findings from initial stages of a multi-stakeholder process at implementation level in the Breede Valley sub-district. Source: Adapted from Mejia Acosta & Fanzo (2012).

This adapted framework captures (on the left) the need to identify, analyse and engage stakeholders in a given context and to build or unlock their Commitment, Leadership, Accountability and Responsiveness. People, Partnerships and Relationships are attributes required for the success of multi-sectoral work and frameworks provide guidance and structure. The trio of elements of an enabling environment are prominently portrayed in the proposed adapted framework as important elements to advance nutrition governance.

#### 8.4 Revisiting the research question

In reviewing the research question after distilling and synthesizing the research findings, it is concluded that initial stages of an MSP (co-seeing and co-understanding that led to the beginning of acting together) supported the development of commitment as well as the advancement and unlocking of capacity to address IYCN at implementation level.

A detailed exploration of initial stages of an MSP at implementation level has proved to be a valuable practice and research model to create awareness of IYCN as an issue of crosscutting importance at implementation level. In considering their roles as “stakeholders” participants were enabled to think about their roles in addressing IYCN. This made them aware of their priorities, powers and influences. They pledged commitment for the cause of IYCN, as seen

through the lens of their own sphere of influence. They also referred to other stakeholders' potential roles when a specific issue was recognised as being out of their immediate scope or reach.

Available capacity to address IYCN was identified and capacity needs were expressed. Through engaging with one another, mapping their relationships and powers, and reflecting on the process allowed stakeholders to identify their collective stakeholder capacity. This included their specific reference to forums in the Breede Valley that were believed to have the characteristics and power to advance the IYCN agenda.

The ensuing phase of the CNSP should take the challenge of joint planning for implementation of actions to address IYCN further.

## **8.5 Limitations**

It is acknowledged that even when applying systematic guidelines and methods to identify, engage and analyse stakeholders for a specific cause, information produced by such processes is subjective, since it is based on what stakeholders are willing to communicate to researchers (Schmeer, 1999).

Stakeholder analysis methods, including interviews, a stakeholder engagement workshop using the Net-Map tool, and focus group discussions, take considerable time (Schiffer, 2007). When stakeholders from high-ranking positions are involved or extensive logistical arrangements are required to set up the contact sessions, stakeholders can become agitated. Repeated engagement sessions can also create research fatigue. In this study, stakeholders were accommodating throughout the research process. After more than a year of periodic interactions during the research process the researcher sensed participant fatigue. This contributed to the conclusion of the research. The time invested by participants might have been justified for a research study, but the methods need to be more time-efficient for a practice model. This point will be elaborated in the recommendations section.

Clearly change processes, reflection and personal or institutional commitments to issues pertaining to capacity development take time and cannot be undertaken hastily. It should

therefore be stressed to those who wish to pursue such processes, that time should be seen as an investment in MSPs for issues of cross-cutting importance.

Stakeholders' willingness to act could have been over-interpreted to some extent, since participants may have felt obliged to respond positively. However, the prompting was done toward the end of the initial interview process and again after the stakeholder workshop when participants have had ample opportunity to think through the topic and come to a specific conclusion around their role as a stakeholder and what they could commit to doing.

Exploring commitment and capacity through qualitative methods could be seen as subjective. However, numbers and indices do not capture the nuances of personal and professional perspectives as effectively as qualitative methods. A combination of qualitative and quantitative methods could therefore provide a richer picture of commitment and capacity needed to address IYCN.

As described in the literature, participatory action research entails a commitment to social action and should build capacity for social change within communities. In this specific research project, participants did not reach the point of self-organizing to address the problems they identified in their communities through the research process. They did, however, identify an existing structure, the Liaison group, to prioritise and place IYCN on the group's agenda. It should be emphasised that the research focused on commitment and capacity of stakeholders and their relationships, power and interest as it relates to IYCN at implementation level. It did not assess the impact of stakeholder arrangements for IYCN following the initial stages of the multi-stakeholder engagement process, nor the change over time in actual nutrition outcomes. These remain questions that will have to be tested in additional empirical research in follow-on processes to the reported research.

The researcher's primary role was that of "researcher". She also adopted an advocacy role, since the topic of research had to be introduced to participants from various sectors with diverse focus areas to enable them to identify their "role as stakeholders in IYCN". The importance of nutrition within the first 1000 days of life inherently lends itself to advocacy on the topic. Furthermore, the research process was developed to bring together public and

private entities with the aim of exploring stakeholder commitment and capacity to address IYCN. The IYCN agenda was therefore promoted implicitly and explicitly. This potential bias could be seen as a limitation, although the research process did require sharing the IYCN profile of the sub-district with the stakeholders, stating the consequences of poor IYCN in the short and long term as well as prompting stakeholders to think about their roles, relationships and powers in the context of IYCN.

The participatory nature of the research did draw the researcher into the centre of the sub-district. The researcher was aware of the potential danger of being seen as the expert on the topic of research and was careful to remain engaged with stakeholders but not get engulfed in the process. She responded to requests from stakeholders (invitations to present on nutrition during the first 1000 days and the preliminary research findings) in as far as her teaching, research and community engagement responsibilities allowed. When she was invited to the Business Forum meeting, she asked permission from the chairperson to invite the INP Manager of the district to accompany her. She introduced the INP Manager to the forum and asked her to address the forum about the INP priorities and interventions in the sub-district. In this way the researcher attempted to portray local ownership of IYCN governance to the forum.

Although care was taken to instil a sense of ownership of the data and the process to the participants, there is the danger that participants could be left feeling dependent on Stellenbosch University to address the issues raised by the research. The researcher was cautious during engagements and portrayed the University as a stakeholder for IYCN and as a partner in the sub-district, as identified by the initial stakeholder identification and analysis process. In the broader context of a community-university arrangement in the Breede Valley and beyond, the Faculty of Medicine and Health Sciences, with the Vice-rector Community Engagement taking the lead, should continuously communicate the principles of engagement to the relevant stakeholders, including the Rural School, government departments, private sector and community representatives in the Breede Valley, in order to avoid undue reliance and dependence on the university to act on their behalf. Equally, the University needs to remain grounded and humble by displaying an openness to learn from

and give back to the communities engaged with and remain reflective about potential and real power relations, including issues of gender, race, class and religion.

## **8.6 Recommendations**

The research has shown the relevance of nutrition and IYCN in particular, as a development issue of cross-cutting importance for multiple stakeholders at implementation level. The research contributes to rethinking how the nutrition community in SA consider nutrition practice and the research therefore has important implications for academic and nutrition practice in the country. The nutrition community need to do more than acknowledge the various stakeholders who can impact IYCN; they need to learn how to engage them and how to learn from them. Without understanding the “black box” of IYCN governance, nutritionists and dietitians will not be able to address IYCN comprehensively in any setting. This has implications for undergraduate nutrition/dietetics training curricula as well as for continuous professional development for qualified nutritionists and dietitians who need to learn skills for stakeholder engagement.

One-way of making the research model more practical, would be to fast-track the process. Careful background work would be required, including gathering of local data; engaging with stakeholders formally and informally to gauge their commitment, capacity and powers. This would be in preparation for a multi-stakeholder engagement process. This process could be initiated with a multi-stakeholder workshop where the local IYCN problem is stated; the IYCN stakeholder landscape is mapped; possible strategies for change and interventions are discussed and specific goals set. The momentum could be kept going through periodic follow-up engagements and tracking of goals and outcomes. Ultimately each practitioner should know the area of engagement well enough to adapt the available tools and approaches to best serve the given context.

Particular skills and competencies in multi-stakeholder processes that might be required by particular categories, such as employees of the INP, could be presented as continuous professional development (CPD) accredited sessions at nutrition symposia (e.g. the SU Division of Human Nutrition’s annual Continuous Nutrition Education event), as a master



class during the Biennial South African Nutrition Congress, or as a short course through the SU Faculty of Medicine and Health Sciences.

Following a stakeholder analysis, policy makers and managers must take additional steps to increase support or shape agreement for improvement. The information should be used to develop and implement strategic communication, advocacy, and negotiation plans or to hold consensus-building workshops. This will aid the development of an enabling environment for intervention planning and pose opportunities for further CBPR. The commitment made by the Liaison Group could be followed-up with further research; likewise the opportunity posed via the IGR Framework Act (Act No. 13 of 2005) and the district intergovernmental forum (DIF) can be explored in research for the advancement of the IYCN agenda at local government level.

The story of the importance of the first 1000 days fits well in promoting health and preventing disease strategies, a focus of the NDP 2030. This specific perspective could be taken up and advanced by DOH, since this part of the plan falls specifically within their scope. Since *“every vision, policy, plan, programme, decision or campaign will henceforth be directed and based on the NDP”*, as stated by the Minister of Health in his 2015/2016 budget speech (Motsoaledi, 2015), there should be no reservation in taking this angle to advance the importance of the first 1000 days of life at the national, provincial and implementation levels.

The local Business forum in the Breede Valley also holds promise as a discussion forum for possible future research collaboration as well as knowledge sharing. The engagement with the forum might lead to a prospective PhD project on workplace support for breastfeeding mothers. This forum has already engaged with the SU Rural School around research and business partnerships in sustainable development issues and holds promise for further collaboration.

Legislation and policy concerning IYCN should be assessed for its impact in creating a broader enabling environment for improved IYCN. It is too early to determine the impact of Regulation 991 on IYCF and IYCN in SA, since the full scope of legislation only came into

effect in 2015. The draft ECD policy will take some time still to be finalised, since it was only opened for public comment in March 2015. Both these processes should be researched for impact in the near future.

Much more deliberate actions channelled via multiple levels and avenues should be undertaken to address IYCN. It is a developmental issue addressed in relevant documents in the country, but there is a need for IYCN champions to specifically highlight its importance. Hopefully this research will inspire nutrition colleagues to actively engage with multiple stakeholders in nutrition practice and to promote and embrace working multi-sectorally to elevate and keep nutrition, with a specific focus on IYCN and the first 1000 days, on the development agenda at various sub-district, district, provincial and national levels in the country.

### **8.7 Concluding statement**

Bearing in mind the scope, context and limitations of this research, the core conclusion is that initial stages of an MSP have supported the development of commitment and revealed collective capacity that could be advanced and unlocked to address IYCN at the sub-district level in the Breede Valley, Western Cape province, South Africa. Such an approach could be helpful in scaling-up efforts to improve IYCN at sub-district level elsewhere in the province and possibly in other provinces in the country.

The proposed expansion of the definition of the enabling environment and the adaptation of the nutrition governance framework, to include a focus on stakeholder capacity, could be fed back into the international debates and agendas for continued deliberation, research and action to improve IYCN as a global, national and local priority.

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## **Addenda**

Addendum 1: Discussion guide for interviews

<p><b>Research study: Exploring stakeholder commitment and capacity to address IYCN in the Breede Valley sub-district, Western Cape, South Africa</b></p> <p><b>DISCUSSION GUIDE - First round interviews</b></p>
<p><b>Introduction &amp; Background. Explanation of research and signing of Consent form</b></p>
<p>Opening question: When I say: “Infant and Young Child Nutrition or Infant and Young Child Feeding” - what do you understand by the term / these words / what comes to mind?</p>
<p>What do you think are causing problems with IYCN in this area?</p>
<p>What do you think should be done to address IYCN generally?</p>
<p>What are the barriers to improving the situation?</p>
<p>What resources are needed to improve the situation?</p>
<p>How would you describe your role as a stakeholder in IYCN?</p>
<p>What are the barriers to fulfilling this role / What is standing in your way to fulfil your role?</p>
<p>What do you need (resources) to fulfil this role?</p>
<p>Which resources are available?</p>
<p>Is there anything else that you would like to state or share?</p>
<p><b>Close interview and inform stakeholder of planned workshop.</b></p>

Addendum 2: Discussion guide for focus group discussions

**Research study: Exploring stakeholder commitment and capacity to address IYCN in the Breede Valley sub-district, Western Cape, South Africa**

**DISCUSSION GUIDE: Last Phase - Focus Group Discussions**

**Opening and welcoming. Signing of Consent form.**

Reflection on research journey: baseline research indicating poor IYCN; stakeholder identification / first round interviews / workshop / follow-up interviews or communication / now – focus group discussion or interview.

Opening question: *How should we be telling the story of IYCN in the Breede Valley?*

Statement: It has been said by other researchers that an “enabling environment” is needed to advocate for nutrition and bring about change to the current situation.

**Show poster: Definition - Enabling environment (global/national level)**

*“political and policy processes that build and sustain momentum for the effective implementation of actions that reduce malnutrition”*

(Discuss terms “political” and “policy” in groups not familiar with these terms)

Statement: It is acknowledged in the literature that there is no definition for “enabling environment” at implementation level.

Follow-on question: *“How would you describe an enabling environment to create momentum for change in IYCN here at implementation level?”*

If 3 linked elements are not discussed above, show small posters with three linked elements and discuss applicability of elements at implementation level:

- knowledge and evidence / politics and governance / capacity and resources

Is there anything else that you would like to state or share?

**Close FGD / interview and thank stakeholder/s for time and effort. Explain that this phase of research is concluded, but that the research project (parent project) is still continuing.**

Addendum 3: Approval from the Human Research Ethics Committee (HREC), Faculty of Medicine and Health Sciences, Stellenbosch University, to conduct the research



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**Approval Notice**  
**New Application**

08-Apr-2013  
du Plessis, Lisanne LM

**Ethics Reference #: S13/03/043**

**Title:** Exploring stakeholder commitment and capacity to address infant and young child feeding practices in the capital of the Breede valley, Western Cape Province, South Africa

Dear Mrs. Lisanne du Plessis,

The New Application received on 08-Mar-2013, was reviewed by Health Research Ethics Committee I via Committee Review procedures on 03-Apr-2013 and has been approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: 03-Apr-2013 -03-Apr-2014

**Present Committee Members:**

Kinnear, Craig CJ  
Theunissen, Marie ME  
Kearns, E  
Weber, Franklin CFS  
Unger, Marianne M  
Rohland, Elvira EL  
Theron, Gerhardus GB  
Els, Petrus PJJS  
Potgieter, Sunita S  
Hendricks, Melany ML  
Pillay, Mershen M

Please remember to use your **protocol number** (S13/03/043) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

**After Ethical Review:**

Please note a template of the progress report is obtainable on [www.sun.ac.za/rds](http://www.sun.ac.za/rds) and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372  
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

**Provincial and City of Cape Town Approval**

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za) Tel: +27 21 483 9907) and Dr Helene Visser at City Health ([Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za) Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.  
For standard HREC forms and documents please visit: [www.sun.ac.za/rds](http://www.sun.ac.za/rds)

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

**Included Documents:**

CV1  
APPLIC FORM  
DEC LETTER  
CV3  
PROTOCOL  
CHECKLIST  
COVER LETTER  
LETTER  
DEC LETTER  
SYNOPSIS  
DEC LETTER  
CV2

Sincerely,



Franklin Weber  
HREC Coordinator  
Health Research Ethics Committee 1



# Investigator Responsibilities

## Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

- 1. Conducting the Research.** You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.
- 2. Participant Enrolment.** You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.
- 3. Informed Consent.** You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.
- 4. Continuing Review.** The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur**. If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.
- 5. Amendments and Changes.** If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. **You may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.
- 6. Adverse or Unanticipated Events.** Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Health Research Ethics Committee Standard Operating Procedures [www.sun025.sun.ac.za/portal/page/portal/Health\\_Sciences/English/Centres%20and%20Institutions/Research\\_Development\\_Support/Ethics/Application\\_package](http://www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package) All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.
- 7. Research Record Keeping.** You must keep the following research related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC
- 8. Reports to the MCC and Sponsor.** When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.
- 9. Provision of Emergency Medical Care.** When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.
- 10. Final reports.** When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.
- 11. On-Site Evaluations, MCC Inspections, or Audits.** If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Addendum 4a: Approval from Human Research Ethics Committee (HREC), Faculty of Medicine and Health Sciences, Stellenbosch University, for an amendment to the protocol



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jou kennisvenoot • your knowledge partner

### Ethics Letter

14-Apr-2014

**Ethics Reference #:** S13/03/043

**Clinical Trial Reference #:**

**Title:** Exploring stakeholder commitment and capacity to address infant and young child feeding practices in the capital of the Breede valley, Western Cape Province, South Africa

Dear Mrs. Lisanne du Plessis,

Your letter dated 26 February 2014 refers.

The HREC has approved your application of a protocol amendment to add focus group discussions to your project.

The consent form for focus group discussions is also approved.

If you have any queries or need further assistance, please contact the HREC Office 0219389657.

Sincerely,

REC Coordinator  
Franklin Weber  
Health Research Ethics Committee 1

Addendum 4b: Approval from Human Research Ethics Committee (HREC), Faculty of Medicine and Health Sciences, Stellenbosch University, for an amendment to the protocol



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### **Ethics Letter**

23-Jun-2015

**Ethics Reference #:** S13/03/043

**Clinical Trial Reference #:**

**Title:** Exploring stakeholder commitment and capacity to address infant and young child feeding practices in the capital of the Breede valley, western cape province, south africa

Dear Mrs. Lisanne Du Plessis,

Your letter dated 08 June 2015 refers.

The HREC approved your application for a protocol amendment and therefore will allow you to change the wording of the objectives of this project.

If you have any queries or need further assistance, please contact the HREC Office 0219399657.

Sincerely,

REC Coordinator  
Franklin Weber  
Health Research Ethics Committee 1

Addendum 5: Approval from Human Research Ethics Committee (HREC), Faculty of Medicine and Health Sciences, Stellenbosch University, for an amendment to the research title



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### **Ethics Letter**

22-Jul-2015

**Ethics Reference #:** S13/03/043

**Clinical Trial Reference #:**

**Title:** Exploring stakeholder commitment and capacity to address infant and young child nutrition in the capital of the Breede Valley, Western Cape Province, South Africa

Dear Mrs. Lisanne Du Plessis,

Your letter dated 15 July 2015 refers.

The HREC approved the change to your project title.

If you have any queries or need further assistance, please contact the HREC Office 0219399657.

Sincerely,

REC Coordinator  
Franklin Weber  
Health Research Ethics Committee 1

Addendum 6: Participant information leaflet and consent forms for interviews

## **PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

**TITLE OF THE RESEARCH PROJECT:**

**Exploring stakeholder commitment and capacity to address infant and young child feeding in the Breede Valley, Western Cape Province, South Africa**

**REFERENCE NUMBER:** S13/03/043

**PRINCIPAL INVESTIGATOR:** Lisanne M. du Plessis

**ADDRESS:** Division of Human Nutrition, PO Box 19063, Tygerberg, 7500

**CONTACT NUMBER:** 021 – 938 9175

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

**This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.**

### ***What is this research study all about?***

Mothers, fathers and families are primarily responsible to care for and feed their babies and children. However, there are many other people in the community who can impact on or influence the mother and family's ability to care for and feed their children. This research wants to investigate the perceptions and opinions of several important stakeholders who can influence the feeding practices of babies and young children from this area. We would like to know how organisations are currently supporting infant and young child feeding and how they would like to support it in future. We plan to conduct about 15 to 20 before/after interviews and host a workshop with stakeholders to produce a general report. The information will be used to plan actions to improve infant and young child feeding in future.

### ***Why have you been invited to participate?***

You are considered to be knowledgeable about stakeholders who can influence the actions needed to improve the feeding practices of babies and young children.

***What will your responsibilities be?***

If you agree to take part, you will be asked to participate in a brainstorming meeting to identify stakeholders who can influence the actions needed to improve the feeding practices of babies and young children. The meeting will take about two hours.

With your permission we would like to record the meeting proceedings. The recording will be transcribed and the information will be used for analysis in order to produce a report on the findings of the research. Researchers from Stellenbosch University will work with the data. Your name will not appear on any record. A number will be assigned to your position and that number will be used to code the information throughout the analysis. The data will be handled confidentially and recordings will be destroyed at the end of the research.

***Will you benefit from taking part in this research?***

The information obtained from this research may be of use to other researchers in the field of nutrition. The broader community might also benefit in the long term if the feeding practices of young children can be improved. You will not benefit personally, but the information might be insightful to you and your organisation.

***Are there any risks involved in your taking part in this research?***

There are no risks involved in your participation in this research project. The time that you will kindly sacrifice to participate in the meeting, might be an inconvenience.

***Will you be paid to take part in this study and are there any costs involved?***

No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

***Is there anything else that you should know or do?***

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study staff. You will receive a copy of this information and consent form for your own records.

**INFORMED CONSENT TO TAKE PART IN THE RESEARCH STUDY**

By signing below, I ..... agree to take part in this research study.

**I declare that:**

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2013.

.....

Signature of participant

.....

Signature of witness

### DECLARATION BY INVESTIGATOR

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2013.

.....

Signature of investigator

.....

Signature of witness

### INFORMED CONSENT FOR RECORDING OF INTERVIEW

The purpose of the meeting and the handling, use and final destruction of the recordings, have been explained to me. The researcher has offered to answer any of my questions relating to the procedure of the recording. I understand the explanation and I have been given a copy of this form for my records.

Signed at (*place*) ..... on (*date*) ..... 2013.

.....  
Name of participant

.....  
Signature of participant

.....  
Name of witness

.....  
Signature of witness

.....  
Name of investigator

.....  
Signature of investigator



Addendum 7: Participant information leaflet and consent forms for the workshop

## **PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

**TITLE OF THE RESEARCH PROJECT:**

**Exploring stakeholder commitment and capacity to address infant and young child feeding in the Breede Valley, Western Cape Province, South Africa**

**REFERENCE NUMBER:** S13/03/043

**PRINCIPAL INVESTIGATOR:** Lisanne M. du Plessis

**ADDRESS:** Division of Human Nutrition, PO Box 19063, Tygerberg, 7500

**CONTACT NUMBER:** 021 – 938 9175

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

**This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.**

### ***What is this research study all about?***

Mothers, fathers and families are primarily responsible to care for and feed their babies and children. However, there are many other people in the community who can impact on or influence the mother and family's ability to care for and feed their children. This research wants to explore the roles and influences of stakeholders to address feeding practices of babies and young children in this area. We would like to know how organisations are currently supporting infant and young child feeding and how they would like to support it in future. We want to conduct this workshop to produce a general report on the findings. The information from this workshop will be used to plan actions to improve infant and young child feeding in the Breede Valley.

### ***Why have you been invited to participate?***

You are considered to be a stakeholder in the actions needed to improve the feeding practices of babies and young children.

***What will your responsibilities be?***

If you agree to take part, you will be asked to participate in the workshop. It will take about half a day. The discussions and exercises will explore your networks and influences to impact on infant and young child feeding.

With your permission we would like to record the workshop proceedings. The recording will be transcribed and the information will be used for analysis in order to produce a report on the findings of the research. Researchers from Stellenbosch University will work with the data. Your name will not appear on any record. The data will be handled confidentially and recordings will be destroyed at the end of the research.

***Will you benefit from taking part in this research?***

The information obtained from this research may be of use to other researchers in the field of nutrition. The broader community might also benefit in the long term. You will not benefit personally, but the information might be insightful to you and your organisation.

***Are there any risks involved in your taking part in this research?***

There are no risks involved in your participation in this research project. The time that you will kindly sacrifice to participate in the workshop, might be an inconvenience.

***Will you be paid to take part in this study and are there any costs involved?***

No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

***Is there anything else that you should know or do?***

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study staff. You will receive a copy of this information and consent form for your own records.

**INFORMED CONSENT TO TAKE PART IN THE RESEARCH STUDY**

By signing below, I ..... agree to take part in this research study.

**I declare that:**

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2013.

.....  
Signature of participant

.....  
Signature of witness

### DECLARATION BY INVESTIGATOR

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2013.

.....  
Signature of investigator

.....  
Signature of witness

### INFORMED CONSENT FOR RECORDING OF WORKSHOP PROCEEDINGS

The purpose of the workshop and the handling, use and final destruction of the recordings, have been explained to me. The researcher has offered to answer any of my questions relating to the procedure of the recording. I understand the explanation and I have been given a copy of this form for my records.

Signed at (*place*) ..... on (*date*) ..... 2013.

.....  
Name of participant

.....  
Signature of participant

.....  
Name of witness

.....  
Signature of witness

.....  
Name of investigator

.....  
Signature of investigator

Addendum 8: Participant information leaflet and consent form for focus group discussions

## **PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

**TITLE OF THE RESEARCH PROJECT:**

**Exploring stakeholder commitment and capacity to address infant and young child feeding in the Breede Valley, Western Cape Province, South Africa**

**REFERENCE NUMBER:** S13/03/034

**PRINCIPAL INVESTIGATOR:** Lisanne M. du Plessis

**ADDRESS:** Division of Human Nutrition, PO Box 19063, Tygerberg, 7500

**CONTACT NUMBER:** 021 – 938 9175

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

**This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.**

### ***What is this research study all about?***

Mothers, fathers and families are primarily responsible to care for and feed their babies and children. However, there are many other people in the community who can impact on or influence the mother and family's ability to care for and feed their children. This research wants to explore the roles and influences of stakeholders to address feeding practices of babies and young children in this area. We would like to know how organisations are currently supporting infant and young child feeding and how they would like to support it in future. We want to conduct this focus group discussion to produce a general report on the findings. The information from this discussion will be used to plan actions to improve infant and young child feeding in the Breede Valley.

### ***Why have you been invited to participate?***

You are considered to be a stakeholder in the actions needed to improve the feeding practices of babies and young children.

***What will your responsibilities be?***

If you agree to take part, you will be asked to participate in the focus group discussion. It will take about one and a half hour. With your permission we would like to record the discussions. The recording will be transcribed and the information will be used for analysis in order to produce a report on the findings of the research. Researchers from Stellenbosch University will work with the data. Your name will not appear on any record. The data will be handled confidentially and recordings will be destroyed at the end of the research.

***Will you benefit from taking part in this research?***

The information obtained from this research may be of use to other researchers in the field of nutrition. The broader community might also benefit in the long term. You will not benefit personally, but the information might be insightful to you and your organisation.

***Are there any risks involved in your taking part in this research?***

There are no risks involved in your participation in this research project. The time that you will kindly sacrifice to participate in the discussions, might be an inconvenience.

***Will you be paid to take part in this study and are there any costs involved?***

No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

***Is there anything else that you should know or do?***

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study staff. You will receive a copy of this information and consent form for your own records.

**INFORMED CONSENT TO TAKE PART IN THE RESEARCH STUDY**

By signing below, I ..... agree to take part in this research study.

**I declare that:**

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2014.

.....  
Signature of participant

.....  
Signature of witness

**DECLARATION BY INVESTIGATOR**

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2014.

.....  
Signature of investigator

.....  
Signature of witness

**INFORMED CONSENT FOR RECORDING OF WORKSHOP PROCEEDINGS**

The purpose of the discussions and the handling, use and final destruction of the recordings, have been explained to me. The researcher has offered to answer any of my questions relating to the procedure of the recording. I understand the explanation and I have been given a copy of this form for my records.

Signed at (*place*) ..... on (*date*) ..... 2014.

.....  
Name of participant

.....  
Signature of participant

.....  
Name of witness

.....  
Signature of witness

.....  
Name of investigator

.....  
Signature of investigator

Addendum 9: Permission from Department of Education, Western Cape Government, to conduct the research



**Western Cape  
Government**  
Education

Directorate: Research

[Audrey.wyngaard@ed.gov.za](mailto:Audrey.wyngaard@ed.gov.za)

tel: +27 021 467 9272

Fax: 0865902282

Private Bag x9114, Cape Town, 8000  
[www.ed.gov.za](http://www.ed.gov.za)

**REFERENCE:** 20130610-12540

**ENQUIRIES:** Dr A.T Wyngaard

Mrs Lisanne Du Plessis  
PO Box 19063  
Division of Human Nutrition  
Tygerberg  
7500

Dear Mrs Lisanne Du Plessis

**RESEARCH PROPOSAL: EXPLORING STAKEHOLDER COMMITMENT AND CAPACITY TO ADDRESS INFANT AND YOUNG CHILD FEEDING PRACTICES IN THE CAPITAL OF THE BREEDE VALLEY, WESTERN CAPE PROVINCE, SOUTH AFRICA**

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Approval for projects should be conveyed to the District Director of the schools where the project will be conducted.
5. Educators' programmes are not to be interrupted.
6. The study is to be conducted from 15 July 2013 till 20 September 2014.
7. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
8. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
9. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
10. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
11. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
12. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Research Services  
Western Cape Education Department  
Private Bag X9114  
CAPE TOWN  
8000

We wish you success in your research.

Kind regards.

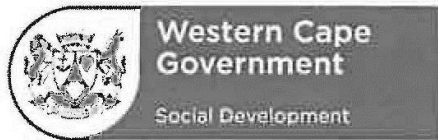
Signed: Dr Audrey T Wyngaard

Directorate: Research

DATE: 11 June 2013



Addendum 10: Permission from Department of Social Development, Western Cape Government, to conduct the research



Directorate Research, Population and Knowledge Management

tel: +27 21 483 4595 fax: +27 21 483 5602  
14 Queen Victoria Street, Cape Town, 8000  
[www.capecapegateway.gov.za](http://www.capecapegateway.gov.za)

Reference: 9/2/114/3/2/4

Enquiries: Mr Clinton Daniels

Tel: 021 483 8658

Ms L. Du Plessis

PO Box 19063

Tygerberg

PAROW

7500

Dear Ms Du Plessis

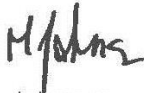
**RE: APPROVAL TO UNDERTAKE RESEARCH**

1. Your request for ethical approval to undertake research in respect of ***'Exploring stakeholder commitment and capacity to address infant and young child feeding practices in the capital of the Breede Valley, refers.***
2. It is a pleasure to inform you that ethical approval has been given by the Research Ethics Committee (REC) of the Department, subject to the following conditions:
  - That the Secretariat of the Research Ethics Committee be informed in writing of any changes made to your proposal after permission has been granted.
  - That ethical standards and practices be maintained throughout the research study, in particular ethical principles such as informed consent, confidentiality and anonymity.
  - Despite the REC's approval, research participants, specifically staff of the Department, must provide voluntary written consent to participate in the research and they have the right to refuse participation.
  - That the Department be informed of any intended publications and presentations (at conferences and otherwise) of the research findings. This should be done in writing to the Secretariat of the REC.
  - Please note that the Department supports the undertaking of research in order to contribute to the development of the body of knowledge as well as the publication and dissemination of the

results of research. However, the manner in which research is undertaken and the findings of research reported should not result in the stigmatisation, labelling and/or victimisation of beneficiaries of its services.

- The Department should receive a copy of your final dissertation, as well as articles subsequently written for publication.
- The Department should be acknowledged in all scientific/conference papers and contributions that result from the data collected in the Department.
- Please note that the Department cannot guarantee that the intended sample size as described in your proposal will be realised.
- Please note that logistical arrangements for the research must be made with the Regional Manager of the Cape Winelands Office.
- Please note that logistical arrangements for conducting research remain subject to the operational requirements and service delivery priorities of the Department and any additional protocols, regulations and delegations that may apply at the time.
- Failure to comply with these conditions can result in this approval being revoked.

Yours sincerely



Ms M. Johnson

Chairperson: Research Ethics Committee

Date: 6/9/13

Addendum 11: Permission from Department of Health, Western Cape Government, to conduct the research



**STRATEGY & HEALTH SUPPORT**

Health.Research@westerncape.gov.za  
tel: +27 21 483 6857; fax: +27 21 483 9895  
5<sup>th</sup> Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001  
[www.capegateway.gov.za](http://www.capegateway.gov.za)

REFERENCE: RP 089 /2013  
ENQUIRIES: Ms Charlene Roderick

**PO Box 19063  
Tygerberg campus  
Parrow  
7550**

For attention: **Lisanne M du Plessis**

**Re: Exploring stakeholder commitment and capacity to address infant and young child feeding practices in the capital of the Breede Valley, Western Cape Province, South Africa**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the **Ms S Neethling on 023 348 8120** to assist you with any further enquiries in accessing the following sites:

**Cape Winelands District**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator ([Health.Research@westerncape.gov.za](mailto:Health.Research@westerncape.gov.za)).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

A handwritten signature in black ink, appearing to be "NT Naledi", written over a circular stamp or watermark.

**DR. NT Naledi**  
**DIRECTOR: HEALTH IMPACT ASSESSMENT**

**DATE:** 1/10/2013  
**CC** DR L PHILLIPS

**DIRECTOR: CAPE WINELANDS**

Addendum 12: Permission from Cape Winelands District Municipality: Community Development and Planning Cluster, to conduct the research

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**From:** [Name removed to protect the person's identity]  
**Sent:** 02 July 2013 09:41 AM  
**To:** Du Plessis, LM, Mev <[lmdup@sun.ac.za](mailto:lmDup@sun.ac.za)>  
**Cc:** [Names removed to protect the persons' identity]  
**Subject:** RE: Permission to conduct research

MS DU Plesis

Permission is granted, kindly communicate your schedule to me per email, in the future please CC all correspondence addressed to me to my personal assistant, Ms [Name removed to protect the person's identity].

Wish you a fruitful and constructive working partnership with us.

Kind regards,

[Name removed to protect the person's identity]

**From:** Du Plessis, LM, Mev <[lmdup@sun.ac.za](mailto:lmDup@sun.ac.za)>  
**Sent:** 17 June 2013 09:23 PM  
**To:** [Names removed to protect the persons' identity]  
**Cc:** [Names removed to protect the persons' identity]  
**Subject:** Permission to conduct research

Dear [Names removed to protect the persons' identity]

I hope that you are well.

I am currently conducting research in the Worcester area entitled: “*Exploring stakeholder commitment and capacity to address infant and young child feeding in the capital of the Breede Valley, Western Cape Province, South Africa*”

Can you please direct me to the authority who needs to grant permission to enable me to conduct interviews with officials from the Rural and Social Development Department of Local government – Cape Winelands District Municipality?

Regards,  
Lisanne

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**Lisanne du Plessis**

*Senior Dosent / Lecturer*



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