# Country group Road Map

## *South Africa - DRAFT*

## Content



## Participants:

| First Name | Last Name | Organization / Post | Email | Participation |
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## A. Objective of the group work

**To build consensus on key nutritional problems in the country and identify ways to ensure these nutritional problems are effectively addressed in food security and agriculture strategies and investment plans**

*(Specify the name of the policy/investment plan which was reviewed during country group work)*

**NAFSIP not drafted yet**

## B. Background

*You could provide here further information about the status of your country in the CAADP process:*

0. *Launch of the process (Focal Point appointed, CAADP launch, TC appointed, experts engaged)*
1. *Compact design and signature*
2. *Development of Investment Plan*
3. *Technical review of Investment Plan*
4. *Business meeting*
5. *Implementation*
6. *M&E / Impact assessment*

*You could also insert here key activities that were carried out in preparation for the workshop (i.e. setting up a multi-sectoral country team, production of the NCP, identification of key relevant policy and strategies (including main National Agriculture and Food Security Investment Plan – NAFSIP; organization of a pre-workshop meeting with country team members, etc.) and specify the objectives of these pre-workshop activities.*

**Drafting Compact**

## C. Analysis of nutrition problems

1. **What are the main nutrition problems in your country? Have malnutrition rates changed over the last decade? Will it change further in future 10 years? If so, how? What do you think are the major reasons for these changes?**
   *Guidance: Consider the various types of malnutrition. Analysing trends (seasonal and historical) can help identify causes of malnutrition and understand the evolution of the situation. Do not forget to consider issues within urban areas and urban-rural linkages; as well as HIV and AIDS*

*MAIN NUTRITION PROBLEMS*

- Underweight and overweight in adult men and women
  - Overweight and obesity rates were at 30% for men and 55% of women at national level (2003)
  - Obesity increased from 27% in 2003 to 39.2% in 2012 among women

- Stunting

- 24% in 2005 (Food Consumption Survey) and 26.5% of children between 1-3 years (SANHANES-1, 2013)
- 16.4% in 2005(Food Consumption Survey) and 11.9% of children between 4-6 years (SANHANES-1,2013)
- 19.5% of children under 5 years (NFCS, 2005)
- 20% of children under 5 years (Labadarios et al (2000))

▪ Underweight
- Underweight affects 9.3% of children
- 6.1% of children between 1-3 years
- 4.5% of children between 4-6 years

▪ Overweight
- 5% of children under 5 years are overweight

▪ Wasting
- 4.5% of children under 5 years (NFCS,2005

▪ Micro-nutrient deficiency
- 64% of pre-school children with Vitamin A deficiency
- 28% of women with Vitamin A deficiency
- Anaemia 30% of children and women
- 43% of children
- with Zinc deficiency

*TRENDS*

▪ The national stunting prevalence has decreased from 21.6% in 1999 to 18% in 2005
▪ Underweight affects 9.3% of children
▪ Wasting increased slightly between 1994 and 2005, but remained below the public health concern threshold.

*EXPECTED FUTURE CHANGES*

▪ We are of the opinion that the situation will change for the better, due to the current strategy and policy frameworks for improving food security and nutrition.

▪ Major reasons for change:
- NATIONAL DEVELOPMENT PLAN (NDP) 2030
- MEDIUM TERM STRATEGIC FRAMEWORK (MTSF)
- RURAL DEVELOPMENT AND FOOD AND NUTRITION SECURITY
- NATIONAL MEDIUN TERM INVESTMENT PROGRAMME (NMTIP)
- FOOD SECURITY AND NUTRITION POLICY (Draft)
- INTERGRATED FOOD SECURITY STRATEGY(IFSS)
- INTERGRATED FOOD SECURITY AND NUTRITION PROGRAMME (IFSNP)
- INTERGRATED SUSTAINABLE RURAL DEVELOPMENT PROGRAMME
- AGRI-BEE CHARTER
- INTERGRATED NUTRITION PROGRAMME
- NATIONAL FOOD FORTIFICATION PROGRAMME
- HEALTH SECTOR STRATEGIC FRAMEWORK

(Additional data)

- Under 5 mortality rate per 1000 live births is estimated to be 43
- Infant mortality rate per 1000 live birth is estimated at 162
- Maternal mortality rate per 100 000 lively births 410
- HIV/AIDS prevelance between adults between 15 -49 years is estimated at 17.3%
- TB prevelance and diabetes
- Access to improved drinking water in rural areas is estimated at 78%
- Access to improved sanitation in rural areas is estimated at 65%
- Poverty and ***inequality rate is estimated at 0.67% which indicates increase from 0.64% (1995-2008)***
- Approximately 40% of households do not meet their daily energy requirements
- Children (20-23 months) still breastfeeding is estimated at 31%
- Children (0-6 months) exclusively breastfeeding is estimated at 8%
- Vitamin A supplements coverage rate for children beween 6-59 months estimated at 21%

**2. Are particular geographic areas / population groups (age, gender, infant and young child, people leaving with HIV, type of socio-economic groups, etc.) more vulnerable to malnutrition? Which ones, and why?**

***Background that defines nutrition sensitive agriculture and its importance in development and in nutrition and health***

Although Health is a key development goal, South Africa principally suffers today from a quadruple burden of disease: from HIV and AIDS and TB, high levels of Maternal and Child mortality; Intentional and non-intentional injuries; and non-communicable diseases (NCDs). The major NCDs are linked to common risk factors, namely unhealthy diets (high intake of energy dense foods containing fats, salt and sugar), physical inactivity, and harmful use of alcohol, tobacco use and in some cases infections. Unequal development including poverty and health illiteracy is strongly associated with increased NCD morbidity and mortality. People living with Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) are at higher risk for developing NCD including cancers, heart disease, mental disorder and diabetes. Maternal and child health are inextricably linked with NCD and their risk factors, while prenatal malnutrition and low birth weight create a predisposition for obesity, high blood pressure, heart disease and diabetes later in life. NCD in pregnancy create risks for both mother and child. Added to this is the fact that more than half of people who have hypertension and diabetes in South Africa are not even aware of their condition. An estimated 17 million visits at health centres per annum for these conditions, results in significant health care costs and use of human resources. NCDs have economic consequences on individuals, households and society.

**The National Strategic Plan (NSP's) for HIV, STDs and TB** goals and strategic objectives are guided by evidence from various reports, including the *Know Your Epidemic* (KYE) report, a situation analysis of TB in the country and other epidemiological studies.

These studies identified key populations that are most likely to be exposed to or to transmit HIV and/ or TB. For HIV, key populations include young women between the ages of 15 and 24 years; people living close to national roads and in informal settlements; young people not attending school and girls who drop out of school before matriculating; people from low socio-economic groups; uncircumcised men; people with disabilities and mental disorders; sex workers and their clients; people who abuse alcohol and illegal substances; men who have sex with men and transgender individuals.

It is estimated that 80% of the South African population is infected with the TB bacillus; however, not everyone who is infected will progress to active TB disease.2 Certain populations are at higher risk of TB infection and re-infection, including: healthcare workers; miners; prisoners; prison officers and

household contacts of confirmed TB patients. In addition, certain groups are particularly vulnerable to progressing from TB infection to TB disease. These include children; people living with HIV; diabetics; smokers; alcohol and substance users; people who are malnourished or have silicosis; mobile, migrant and refugee populations; and people living and working in poorly ventilated environments. These groups are considered key populations for TB. Within each strategic objective, these key populations will be targeted with different, but specific interventions,to achieve maximum impact.

**NDP 2030 identifies the following nutritionally vulnerable sub groups:**

- Micro nutrient deficiencies in children under 18 months
- Pregnant women and children under five years
- Labadarios et al (2000) pointed out that at the national level, stunting was by far the most common nutritional disorder, affecting at that time nearly one in five children. Stunting, is indicative of chronic long-term dietary inadequacy but is also reflecting socioeconomic deprivation, and mostly used as a measure of nutritional status in children (Vorster et al. 1997).

- In the 2013 SANHANES-1 Study similar pattern emerged for the prevalence of stunting of 26.5 % of children aged 1-3 years and 11.9 % of children aged 4-6.

    - The same study comes with an underweight prevalence, of 6.1% of the children in the group 1-3 years and 4.5% of the children in the group 4-6 years.

- The South African Demographic and Health Survey (SADHS, 1998) recorded the significant difference in the health situation between the different groups within the country, with the mortality rate in rural areas as high as 7.12%, compared to a 4.32% rate in urban areas, and obesity rates in children in urban areas (5.5%) were recorded higher compared to the national average (4.8%). Stunting rates are higher in younger children (1- 3 years) and for those living in rural areas and on commercial farms (26.5%) compared to children living in urban areas (16.7%) (NFCS, 1999).
- Poor more vulnerable to malnutrition: The poorest South Africans (30%) spend 31% of their total expenditure on food according to the latest Statistics South African Income and Expenditure Survey (StatsSA, 2012). Based on these statistics, a household with an income of $168 per month will spend roughly $52 per month on food, which amounts to $1.73 per household, per day (Schonfeldt et al., 2013).

- The Food Consumption Survey (2005) stated that, 18% of children in South Africa are stunted.

    - Stunting is higher in rural formal areas (24.5%) tribal areas (19.5%) and urban informal areas (18.5%).
    - Stunting decreased with age from 23.4% in 1-3 years ; to 16.4%

- Data indicates that many South African children under 14 years of age are stunted (15.4% of all children under 14 years, and 26.5% of children under 3 years) with increasing rates of overweight and obesity (23.6% of girls and 16.2% of boys between the ages of 2 and 14 years) observed. These continue to co-exist with persistent vitamin A (43.6%) and iron (9.2%) deficiencies in children. The majority of South African adults, and especially women, are overweight (24.8%) or obese (39.2%), while many women also suffer from the consequences of micronutrient deficiencies, i.e. anaemia (22%) and vitamin A deficiency (13.3%) (SANHANES-1, 2012).
- Furthermore, the Food Security and Vulnerability Assessment (2010) indicate that, the highest prevalence of overweight to be in Gauteng (6.4%), and KwaZulu Natal (6.3%) and about 26.6% of women are overweight and 24.9% are obese.

- The study also indicates that at the provincial level, the prevalence of wasting to be highest in the Western Cape (11.5%), followed by Mpumalanga (7.5%). Additionally, the prevalence of severe wasting is also higher in these provinces, i.e. 4.4% and 2.3 % respectively. Although Northern Cape and Free State had a wasting prevalence of 19.1% and 14.1% respectively, they do not show any severe wasting.
- Estimated HIV prevalence (%) among South Africans, 2 years and older, by age, 2002-2008

| **Age** | **2002 (%)** | **2005 (%)** | **2008 (%)** |
|---|---|---|---|
| Children (2-14 years) | 5.6 | 3.3 | 2.5 |
| Youth (15-24 years) | 9.3 | 10.3 | 8.7 |
| Adults (25 and older ) | 15.5 | 15.6 | 16.8 |
| **Total (2 and older)** | **11.4** | **10.8** | **10.9** |

**3. Are the main nutrition problems and causes for malnutrition that you have identified already described in your NAFSIP? If not, which information should be added?**

South Africa does not have a NAFSIP at the moment however, the key message is: Affordability can be an issue; vs. availability and acceptability vs. nutrionally balanced.We need to integrate indigenous foods in the dietary basket. Moreover, it is important how we communicate this information to the community, and be linked to community based initiatives.

## D. Objectives and targets related to nutrition issues

**4. What specific objectives and targets would you need to include in your CAADP Compact and / or CAADP Investment plan to ensure that nutrition is effectively addressed (incl. linkages between HIV and nutrition)?**

Strategic goal (4, 5, 6)

The strategic goal of the Food Security and Nutrition Policy is to ensure the availability, accessibility; affordability and consumption of safe and nutritious food at national and household levels, to reduce stunting and micro-nutrient deficiency for children under 5 (use the WHO Compact targets set by DOH)

| **Objectives** | **Targets** | **Interventions** |
|---|---|---|
| 1. To design a comprehensive intervention plan involving all key stakeholders | Involve DAFF, DSD, DOH, DBE, DRDLR, Treasury, DWA, Food bank SA, bi lateral and multi-lateral agencies, NGOs, Traditional leaders, private sector, DTI, commodity groups, COGTA.<br>Completed three months | High level buy in<br>Workshops at all spheres of Government |

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| | after inception of the program. | |
| 2. To strengthen existing task teams and forums to increase integration and cooperation between sectors and across the different spheres of Government. | On going/continuous | Review and identify strengths and weaknesses<br>Create task teams/forums where gaps exists<br>Workshops at all spheres of Government |
| 3. To revise structures of DAFF, DSD, Dept of Education and DOH in order to ensure that the structure supports nutrition. | Revision and draft structures completed six months after program inception | Develop concept note<br>Identify champions at high level in each key departments<br>Stakeholder engagements to get buy-in<br>Align revised structures with objectives and available resources |
| 4. To link local producers with the school feeding supply system and ensure that they produce what is needed. Expand current examples in KZN and EC to other provinces. | Program expansion to all 9 provinces.<br>Linkages supply at least 20% of school food needs in high production areas. | Identify and capacitate potential producers<br>Capacitate food handlers in improved food handling techniques<br>Adjust menu to enable local procurement |
| 5. To improve **nutrition education**, including District level nutrition services to assist households and communities monitoring nutritional indices: work hand in hand with agriculture and integrate with extension program. Assisting with better food management, food safety and improved meal planning. Diversified consumption. | Nutrition integrated into school curriculum by two years after inception.<br>Number of food security and nutrition workers at all spheres of Government in DAFF, social development and DoH increased.<br>Community nutrition education program targeted initially at 23 districts implemented before the end of year two. | Develop a nutrition school curriculum and integrate nutrition education into the school curriculum<br>Review the existing DOH nutrition programs to establish whether it is appropriate for community based initiatives and the linkages between agriculture and nutrition<br>Capacity building of community based workers and the community. |
| 6. To diversify and increase the production of nutrient dense foods particularly in rural areas. Establishment of home and community gardens, as well as assistance programmes for the poor. | Number of smallholder and subsistence producer households involved increased by 2% (380000) two years after inception.<br>Greater variety of nutrient dense crops and livestock produced.<br>Special program targeting poor, orphans, the elderly | Strengthening the promotion of agricultural production and provision of technical support.<br>Introduce new and improved crop varieties by working with ARC.<br><br>Expand food gardens at health facilities and involve beneficiaries in the process and promotr the |

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| | and chronically ill (HIV/Positive, TB) and household at risk of contracting TB established. | use of space and labour saving technologies (e.g. tower gardens etc) |
| 7. To promote and support urban and peri-urban agricultural production. | X number of home based gardens established.<br>Increased utilisation of unused space e.g. roof tops, unused municipal land, use of space saving technologies (e.g. tower gardens etc) | Inclusion of urban and peri-urban agriculture in the national and provincial and policy and strategy agendas.<br>Research and introduction of new innovative urban production methods.<br>Food and nutrion security campaigns in urban and peri-urban areas. |
| 8. To provide and subsidise inputs and support services for increased and diversified food production (nutrient dense crops and small scale livestock). | CASP, ilema/ letsema revised to focus on promoting and funding the production of more diverse and nutrient dense crops. | Provision of farm infrastructure to small holder farmers.<br>Adjust the composition of existing programs e.g. CASP, Ilema/Letsema to focus on promoting and funding the production of more diverse and nutrient dense crops , livestock and acquaculture. |
| 9. To support and promote more effective food storage, processing and distribution networks, involving both government and private agencies, to maximise nutritional value, eliminate waste and ensure better access to nutritious and safe food by all. | X programs established to Improve and promote low tech storage technologies to prevent post-harvest loss, processing and add value. | Improve and promote low tech storage technologies to prevent post-harvest loss, processing and add value.<br>Revise MAFISA and CASP to support improved storage facilities and processing and support indigenous food preservation technologies.<br>Establish linkages with private enterprises to improve processing and distribution. |
| 10. To improve **market participation** of the emerging agricultural sector through public-private partnerships (e.g. food bank and small holder linkages) including off-take and other agreements, a government food purchase programme that supports smallholder farmers, as well as through the implementation of the Agri-BEE Charter, which requires agro-processing industries to broaden their supply | Percentage of smallholder commodities bought by private enterprise increased by 5% ; two years after inception.<br>Establish new linkages (3 per province per year) | Establish new linkages between small holders and private enterprises.<br>Intensify extension to focus on quality and timeous delivery. |

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| bases to include the emerging agricultural sector. | | |
| 11. To promote healthy food choices through food distribution networks (food banks), subsidies of nutrient dense value chains, aggressive social marketing (over nutrition). | At least 2 campaigns targeting women per province per year.<br>Food garden activities to emphasize need to balance intakes and reduce carbohydrates, sugar and oils in favor of vegetables and fruit. | Educational campaigns aimed at reducing obesity and promoting healthy eating habits. |
| 12. To improve agricultural, food security and nutrition information management systems, with periodic scientific reviews of the state of food security and nutrition in the country. | By the end of year 2 existing systems reviewed and improved.<br>Scientific food security and nutrition reviews every 3 years. | Review and improve existing systems.<br>Establish scientific food security and nutrition review system. |
| 13. To initiate national early warning system for food and nutrition insecurity. | By the end of year 2 the system will be established. | Develop and promote early warning system. |
| 14. To explore and support research into bio-fortification in relation to micro-nutrient deficiencies. | At least 2 new varieties that address micro-nutrient deficiencies developed every five years. | Identify crops that can make a potential impact on micro-nutrient deficiencies.<br>Establish bio-fortification research programme. |

5. **On the basis of the nutrition objectives that you have formulated above (<u>related to agriculture</u>), how could specific objectives in the NAFSIP be revised / formulated to better address nutrition issues?**

   TBD

6. **Should any specific population groups (age, gender, infant and young child, people leaving with HIV, type of socio-economic groups, etc.) or geographical areas be targeted to achieve these objectives?**
   TBD

7. **What nutritionally vulnerable groups / geographic areas do you recommend to add / further target in the NAFSIP?**

   - The group came up with the following profile for RSA

| | |
|---|---|
| **Hidden Hunger** | People allergic with no knowledge of alternatives<br>Wrong preferences<br>Culture-girls not to eat eggs<br>People with lack of nutrition information |

| | |
|---|---|
| | Lack of variety /not by choice<br>Lack of knowledge or other food varieties |
| **Chronically hungry** | Homeless<br>Asylum seekers<br>Lack of nutrition information<br>Under 5 (poor caring parents<br>HH depending on social grants |
| **Acute** | Casual labourers: Men on the side of the road (job seekers)<br>Seasonal workers e.g. in farms<br>People living on streets<br>Families that have lost the breadwinner (death)<br>People affected by disaster-where everything is wiped out and for a week or two the family is hungry<br>People in the dispose : ill for a period of time (temporal illness)<br>Orphaned Children and those dependent on remittances<br>Child headed households<br>Victims of crime |
| **Starvation** | People who are continuously hungry and do not know where the food will come from and those outside social safety nets<br>No social networks and entitlements<br>Those not concerned with what they eat (disregarding nutrition)<br>Disaster affected areas, severely politically instable areas<br>People with retarded mental capacity |

## E. Interventions to enhance the nutritional impact of agriculture investments

8. **How can existing food and agriculture programmes be "transformed" to support the achievement of the propose nutrition objectives / targets and meet the needs of identified target groups? Suggest concrete steps to take / interventions.**

*Guidance: Start by identifying existing programmes and think about what worked / did not work until now. Then identify ways to maximise the nutritional impact of these programmes. Make sure that proposed interventions are adapted to different livelihoods. Make sure that the proposed strategies are:*

- *relevant to address the nutrition problems and causes that were identified,*
- *feasible given existing capacities*
- *have maximum impact for minimum investments*
- *provide opportunities to create synergies and complementarities with other initiatives*

9. **How can agriculture policies and investments create incentives (for producers, processors, retailers and consumers) to improve nutrition? Suggest concrete steps to take / interventions.**

- Subsidies, Land policies, improved infrastructure, improved agro-processing systems, market support (Public Private Partnership (PPP)), investment in quality improvement training for producers, food safety (quality standards), investments in social protection (school feeding programme, food bank), and commercial food fortification could create incentives to improve nutrition (nutrition-dense crops).

10. **Should any new interventions be piloted / implemented to complement existing programmes? Suggest concrete steps to take / interventions.**

- Review and enhance existing programmes (to be nutrition sensitive)
- Enhance existing structures (to be nutrition sensitive)

## F. Priorities for information systems

11. **Do existing information systems provide the information you need to adequately plan nutrition and agriculture interventions? If not, how should these be strengthened? What are priority actions for improving food and nutrition security information systems?**

- No uniform and regular measurement of malnutrition indicators at a national level
- Need to develop a food security index to measure household food security through household surveys
- Agricultural administrative data base system in poor state and in need of urgent improvement
- Need to fund and conduct regular smallholder and subsistence producers' surveys
- Need to invest in mobile technologies to improve data systems

## G. Institutional arrangements and coordination mechanisms

12. **What needs to be coordinated and for what: what do you want to achieve with coordination?**
**Implementation of policy and programs**

- To avoid duplication
- Better targeting of beneficiaries
- Efficient use of resources
- To monitor progress and impact

13. **How should existing coordination mechanisms be strengthened to better integrate nutrition in agriculture policies and programmes, and better integrate agriculture in nutrition policies and programmes?**

- Regular Food Security Cluster Meetings should be held
- Revive the Integrated Food Security and Nutrition Task Team at national level
- Strengthening and reviving of Food Security Forums to include nutrition
- Investigate methods to link food security and nutrition initiatives to War on Poverty
- Performance indicators of senior managers in DAFF, DOH, DSD, DBE, DRDLR should include food security and nutrition to enhance coordination.

14. **Which partners (national institutions, development partners, private sector) / initiatives (SUN, REACH, etc.) should be involved for strengthening the nutritional impact of agriculture policies and programmes?**

- Involve DAFF, DSD, DOH, DBE, DRDLR, Treasury, DWA, Food bank SA, bi lateral and multi-lateral agencies, NGOs, Traditional leaders, private sector, financial institutions, media, DTI, commodity groups, COGTA.

## H. Capacities needed for integrating nutrition in agriculture

15. **What are the most critical capacity gaps for achieving the proposed objectives? How would you address these gaps in the short and long term?**
*Guidance: Look at operational, strategic and research capacities for both individuals and institutions.*

| | |
|---|---|
| Funding | Sufficient financial resources allocated to food security and nutrition initiatives |
| Coordination | Revive and strengthen existing structures |
| Food Security and Nutrition skills | Introduction of nutrition education in the school curriculum and at community level |
| Lack of recruitment for trained nutritionists | Modify structures at community level to include more food security and nutrition workers |
| Poor incentives for retention | Improve working conditions |

## I. Costing / funding issues

16. **How can you use existing resources to address some of the priorities (in terms of interventions, information systems and capacities) identified above? Where would you need new resources?**

- Use available technical and financial resources (NEPAD, FAO etc) more effectively.

## J. Next Steps

*Guidance: Think about:*

- *How each team member will report back to their individual organization?*
- *How to sensitize/influence decision-makers to take on board recommendations coming out from the workshop?*
- *What are the key events/opportunities to integrate your suggestions on nutrition (e.g. in the CAADP process; during a SUN meeting; during a national high level meeting, etc.)?*
- *What are your needs for external support/assistance?*
- *Who will be the main contact person for nutrition-related issues in the CAADP process after the workshop?*

| Action point | Responsible person | Date | Comments |
|---|---|---|---|
| ▪ Back to office report on the workshop to the Director Subsistence Farming, Chief Director: Food Security and Chief Director: International Relations | Ms . D Kunene and/ Ms. E Moshesha | 16 September 2013 | |
| ▪ Report to DDG and colleagues involved in Statssa | Isabelle | 17/09/2013 | |
| ▪ Report to FAO Representative, Programme Team which involve Investment Officer responsible for CAADP | Lot Mlati | 25/9/2013 | |
| ▪ By elevating the recommendations and involvement of the Chief | Ms. D Kunene and/Ms. E Moshesha | 16 September 2013 | |

| Action point | Responsible person | Date | Comments |
|---|---|---|---|
| Director Food Security's Office<br>▪ By including Food Security and Nutrition Directors at different Forums | Ms. D Kunene and/Ms. E Moshesha | Ongoing basis | |
| ▪ Report to data forum for outcome 7, DPE, Presidency | Isabelle | 30 September 2013 | |
| ▪ Engage DAFF Focal person on CAADP<br>▪ Send inputs on nutrition with regards to draft policy on food security and nutrition | Lot | 25/10/2013 | |
| ▪ Food Security Cluster Meeting<br>▪ Integrated Food Security and Nutrition Task Team Meetings<br>▪ Food Security Forums | Chief Director Food Security<br><br>Food Security Directors<br><br><br><br><br><br>Food Security Officers | Ongoing basis<br><br><br><br>Ongoing basis<br><br><br><br><br>Ongoing basis | |
| ▪ Review CPS questionnaire to ensure that WHO compact and other nutrition/food security considerations are adequately addressed | Isabelle | 30/09/2013 | Pending |

| Action point | Responsible person | Date | Comments |
|---|---|---|---|
| ▪ The key events are CAADP provincial and National consultations | Lot Mlati | Ongoing | |
| ▪ Financial and technical resources | NEPAD, FAO etc | Ongoing basis | |
| ▪ Include some of the nutrition and FS considerations in the CPS questionnaire for years 2 and 3 | Isabelle | 30/10/2014 | |
| ▪ FAO will work with Investment Officer responsible for CAADP and with Sub-Regioal Office for Southern Africa | Lot Mlati | ongoing | |
| ▪ Country Focal point and<br>▪ Chief Director Food Security | Ms. N Vuthula<br><br>Mr. Z Dlamini | Ongoing basis | |
| ▪ Liaise closely with Economic stats about the survey of smallholder and subsistence farmers | Isabelle | Continuous | |
| ▪ FAO Country Focal point for CAADP | Lot | Ongoing basis | |