REPUBLIC OF NAMIBIA

OFFICE OF THE PRESIDENT

NATIONAL PLANNING COMMISSION

REPORT

on the

Multi-Stakeholder Malnutrition Intervention

Omaheke Region,

4 - 16 February 2024

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Background

Despite Namibia's status as upper-middle income country, it is the second most unequal society worldwide with a Gini coefficient of 59.1 (World Bank, 2015) and 43.3% of the population living in multidimensional poverty.[1] Namibia also bears the triple-burden of malnutrition[2] with overnutrition (= overweigh/obesity) coexisting alongside undernutrition (= stunting/wasting) and 'hidden hunger' (= micro-nutrient deficiencies).

According to 20016 data, an average of 2,542 child deaths per year are 'directly associated with undernutrition' and stunting is estimated to cost at least 5.22% of Namibia's GDP annually, over EUR 560 million in 2016[3]. At least one in three households cannot afford a basic nutritious diet, which affects up to 70% of the population in certain regions of Namibia.[4]

Since independence, the Namibian Government has been aware of this challenging situation and developed an initial Food and Nutrition Policy in 1995. The revised **Food and Nutrition Security (FNS) Policy**, including FNS Coordination Structures and a costed Implementation Action Plan, has been launched by the Prime Minister, Rt. Hon. Dr. Saara Kuugongelwa-Amadhila, in December 2021.[5] However, only FNS Coordination Structures have been put in place at national level, while there are no sub-national coordination mechanisms in any of Namibia's 14 regions yet.

The Omaheke region is among the hardest hit, with a spike in malnutrition cases and deaths occurring between December and March each year. This prompted the Omaheke Governor to establish an intersectoral multi-stakeholder malnutrition task force under the Regional AIDS Coordination Committee (RACOC) in March 2022.

Since 2022, several joint visits by government, United Nations agencies and the Nutrition and Food Security Alliance of Namibia (NAFSAN) have taken place, and a number of reports were compiled and actions taken and/or suggested to be taken (→ see list of documents in the desk review section) - yet with limited success so far.

The Office of the Governor subsequently raised concerns again about the devastating situation in the Omaheke Region at the end of 2023, which lead to a high-level meeting at the Prime Minister's Office on 1 February 2024, in which several recommendations were made, including this joint multi-stakeholder investigation that took place from 4 – 16 February 2024 and that is covered in this report.

This report was compiled under the leadership of the Executive Director of the National Planning Commission (NPC), supported by the Office of the Governor; Ministry of Gender Equality, Poverty Eradication, and Social Welfare (MGEPESW); Ministry of Health and Social Services (MHSS); Nutrition and Food Security Alliance of Namibia (NAFSAN); Ministry of Agriculture, Water, and Land Reform (MAWLR), and with involvement of the Ministry of Urban and Rural Development (MURD); Office of the Prime Minister (OPM); and the Omaheke Regional Council.

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[1] Oxford Poverty and Human Development Initiative (2021). *Namibia Multidimensional Poverty Index Report*

[2] UNICEF (2020). *New insights: 21st century malnutrition: Unpacking the triple burden for children nutritional wellbeing* - https://www.unicef.org/globalinsight/stories/new-insights-21st-century-malnutrition

[3] National Planning Commission in collaboration with WFP, GIZ, UNICEF and NSA (2022). *Cost of Hunger in Africa (COHA) Namibia – The Social and Economic Impact of Child Undernutrition in Namibia*.

[4] National Planning Commission in collaboration with WFP, GIZ-F4R (2021). *Fill the Nutrient Gap, Namibia*.

[5] All documents online: https://opm.gov.na/national-food-and-nutrition-security & www.nafsan.org/nfns

Objectives of the Multi-Stakeholder Investigation

A multi-stakeholder team consisting of representatives from some government ministries (primarily MHSS and MGEPESW, as well as NPC, OPM, MAWLR and MURD), NAFSAN (as official technical partner within the FNS Policy), and temporary also UNICEF and WHO, visited the Omaheke region from 4 to 16 February 2024. The team worked closely together with the Office of the Governor and local NGOs actively working in community health.

The **Objectives of the Investigation** were based on the recommendations from the meeting at OPM on Thursday, 1 February 2024 (listed in *Appendix: 'Recommendations of Malnutrition Task Team Meeting at OPM'* and pp. 25-26), whereby MHSS had already planned to conduct an assessment visit to all hospitals and clinics in the region prior to said meeting. Hence, the multi-stakeholder team focused on the following objectives during these two weeks:

1. Conduct a **Rapid Assessment** of all the hotspots in communities and health facilities and communities to learn and share more information about the situation on the ground,
2. Develop a **Post-Discharge Strategy** to avoid readmission or malnutrition cases,
3. Assist the region in fine-tuning its **Communication and Behaviour Change Strategy**,
4. Develop a costed **Response Plan** that covers all relevant areas to address visible and underlying issues related to malnutrition, hereby involving all relevant stakeholders, including civil society, private sector, academia, and UN agencies.
5. Make suggestions regarding the **Regional** and **National FNS Coordination Structures**, based on experiences during the two weeks in the context of Namibia's FNS Policy,
6. Provide **Updates** and/or **Practical Ways Forward** on the other recommendations from the 1 February 2024 meeting and on other relevant findings during these investigations.

It is important to highlight that as much as the situation in Omaheke is critical and demands urgent action, it is only one of several regions in Namibia that are experiencing concerningly high numbers of malnutrition cases and deaths. Hence, all past, present and future interventions and experiences from the **Omaheke region** are highly recommended **to serve as pilot**, so that what works here can be scaled up, replicated and adjusted for other Namibian regions as well.

In addition, there are also important lessons to be learned on **national level** in terms of **coordination and implementation** of cross-sectoral multi-stakeholder efforts towards ensuring **food and nutrition security** in Namibia.

Key Outcomes

Given the limited time for this ad-hoc assignment being given to a team that unfortunately did not comprise of all the necessary stakeholders and which experienced several leadership and coordination challenges, several concrete outcomes could be achieved.

An **initial assessment** was conducted and highlighted some key recommendations, although it was not of as high quality as could have been possible if proper time, planning and resources had been availed. This is why it was referred to as a ***Rapid Assessment***, hence it is imperative for more time and resources to be availed for a more high-quality assessment to be conducted.

Major initial steps towards the development of a comprehensive **post-discharge strategy** were taken, which will help to better connect interventions at health facilities (where symptoms and consequences of malnutrition become brutally visible and receive treatment, yet which are also a central point for prevention) and interventions in communities (where the various root causes of malnutrition lie, for which comprehensive multi-sectoral interventions are required to address them effectively). This development of this novel approach is still in progress, yet some immediate actions have already been taken while short- and long-term planning is ongoing, whereby allocating and securing funds for a designated coordinator of this strategy will be crucial for its success in terms of final development, implementation and possible scaling up.

While lack of food and poverty are the major root causes, there is also a clear lack of knowledge and even misperceptions around malnutrition and how it can be prevented, as well as a need for basic good nutritional practices to be understood, especially among mothers/parents/caregivers and young children. Much more inspiration and knowledge needs to be shared in terms of local food production and creating awareness of overall health and food systems. Building on previous efforts and ideas from the task team in Omaheke, an initial draft **Communication and Behaviour Change Strategy** was developed and partially costed. Linkages and synergies with already existing campaigns, such as Namibia's Right Start Campaign (www.rightstart.com.na) and the established *'Advocacy, Communication and Social Mobilisation'* Working Group under the National Food and Nutrition Security (NFSN) Policy are hereby of utmost importance to ensure proper alignment and synergies with all NFSN activities and implementing partners.

Towards the end of the visit, a costed **Response Plan** started to be developed in an excel format, which captures some of the most important necessary interventions. However, it still needs to become fully and comprehensively alignment with all outcomes and recommendations from this intervention including previous reports (desk study, p.6). Further integration of this Response Plan into the overall NFNS Policy's Implementation Action Plan will then require deliberate efforts by the national FNS Secretariat responsible for overall coordination efforts.

A final key finding from this intervention is that **Coordination** at both national and regional levels, since the launch of Namibia's revised Food and Nutrition Security Policy in 2021, has been insufficient, while the need for efficient coordination through a properly placed and well-capacitated FNS Secretariat as the 'engine' of this NFNS policy has become clear.

The following chapters elaborate on these outcomes and findings in more detail.

Rapid Assessment Findings

Desk Review

Although an in-depth desk review was not conducted at the time of this intervention, the following previous reports and assessments were identified as being relevant for analyzing and understanding the situation in Omaheke and in Namibia in general, so that they can inform comprehensive action planning in the future:

Reports/Interventions – Omaheke

Title	Author	Year
Roadmap to Sustainable Interventions: Multi-Sectoral Inputs for Malnutrition in the Omaheke Region	Various *(download)*	2022, March
Report – Joint Multi-Sectoral Team Visit to Investigate Increased Severe Acute Malnutrition Admissions in Omaheke Region	Various *(download)*	2022, April
Report – Technical Support and Supervision Visit to Omaheke in Response to High Fatality of Severe Acute Malnutrition Admission	UNICEF *(download)*	2023, March
Report - Visit to Omaheke Region to identify key stakeholders and existing coordination structures and mechanisms regarding Nutrition & Food Security	NAFSAN *(download)*	2023, April
Letter to the Rt. Hon. Prime Minister – Proposed Interventions for Mitigation of Malnutrition in Omaheke Region *(download)*	Omaheke Governor	2023, Sept.
Workshop Report – FNS Working Group on Communication, Advocacy and Social Mobilization, Omaheke Region Gobabis: 2-4 October 2023	OPM *(download)*	2023, Nov.

Namibia – National Level

Title	Author	Year
Participatory Rapid Assessment of Integrated Early Childhood Development Programmes among San Communities in Namibia *(download)*	UNICEF	2017
The Costs of Inaction: ECD in Namibia *(download)*	InterTeam Namibia	2019
Revised National Food & Nutrition Security (NFSN) Policy *(download)*	OPM	2021
Food & Nutrition Security Coordination Structures *(download)*	OPM	2021
Implementation Action Plan for the Revised NFSN Policy *(download)*	OPM	2021
Action Plan - Namibia National Integrated Rural Transformation Programme	OPM	2022
Fill the Nutrient Gap – Namibia *(download)*	NPC	2022
Cost of Hunger in Africa (COHA) Report: The Social and Economic Impact of Child Undernutrition in Namibia *(download)*	NPC	2022
Namibia 2021 - Vulnerability Assessment and Analysis Findings *(download)*	OPM	2022
Action Plan - Food Insecurity and Malnutrition amongst Children from the Marginalized Communities *(download)*	MGEPESW	2023
Namibia 2022 - Vulnerability Assessment and Analysis Findings *(download)*	OPM	2023

Healthcare Facility Level:

Patients and paediatric patients' care-givers default on follow-up treatments/check-ups due to distance to the health facilities. Long distances to healthcare facilities and lack of transport for outreach services are also major contributing factors.

Most facilities experienced erratic stocks of Ready-to-Use Therapeutic Food (RUTF). There is also a shortage or disruption in the supply of medication critical to the management of malnutrition. Some health facilities share critical equipment and required instruments among different observation rooms, e.g. Nutrition Assessment Counselling and Support (NACS) books and scales - and at times Mid-Upper Arm Circumference (MUAC) measurements are not taken.

There is generally a high rate of teenage pregnancies and lack of child spacing as contributing factors to parents' inability to properly care for the children. Parents, for instance, cannot properly breastfeed the children as per the recommended period as they get pregnant within a short period of time. Many women become pregnant while breastfeeding another child, which leads to one or both of these babies eventually ending up malnourished. Harmful norms and beliefs that pregnant mothers should not breastfeed are also likely contributing factors.

Due to staff shortages at some clinics, services get interrupted whenever nurses must attend to emergency cases, or accompany patients who are referred to Gobabis Hospital, or the clinic closes entirely when the staff member is off duty i.e. on leave. Community Health Extension Workers (CHW) have not been trained on the management of malnutrition thus limiting the assistance they can provide to outpatients. Furthermore, there is a shortage of transport, e.g. ambulances have to come from Gobabis Hospital for emergency cases at Omitara Clinic. The limited availability of ambulances also does not permit state-ambulances to bring acute severe malnutrition cases to clinics or hospitals, which requiring patients to be brought to facilities by their caregivers or with assistance from NGO-based CHWs.

Facility staff highlighted that caregivers of discharged paediatric patients often do not adhere to prescribed instructions, due to other underlying social issues, such as poverty, alcohol and drug abuse, child neglect etc., including an inability to afford recommended foods. This phenomenon is aggravated by the lack of regular monitoring in the field through CHWs.

Community Level:

Most - but not all - families that were interviewed and are affected by malnutrition in the areas visited originate from the Marginalized Communities - particularly the San. However, other communities are also affected. Although these Marginalized Communities are provided with food parcels from MGEPESW, the parcels only come on a quarterly basis and are insufficient to cater for the overcrowded households ranging between 11-26 members, and most members of these households are children below the age of 5.

Distances from clinics and health centers contribute to parents not taking children for medical attention on time for early interventions and follow-up treatments. Issues of lack of transport fares and even general availability of transportation especially from the farms/villages worsens the situation. In Otjinene, for instance, parents with malnourished children from distant villages are forced to stay in town to be near the health facility, where they are accommodated by an already struggling extended family members for the period of the child's in-hospital treatment.

They can only travel back after the child is discharged to avoid high additional transportation costs. However, finding shelter in an already overcrowded and struggling extended family home where food is a challenge, negatively impacts the child recovery and can also affect other children in that family.

All villages and settlements visited, communities experience an extremely high rate of unemployment and poverty, which limits peoples' ability to feed their families. Too many families depend on asking for food from neighbours to feed their households.

The water availability in Otjinene and Drimiopsis does not provide or encourage backyard gardening as the water is either unaffordable for them (prepaid); insufficient for communities' basic needs; or far from households (communal taps). In addition, gardening/agriculture is not being prioritized or not strongly rooted in some cultures, while a top-down approach of how projects are at times implemented leads to communities not developing a sense of ownership.

Food consumed at most households is not ideal for children under the age of five. Most households have indicated that they feed children (even those younger than twelve months – who should still be breastfed) with "*Mageu*" - a maize meal soft porridge traditionally fermented for one day. Yet in practice, it is often spoiled by being left to ferment for up to five days (where it becomes alcoholic) and is then still fed to the children.

Most household also eat porridge without food from any other food groups, i.e. there is a lack of a balanced or even varied diet. There is clearly not enough variety of foods consumed, such as vegetables, fruits, meats, dairy products, eggs, legumes (lentils and beans) etc.

Child neglect is also high. Many parents either take children with them to alcohol outlets and/or feed them with traditional alcoholic brews. Those remaining at home are often left in the care of the grandparents or to fend for themselves.

Many children from the already marginalized and vulnerable community are not registered for social grants with the MGEPESW. There seem to be a misunderstanding on the qualification for social grants for vulnerable children as it is purported that only orphans or children with imprisoned parents qualify. Many vulnerable children in both Otjinene and Drimiopsis are not registered for social grants, hereby not counting orphans and children with disabilities.

Besides these challenges with the registration of vulnerable children, there are also budgetary challenges by MGEPESW with disbursing grants for newly registered vulnerable children.

Soup Kitchens:

According to the Governor's office, there are about 19 known soup kitchens in Omaheke that reach over 700 children. In Gobabis, the teams could identify at least nine soup kitchens, most of them located in informal settlements.[6] All these soup kitchens are donor funded and have no sustainable food supply at most with limited nutrition. These soup kitchen feed ±100 children each on an as regular basis as food supply allows, yet only the one at Epako Clinic has a garden.

The soup kitchen at Drimiopsis is attached to Children Sanctuary Namibia, a privately owned children shelter accommodating 14 children. The plan for the soup kitchen was to only cater for 57 children from extremely vulnerable households. However, due to the critical poverty situation in the settlement, the services are extended to over 200 children between 5-15 years.

[6] Val n Op Staan, Light for the Children, Suva Nawa, Tuni Duse, Help Me, and Omaheke Good Hope, as well as at Epako Clinic and at the Maternity Waiting Shelter.

Overall, soup kitchens in Omaheke are run by passionate individual volunteers or by local non-profit civil society organisations, trying to provide food daily. Yet, operating days and hours differ from soup kitchen to soup kitchen, often depending on availability of food and donations. The variety of food offered is not always meeting desired minimal nutritional standards.

Some of these soup kitchens are linked to or offer other services to the children or community members, such as gardening, early childhood development, art and craft or provide space for community members to gather for information sharing or educational purposes. Hence, there is more value to and potential in those places than the name 'soup kitchen' indicates.

The Office of the Governor plans to map, register and support already existing soup kitchens, as they are regarded as necessary in the moment and in the foreseeable future, until the soup kitchens become self-sustainable.

Other Observations by the Rapid Assessment Teams:

- High rates of poverty and unemployment,
- Alcohol abuse and addictions of great concern,
- Young mothers frequently (daily) at shebeens and tombo houses,
- Child abandonment and neglect observed among some parents/caregivers,
- Police officers do not enforce applicable alcohol regulations, due to political influence,
- Reluctancy to engage in agricultural activities and lack of ownership by the community,
- Many children not yet registered for vulnerable grants, although they would qualify, with many of them even lack national identification documents.
- Limited nutritious value in food relief parcels, which mostly contain starch,
- Lack of knowledge on basic nutrition and health issues,
- Limited coordination efforts within the regions,
- No link to national coordination structures of the NFNS policy.

Rapid Assessment Recommendations

Short-Term Actions

1. MHSS should ensure sufficient and constant supply of **therapeutic food** to all **health facilities**.
2. MGEPESW to improve **Vulnerable Children Grants**' registration and pay-out processes to ensure that families can afford sufficiently nutritious food and transport fares to clinics.
3. **Pregnant/breastfeeding mothers** who are diagnosed with HIV from identified hotspots (Kanaan, Drimiopsis, Vergenoeg and Otjinene) should also be provided with food relief.

4. **Integrated community outreaches** must be intensified to include assessment and registration of vulnerable household, registration for national documents and social grants, as well as health education and advocacy on harmful cultural practices.
5. Relevant O/M/As and NGOs should collaborate around **behaviour change campaigns** to address issues of breastfeeding and child feeding practices (e.g. to ensure children are breastfed, and to prevent overly fermented 'Mageu' being given), of safe and nutritious food preparation, of family planning, of sustainable local food production systems, and to address underlying issues of alcohol abuse and addiction.
6. Ensure the **regulation of alcohol outlets**, including the immediate closure of unlicensed ones. Full commitment from law enforcement agencies and officers is hereby necessary to make sure all the laws and regulations related to the selling of alcohol are indeed strictly enforced.
7. Existing **soup kitchens** should be strengthened (ensure ongoing and nutritious food supply) and new ones to established in areas inhabited by vulnerable families, hereby ensuring a bottom-up approach. The support from and collaboration with civil society (e.g. Palms For Life Fund Namibia) and the private sector needs to be revived.
8. All **soup kitchens** to be **mapped and registered** in such a way that guidance and support can be provided and to ensure that certain minimal standards are being met. This will help to support future expansion of the types of services that these soup kitchens can offer, including gardens for food productions, in order to make them more self-sufficient.
9. Strengthen **referrals from hospital to soup kitchens**, with CHW's from government and civil society to comprehensively monitor malnutrition cases to prevent readmissions, therefore also ensure proper detailed documentation of people at health facilities.

   → *Post-Discharge Strategy*

10. MAWLR and MGEPESW to ensure that **assistance** is provided to the **Children Sanctuary Namibia in Drimiopsis** with electrical connection, to equip the borehole with solar connection and to establish a garden for sustainable food production.
11. **Skoonheid community garden** to be equipped with an irrigation system to ensure constant food production.
12. The **Regional Farmers Unions** should be engaged to encourage their members to plant protein-rich crops such as beans.
13. Members of the **Marginalized Communities** living in concentrated areas should be supported with training for sustainable income generating activities such as poultry and pig farming, beading, clothing production, beading and brick-making projects to reduce high unemployment.
14. Empower and involve **Traditional and Community Leaders** in the planning and monitoring of activities in their respective communities.
15. There is an urgent need to intensify the **coordination of plans, implementation and monitoring of activities** at both national and regional level.

Medium- and Long-Term Solutions

1. MGEPESW should upscale and ensure a constant and sufficient supply of food to the Marginalized Communities on a monthly basis, hereby taking into consideration the number of people per household when providing food relief, i.e. in the Marginalized Communities Special Feeding Programme.
2. There is a critical need to establish children shelters and safety homes in regions where there is none, i.e. Omaheke region (similar to Windhoek and Tsumeb, by SOS Village).
3. Although containing the wage bill is critical, there is a need to expand MGEPESW: Division Marginalized Communities staff establishment and include or attach Social Workers to each regional structures to provide psychosocial support, hereby addressing many of the underlying social issues that are at the root of malnutrition.
4. Advocacy and awareness should be intensified to the community on how to use resources efficiently, e.g. social grant, while also providing support to address underlying issues, such as alcohol addition, which is often a symptom of other underlying psycho-social issues.
5. Encourage food production (gardens) at household level, where reliable water supply exists, support the bottom-up establishments of community gardens and large-scale food production through collaboration between government, civil cociety, private sector, academic institutions and development partners. For instance, MAWLR to intensify food production projects at areas that have sufficient water, by providing seedlings and training to communities on establishing backyard gardens and to explore and support options for large-scale food production.
6. MAWLR to ensure sufficient water supply including drilling of boreholes where necessary.
7. There is a critical need to acquire land to relocate some families of the Marginalized Communities from overcrowded and strained areas such as Gobabis, Skoonheid, Vergenoeg, Otjinene and Drimiopsis.
8. MHSS should intensify efforts to fill vacant positions for all health care workers in Omaheke Region and consider supervisors for CHWs to improve coordination.
9. MHSS to upgrade some of the Clinics to Health Centres to avoid referring patients to Gobabis hospital, to procure all equipment and materials (including heaters and IVEC machines necessary for the Paediatric Ward), and to ensure that the ward is child friendly to allow for children to recover fully and parents to learn about proper child development.
10. MHSS to include malnutrition as a notifiable disease.
11. MHSS, NGOs and development partners to conduct Refresher Trainings for Health Care Workers on malnutrition, to enhance their abilities to inform communities appropriately.
12. Government should resolve the infighting over resources among communities e.g. Omitara.
13. **Coordination structures** on **national and regional levels** to be clarified, strengthed and sufficiently capacitated to ensure they are working efficiently and that there are synergies.

Post-Discharge Strategy

The rate of re-admissions of malnutrition cases of children under five is alarming. In the absence of exact statistics, shocking verbal accounts of doctors and other health workers described how *'the same infant/child would be admitted, treated, discharged and re-admitted a few months later, up to 3-4 times, until the small body is simply no longer able to deal with it and gives up'* [by Dr. Jonas Garoeb, MHSS-Omaheke], meaning the child has died, like too many others.

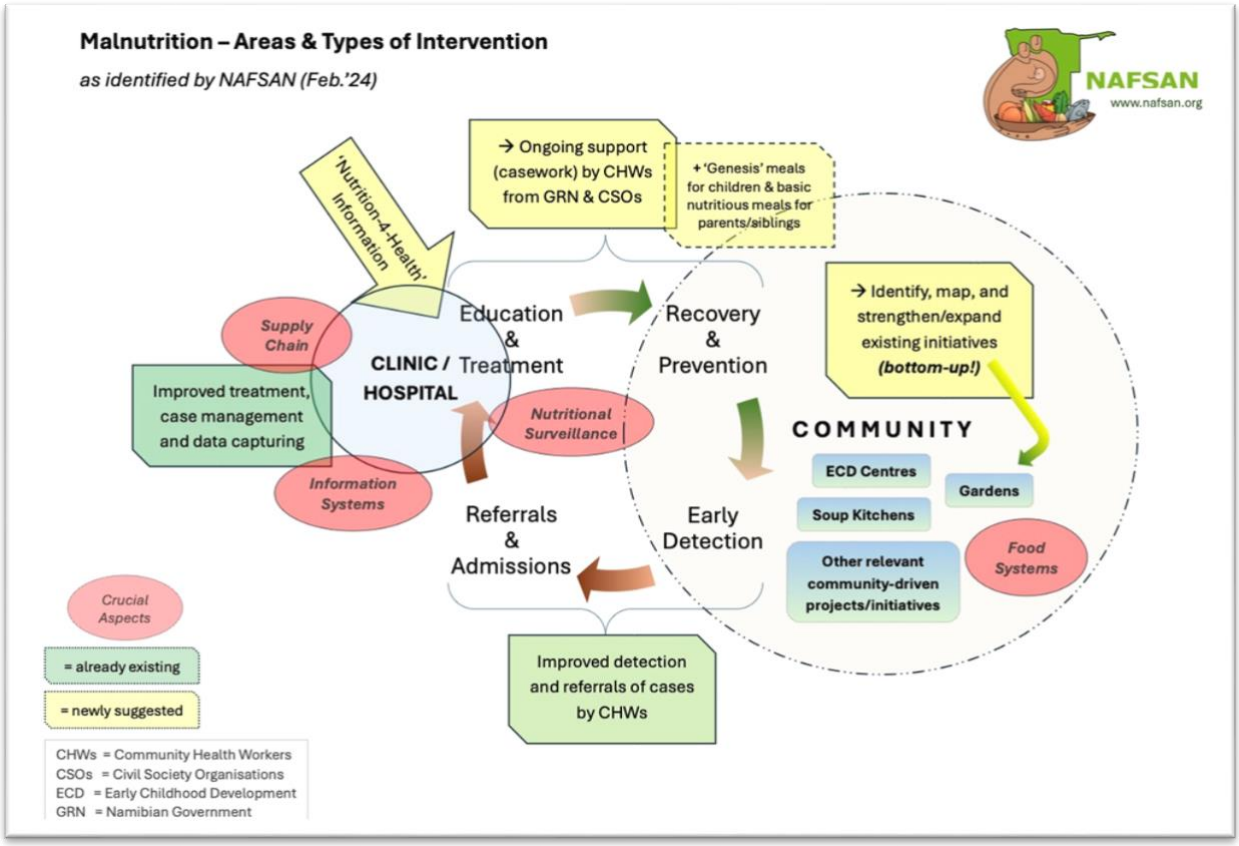
This shows how the health facilities and MHSS can only do so much, given that the root causes and other contributing factors to malnutrition lie outside the hospital in the communities and is part of larger societal problems, with those cases of severe malnutrition that are being admitted in hospital only representing the tip of the iceberg in terms of the problem we are facing.

Linking Health Facility & Community Interventions

As illustrated in the graphic below, the **links between hospitals/clinics and community-based interventions** must therefore be strengthened in a holistic manner, as a matter of urgency.

This has also been highlighted during the meeting of Omaheke's Malnutrition Task Team with the Rt. Hon. Prime Minister on 1 February 2024 under *Recommendation No. 2.13*., which says: *"There must be a post discharge strategy (who, when, how), clarify details thereof."*

Graphic 1 – Post-Discharge Strategy's Areas of Intervention



During the multi-stakeholder visit to Omaheke in February 2024, based on above understanding and against the background of having previously secured donations of therapeutic food and a high-nutrition product for recovery through the Capricorn Foundation, NAFSAN took the lead on facilitating the process of developing a post-discharge strategy for the Omaheke Region, which could serve as a future model for other regions as well.

With financial support from the EU-funded project: *'Making Multi-Sectoral Coordination Work: Collaborating towards better nutrition, food security and development for everyone.'* NAFSAN was able to host two interactive ½ - day sessions with community- and facility-based health workers on Wed., 7 February *(→ notes)* and Tue., 13 February *(→ minutes))at the Epako Library* respectively, as well as visits to the Gobabis Hospital and the Epako Clinic and its garden, with minutes in the appendices of this report.

The following outcomes were also presented on 15 February 2024 at the Governors' Office and reflect the status quo of this still developing comprehensive post-discharge strategy, which covers **six (6) vital interconnected focal areas**:

1. In Hospitals
2. At the Clinics
3. At Patients' Homes & CHWs in the Field
4. Role of Social Workers & Referrals to Services
5. Soup Kitchens & Food Security
6. Coordination & Monitoring

Together with MHSS' regional team and NGOs working in communities on TB/HIV issues through their community health workers, NAFSAN continues to facilitate the development of this comprehensive strategy until such a time that a suitable **Malnutrition Post-Discharge Coordinator** (MPDC) has been identified who will then continue to take the lead.

Initial findings and recommended actions in these six areas are listed below, followed by short term actions and next steps that have already been taken.

Focal Area 1 – Hospital

No.	Challenge / Situation	Recommended Action
1.1	Shortage of medical staffs contributing to late diagnosis, case management and discharge that might contribute to lost follow up	Employ more medical staff (nurses/doctors) – MHSS
1.2		Employ more CHWs & Dispatch CHW to the ward
1.3	Nurses only equipped with basic knowledge, without specialization on pediatrics / nutrition.	Provide in-service training on nutrition & pediatrics.
1.4	Patients and parents mainly lying in bed the whole day, while space for playroom (to rebuild muscles, motor skills, cognitive development etc.) is available, yet it remains completely unutilized.	Renovate/prepare the playroom in the pediatric ward, including adequate toys, also considering better utilization of nearby outside area.
1.5		Ensure child-patients are supported in early childhood development through regular services provided.
1.6		CHWs to engage parents with interactive nutrition sessions in hospital, using the playroom as venue.

1.7	Lack of providing therapeutic food on discharge	Improve supply chain to always ensure consistent availability of therapeutic food.
1.8	Shortage of social workers = number of patients vs social workers (ratio)	Employ more social workers.
1.9	First time of high protein nutrition product ('Genesis') being introduced, with no usage protocol in place.	Provide online training on exact usage for nurses and CHWs and develop clear guidance documents. + in communities refer to Genesis as 'medication' to prevent it to be misused.
1.10	Current stock of Genesis expiry date is already in August'24.	In addition to post-discharge patients receiving it, develop distribution plan for CHWs to provide it to identified moderately malnourished children, including monitoring of cases/children.
1.11	Current stock of Genesis only a short-term measure.	Assess effectiveness, dosage and content of Genesis + suitability for possible continuation.
1.12	Insufficient ongoing nutrition & health education, incl. hygiene.	CHWs to receive Nutrition-for-Health, plus other relevant refresher trainings, to be identified.
1.13		CHWs assigned to health facility to provide ongoing nutrition & health education, including hygiene.

Focal Area 2 – Clinics

No.	Challenge / Situation	Recommended Action
2.1	Facility not fully stocked, e.g. therapeutic food and contraceptives (for proper birth spacing)	Undisrupted supply of contraceptives for family planning as well as RUTFs for malnutrition cases. → *linked to No. 1.7 - Supply Chain*
2.2	Malnutrition not identified and/or not sufficiently prioritized.	Training for nurses on identification, management and prevention of malnutrition (Nutrition-for-Health).
2.3		Provide nutritional assessment charts in all rooms.
2.4		Nurses to do routine nutritional assessment for children during immunization visits or every other visit to the health facility.
2.5	Health care workers' attitude towards malnutrition patients	Explore ways in which to provide services in line with a patient-centred approach, incl. interpersonal skills, customer care, self-care, burn-out prevention.
2.6	Insufficient birth spacing contributes to malnutrition in children.	Continuous health education on family planning and male involvement / child spacing.
2.7	Clients not adhering/ coming back for follow up, often because of lack of transport.	Updated overview of all CHWs (NGOs & GRN) across the whole region with contact details, active collaboration among stakeholders to assist patients with follow-ups. → *linked to No. 5 - Coordination & Monitoring*

Focal Area 3 – CHWs at Patients' Homes in Communities

No.	Challenge / Situation	Recommended Action
3.1	Patients referred by CHWs are sent back by the nurses without being treated, even with MUAC of 11mm (clearly less than 16mm)	Nurses to be informed about protocols for malnutrition cases and engaged around the crucial role of CHWs around malnutrition for nurses to develop a more collaborate attitude.
3.2		Provide escalation protocol, e.g. CHWs to contact supervisor, DTLC, SHPO, etc.
3.3	Patients are not traceable, moving from one place to another, with no contact details.	Hospital register to include 'landmarks' in addition to 'locations' and 2nd or 3rd address.
3.4		Add the name a patient is "known as" (= 'AKA') in brackets, in addition to the official first and surname.
3.5		CHWs to possibly assist with providing adequate registry book with all necessary details.
3.6	CHWs do not yet have sufficient knowledge and skills on all the complex issues re: malnutrition, especially alcohol.	Training on key awareness area, including basic nutrition, identification of malnutrition, MUAC, proper food preparation, preparation of the genesis formula, birth spacing, gardening and food groups, alcohol abuse.
3.7	No nutritious food at home and hygiene problems, leading to readmissions.	CHWs to give nutrition and hygiene education at hospital and at home, emphasizing on nutritional value of local foods.
3.8		Ongoing health education sessions within communities in partnership with different community leaders.
3.9		Unconditional Basic Income Grant to be introduced & income-generation projects supported to help families feed/provide for themselves. + strengthen Soup Kitchens → ***No. 5 Soup Kitchens***
3.10	Severe difficulties tracking patients that are discharged, and disconnect between CHWs and nurses, often due to work overload.	Attach CHW (on rotating basis) to Gobabis hospital who will among others be responsible for assist with taking down comprehensive patients' detail (to enable tracing) and coordinating discharge with CHWs, Social Workers and other stakeholders involved in discharge process. Specific ToRs & clear list of tasks to be developed.
3.11	No post-discharge protocol (incl. monitoring tools, such as logs/books) in place	Develop practical tools and detailed logs/books and reporting mechanisms for following up post-discharge.
3.12	Monitoring and support to patients living far from clinics (health centers) is very difficult, often because of transport challenges.	→ ***Linked to No. 2.7 – Lack of Transport & No. 5 – Need for Improved Coordination***
3.13	CHWs not always equipped enough to deal with cases in rural areas, and patients having to be referred to the health facilities.	Assessments on capacity building and improve coordination to ensure the right people are assigned and equipped with enough materials when working within rural areas.
3.14		Find solutions around CHWs monitoring data of malnutrition patients into health passports. (not diagnosing, but only monitoring data)

Focal Area 4 – Social Workers & Assisted Referrals

No.	Challenge / Situation	Recommended Action
4.1	Lack of referral system in place, with no standard referral form in place. No assisted referrals (followed-up) done.	Develop / review referral system, with referral forms and/or letters in place, including clear details on services the patients need or is referred for, and build in feedback looks and follow-ups.
4.2	Lack of coordination between different social workers from different ministries	Social workers and their superiors across ministries to meet and come up with a plan for better collaboration and integration of services and flow of referrals. Enhance coordination between different SWs from different institutions at different offices.
4.3	Not all referrals from HCWs are being communicated / taken care of.	Strengthen understanding of the crucial role that CHWs play and collaboration between SWs and CHWs.
4.4	Lack of space in hospital space to attend to inpatient/ bed ridden patients (privacy)	Identify office space in the hospital for medical SW. Space availed and designated for counselling at ward, e.g. in empty rooms full of beds to be fixed.
4.5	Insufficiency social protection services	Improve efficiency of grant implementation system, including registration by home affairs which should have representatives within the referral system.
4.6		Consider/ensure grants to cater for chronical ill patient
4.7		Study the benefits, efficiency and impact of an Universal Basic Income Grant on malnutrition.

Focal Area 5 – Soup Kitchens & Food Security

No.	Challenge / Situation	Recommended Action
5.1.	Caretakers and other household members do not have food themselves and will eat up the therapeutic food meant for the children	Sufficient food to be provided to parents of the child, as well as siblings and other relevant household members.
5.2	Lack of food, leading to starvation, i.e. undernutrition-related deaths	Ensure uninterrupted food supply for soup kitchens for next 3 years: nutritious meals 2x/day.
5.3	Not sufficient local food supply for soup kitchens, and lack of diversified diets.	Promotion of and training in backyard gardening in communities
5.4		Establish a garden at every soup kitchen + ECD centres for them to serve as gardening hubs/resource centres
5.5		Training in safe and nutritious food preparation to soup kitchen cooks and caregivers, e.g. use GIZ-F4R recipe book, using Innovation Kitchen @ O-Space (Gobabis)
5.6	No sufficient overview of existing soup kitchens and their state of affairs, incl. potential for further development.	Map existing soup kitchens and keep database updated.
5.7		Coordinating position and person to be identified in region.
5.8		Regular visits to Soup kitchen from nutritionist and social workers for M&E, building rapport and quality assurance.

5.9	Some communities are without any soup kitchen nearby.	Develop and provide guidelines on how to set-up soup kitchens, incl. registration and practical details.
5.10		Help establish soup kitchens closer to needy communities, by working with community (esp. women with children discharged from hospital), to establish soup kitchens in a bottom-up approach.
5.11	Lack of capacities to properly drive the process and ensure implementation of a sustainable bottom-up approach, with lack of coordination among stakeholders.	Employ a Soup Kitchen Development Facilitator (SKDF) for 2-3 years to work in and with communities (especially San people) to assist them in establishing soup kitchens.
5.12	Soup Kitchens alone are not sustainable, i.e. when they only provide food	Provide personal and organizational development support to soup kitchen teams based on individual assessments of these soup kitchens and their team.
5.13		Offer training in gardening, arts and crafting's skills, as well as business management, first targeting caretakers later also interested comm. members.
5.12	Long-term solutions for San people accommodated to understand the mindset (fully embracing gardening is a long-term project and requires bottom-up approaches)	Exchange around various approaches by state- and non-state actors, involving the San communities themselves.

Focal Area 6 – Coordination & Monitoring

No.	Challenge / Situation	Recommended Action
6.1	Lack of coordination among key stakeholders and there is no overview yet as to which CHWs operate in which areas, and lack of clear referral/support systems.	MHSS to appoint **full time post-discharge coordinator (MPDC)** as key driver (facilitator) of the malnutrition post discharge strategy, incl. M&E for at least the first 2-3 years. Develop ToRs and key responsibilities and identify host-institution for deployment in Omahake and linked into regional coordination structures. Ensure exit-strategy for this temporary position is developed once a functioning system is in place.
6.2	Lack of defined coordination structure and referral system.	MHSS to coordinate the development of Standard Operating Procedures (SOPs) for malnutrition cases in terms of post-discharge strategy and ensure implementation.
6.3.	Lack of overview of and coordination among CHWs in the region (under GRN and NGOs).	Regional Council to develop and maintain database and facilitate/ensure good relationships between GRN/NGOs' CHWs. + start and maintain appropriate WhatsApp groups and other IT/communication solutions e.g. for distribution and referral of cases to CHWs
6.4.	GRN CHWs lacking direct supervision, w/ monthly reporting leading to delays/deaths.	MHSS to employ Field Supervisors for CHWs
6.5.	People moving across different places with often no contacts information provided.	→ ***Linked to 3.3 - 3.5 Patients' Registration/Tracing & 2.7 + 3.12. Provision of Transport*** - Ensure it is done and resolve any hick-ups and possible tensions.
6.6.	Lack of supplies at certain health facilities, while other facilities may still have.	Regional Council and Office of the Governor to improvd linkages and facilitate the finding solutions across the region and/or from national level.

6.7.	Lack of data and inconsistencies in data capturing in terms of malnutrition also in connection with other diseases.	Data collection on a regular basis = monthly reports, with ideally weekly monitoring Engagement of stakeholders around data capturing.
6.8.	Implementation of policies, procedures and plans is repeatedly a serious challenge.	Ensure MPDC employed + recognized/supported by all stakeholders + connected with coordination structures

Immediate Actions & Next Steps

The clear need for a **coordinator** and dedicated driver for finalizing the development and overseeing the implementing of such a crucial **post-discharge strategy** has been identified, with UNICEF possibly offering support to MHSS or MGEPESW in this regard.

The Capricorn Foundation and NAFSAN (together with its members) are trying to mobilize resources for establishing a **child-friendly playroom** at the Gobabis Hospital's pediatric ward and to assist in offering early childhood development services that are key for rehabilitation and recovery of pediatric patients and for parents to be practically and interactively educated around their children's nutritional and other developmental needs.

The process of **introducing** 'Genesis' (a **high-protein meal**, 1,000 packets of which were recently donated, covering ±300 children for 3-4 months of **out-of-hospital recovery**) is being fine-tuned by NAFSAN together with regional MHSS staff, DAPP, CoHeNa, and Community Health Workers, which will then form part of an integrated post-discharge strategy pilot.

Palms for Life Fund Namibia (PFL) explores the possibility of providing **short-term assistance** (max. 6 months) in form of **food parcels to parents** (and other household members) of pediatric patients that are to be discharged. This would ensure that the high-protein meals for recovery are indeed being given to the affected children for who they are intended. This way, the results of this pilot can then be properly monitored and evaluated. In addition, long-term efforts to sustainably support food and nutrition security in Omaheke are being explored by PFL Namibia.

The Office of the Governor is in the process of securing donations for feeding of ±700 children through ±19 **soup kitchens**, with NAFSAN having assisted in developing **practical guidance** on affordable yet nutritious food items, weekly meal plans and monitoring tools → pp. 33-37.

The **mapping of a variety of community-based initiatives and resources**, as part of a broader referral and support network, is already part of upcoming activities of the recently established CSO-Hubs on "Nutrition" (DAPP Namibia) and "Food Security" (Light for the Children) in the Omaheke. The concept of having thematic CSO-Hubs is a pilot project by NAFSAN in the Omaheke, Hardap and Otjozondjupa regions under its EU-project: *'Making Multi-Sectoral Coordination Work'*, runnig from December 2022 until May 2025.

Such resource mapping and links to referral/support systems could have **potential synergies** with mapping efforts around community gardens on national level by UNDP, the digitalization of CHWs' monitoring and evaluation tools, as well as the "Namibia Integrated Early Warning System Portal", currently under development by OPM and supported by WFP.

Communication & Behaviour Change Strategies

The primary goal of this draft communication plan is to provide detailed guidance for the implementation of **Social Behaviour Change Communication (SBCC) interventions** aimed at addressing the malnutrition crisis in the Omaheke Region.

The plan emphasises the need for a comprehensive multisectoral campaign, involving government ministries, civil society organisations, private sector, development partners, and other stakeholders, hereby highlighting the key role of the **NFNS Policy's Working Group** on ***'Advocacy, Communication and Social Mobilisation'*** under the Office of the Prime Minister

Objectives

1. Raise awareness about the prevalence and consequences of malnutrition among residents of the Omaheke Region.
2. Provide knowledge about and encourage practicing of nutritious eating habits, proper hygiene, and utilization of available healthcare and other social support and protection services to overcome malnutrition.
3. Equip community leaders and influencers with knowledge and skills to advocate for improved healthcare access and nutrition programs.
4. Empower parents and caregivers with knowledge and skills to prevent and address malnutrition among children and promote breastfeeding.
5. Advocate for multisectoral collaboration, enhanced coordination and increased resource allocation, including from the private sector, to support malnutrition interventions.
6. Establish a foundation for sustained and long-term communication efforts within the Omaheke region, as a possible model for other regions and for national level efforts.

Target Audiences

Marginalized Communities:

Specifically, the San people and other marginalized groups who are disproportionately affected by malnutrition in Omaheke.

Parents and Caregivers:

Individuals responsible for the care and well-being of children, including parents, guardians, and extended family members.

Healthcare Workers:

Frontline healthcare workers, including nurses, community health workers, and nutritionists, who play a critical role in the identification, treatment, and management of malnutrition cases.

Community Leaders and Influencers:

Local community leaders, religious leaders, and influencers who hold sway within their communities and can help disseminate key messages and information, mobilise support, and advocate for necessary changes at the grassroots level.

Educational Institutions:

Schools, colleges, libraries, and educational institutions can serve as important platforms for raising awareness about malnutrition among students, teachers, and other staff members.

Civil Society Organizations and local NGOs:

Organizations working in health, agriculture, and community development in Omaheke.

Government Officials and Decision Makers:

Officials at the regional and national levels responsible for coordinating and implementing activities of the National Food and Nutrition Security (NFNS) Policy and in other relevant programmes and policies.

Key Campaign Messages

The key messages will revolve around the following themes:

Theme 1 - Prevention: Emphasize the importance of preventing malnutrition by promoting healthy eating habits, breastfeeding, and proper childcare practices, as well as highlighting the importance of the First 1000 Days and early childhood development - hereby revitalising and strengthening Namibia's Right Start Campaign – www.rightstart.com.na

Theme 2 - Early Detection: Highlight the significance of early detection and inform about easily identifiable signs and symptoms of malnutrition, while encouraging caregivers to seek medical attention promptly for timely intervention and treatment.

Theme 3 - Treatment and Support: Provide information on available treatment options for malnutrition and the importance of adherence to treatment plans prescribed by healthcare providers, including access to therapeutic foods, nutritional counselling, and psychosocial support as well as accessible social grants for affected individuals and families.

Theme 4 - Food Consumption: Stress the importance of a balanced diet, i.e. variety of food from different food groups, hereby focusing on local, indigenous and culturally appropriate foods for maintaining optimal health and preventing malnutrition, making use of already developed materials, such as https://www.nafsan.org/n4h-materials

Theme 5 - Food Production: Share informative and inspirational audio-visual messages, including practical tips and personal success stories around local food production in home and community gardens to encourage participation, e.g. www.nafsan.org/gardening

Theme 6 - Healthcare Services: Raise awareness about the importance of regular exercises, health check-ups, immunizations, maternal and child health services.

Theme 7: Social Support and Community Engagement: Advocate for the expansion of social support programs, including food assistance, social grants, universal basic income, and actively inform about a variety of community-based initiatives that provide services and opportunities to community members around income generating activities, job and employment creation and other possible contributions towards food and nutrition security.

SBCC - Implementation Strategy

Based on the assessment conducted and engagement with the region's media committee, it has been determined that the most suitable communication strategies to effectively reach the most affected people in the region should be community engagement, face-to-face interventions, and radio broadcasts. However, other communication platforms such as television, social media and newspaper will be utilized as well to ensure comprehensive coverage within the region and extend the message's reach to the wider population of the country.

In this regard, the following needs to be taken into consideration:

- Collaboration with local authorities, community leaders, and NGOs to ensure buy-in and support for the campaign.
- Communication materials and activities must resonate with the cultural beliefs, traditions, and lifestyles of the people in Omaheke, especially the San people.
- Training of community health workers from both government and NGOs, educators, and volunteers to effectively deliver key messages and engage with the target audiences.
- Monitoring and evaluation of the effectiveness of communication interventions through feedback mechanisms, surveys, and focus group discussions.
- Adapt and adjust communication strategies based on real-time feedback and emerging needs identified during the campaign.

Communication Channels

Community Engagement	Cultural Events: Integrate malnutrition messaging into cultural events, festivals, or gatherings, leveraging traditional customs, rituals, and ceremonies to highlight benefits of local indigenous foods/beverages, while at the same time cautioning about harmful traditional nutritional habits and child-rearing practices. Home Visits: Conduct door-to-door visits to engage with individuals and families in their homes, hereby providing personalized information, resources, and support related to malnutrition and healthy nutrition practices, and for making assisted referrals as necessary. Focus Groups: Host small-group discussions to explore specific topics related to malnutrition, allowing participants to share their experiences, perspectives, and insights in a comfortable setting. Community Meetings: Organize gatherings in community centers or local meeting places, religious and schools to deliver presentations, facilitate discussions, and address questions and concerns directly. Peer Education: Train interested community members (especially those with a home garden) as peer educators to disseminate information on malnutrition within their social networks, using their influence and trust to reach a wider audience.

Radio	Partner with local radio stations, e.g. Omaheke Community Radio at 'The O-Space', NBC Radio, DW Academy and NAFSAN to develop and air informative and interactive programs in local languages.
Television	Facilitate live talk shows in the Omaheke region in collaboration with NBC TV, utilizing a mobile van for broadcasting. Engage influential figures such as political leaders, traditional leaders, church leaders, doctors, health workers, and youth to lead discussions on the impact of malnutrition in the region, as well as what can be done to overcome it. These talk shows will provide a platform for raising awareness, sharing insights, and discussing solutions to address malnutrition effectively.
Public Screenings	MICT is regularly organising public screenings in communities, where short educational clips on nutrition and gardening (already produced: Step-by-Step Garden: https://youtu.be/XNww5B_2Tj8 & Maintenance Guide https://youtu.be/Bw81IXX-CEM) can be shown prior to the main movie, the same way as trailers are shown in movie theaters.
Social Media	Utilize social media platforms, such as Facebook, Twitter ('X'), and Instagram, to actively engage with community members, especially the youth, by sharing educational content (e.g. www.rightstart.com.na) and encouraging dialogue on various malnutrition-related topics.
Printed Materials - leaflets, posters, banners, street art, newspapers etc.	This serves as a supplementary medium of information dissemination in English or local languages, e.g. through short and illustrated handouts during community meetings or one-on-one engagements, while posters can be placed everywhere in the community and health facilities. Local artist competitions can also be used to help get key messages out into the public space and be seen and recognised by communities.

Monitoring & Evaluation Plan

Based on agreed-upon specific activities for which sufficient financial resources have been secured and responsibilities assigned, a detailed Monitoring and Evaluation Plan will allow for real-time monitoring of the implementation of these actions and to track overall progress. It further measures the reach and engagement of communication activities through the number of messages and materials developed, attendance records, surveys, and social media analytics.

It may also provide an assessment of changes in knowledge, attitudes, and behaviours related to malnutrition through pre- and post-intervention surveys or focus groups. Solicited feedback from stakeholders and community members is hereby crucial to evaluate the effectiveness and relevance of the identified communication and behaviour change strategies.

The table below serves as example of possible indicators together with the envisioned frequency of reporting. However, such a detailed monitoring and evaluation plan only makes sense to be develop once activities have been agreed upon and financing of such has been secured.

Indicator Cluster	Specific Indicator	Frequency of Reporting	Responsible & Key Partners
	# radio jingles produced	Weekly	…

Mass Communication	# of airings for radio jingles	Weekly	…
	# radio talk shows conducted	Weekly	…
	# TV jingles produced	Weekly	…
	# airings for TV jingles	Weekly	…
	# TV talk shows conducted	Weekly	…
Printed and Visual Media	# information placed in print media	Weekly	…
	# artist competitions conducted	Monthly	…
	# visual art/posters in public spaces	Monthly	…
IEC Materials	# IEC materials produced (by type)	Weekly	…
	# IECs translated (by language)	Weekly	…
	# IEC materials distributed (by type, language, area or organisation)	Weekly	…
Training	# Nutrition-related trainings completed (by subject area)	Monthly	…
	# Health Workers completing training (by gender, age and topic)	Monthly	…
	# Peer Educators and/or Community Leaders completing training (by gender, age and topic)	Monthly	…
Community Engagement = 'Communication and Social Mobilization'	# households and # people reached through house-to-house visits	Weekly	…
	# community engagement and social mobilization sessions conducted	Weekly	…
	# people reached through social mobilization (by age and gender)	Weekly	…
	# public screenings by MICT with gardening clips being shown	Weekly	…
	# people reached via MICT	Weekly	…

Long-Term Sustainability

- Revive and strengthen Namibia's **Right Start Campaign** (www.rightstart.com.na) as an already well-established multi-stakeholder platform (by MHSS, MoEAC, MGEPESW, UNICEF, CSO and other development partners) that covers key nutrition issues, such as breastfeeding, first 1000 days and other aspects key on early childhood development. As malnutrition is a multi-generational problem that requires multi-generational solutions the Right Start Campaign – if sustained for at least 30+ years, has the chance to become an important Namibian brand and a trusted 'household name' for reliable information and central hub for sustainable programmes that empower parents and caregivers.

- Sufficiently capacitate and ensure coordination through the NFSN Policy's *'Advocacy, Communication and Social Mobilisation'* Working Group under OPM, and ensure proper linkages and alignment with NFSN activities on national level via the FNS Secretariat.
- Ensure links and synergies with MHSS' future National Parenting Manual roll-out.
- Empower and enable community health workers to sustain ongoing education efforts on around nutrition within the community, ensuring availability of relevant information and support for continuous dissemination and engagement.
- Strengthen collaboration and coordination between community-based and facility-based health workers as well as social workers, to ensure success of post-discharge strategies.
- Provide ongoing training for health workers deployed in communities and at facilities to ensure consistent and accurate information on malnutrition is provided during patient consultations and community outreach efforts.
- Incorporate nutrition awareness sessions (e.g. based on 'Nutrition-for-Health') into health facilities across the country, especially within maternity wards and paediatric wards.
- Establish a permanent slot on local radio stations dedicated to sharing information on malnutrition, providing regular updates, call-ins, and educational content to listeners.
- Produce informative videos on malnutrition and good nutrition, tackling common problems and practical local solutions, translate them into local languages, and distribute them through various channels for continuous education and awareness.
- Ensure MICT incorporates educative and inspirational nutrition and food security messages into its activities across all regions, such as through 'trailers' (short clips) during public screenings as well as in its other programmes and regional level engagements.

SBCC - Budget (estimated)

Activity to be conducted	Costs
Training on Nutrition: Community health workers and peer educators to be trained to conduct house-to-house visits / community engagements): 5 days for (25 national + 25 regional stakeholders + 90 CHW + 40 youth leaders)	N$ 440 000
Material development (150k), translation (10k), printing (500k), artists (90k)	N$ 750 000
Mass Media – Radio-jingles/clips (30k) & TV-jingles/clips (170k)	N$ 200 000
Community Engagement by CHWs & Interactive Dramas by OYO (350k)	N$ 350 000
Logistics – Transport (900k), S&T (300k), Refreshments (50k), Airtime (5k)	N$ 1 255 000
Total	**N$ 2 995 000**

Other Recommendations from the Meeting at OPM, 1 February 2024

During the two weeks of the intervention, in addition to the rapid assessment, the development of the post-discharge strategy and the communication/behaviour change strategy, as well as other activities, the team tried to address the other recommendations as follows:

No.	Recommendation	Responsible Institutions
1.1.	Identify additional households facing malnutrition to add to already identified 970. Comprehensive List of Beneficiaries	Governor's Office: Jennifer Hewicke and Joel Kanguatjivi Regional Council (RC): Cllr Tebele MGEPESW: Ms. Ursulla Tjipueja San Project: Ms. Desiree Masheshe
	Enhanced Nutritional Parcels	RC, NAFSAN, MEAC, MHSS, MHETI, OPM, MGEPESW,
1.2.	Additional Community Health Workers + Consider contracting of additional nurses (2.21)	MHSS + MGEPESW
1.3.	Support 19 Soup Kitchens with nutritional food	OPM, Governor's Office, Private Sector, NAFSAN (see pp. 33-37)
2.1.	Activate regional Food and Nutrition Security (FNS) Coordination Structures	RC, Governor's Office, Malnutrition Task Force, NAFSAN (CSO-Hubs), OPM, FNS Secretariat, MURD
2.2.	DDRM to help MHSS around aspects of distribution, logistics and coordination	OPM-DDRM
2.3.	Strengthen Constituency Offices and Traditional Leaders in monitoring food distribution	RC, Traditional Leaders + …
2.4.	Strengthen Community Education by CHWs	→ *Communication Strategy* (p.19)
2.5.	Costed proposal for Farm Nuwe Hoop to OPM	Governor's Office + MAWLR
2.6.	Regulate availability of alcohol	MHAISS, RC, Local Authorities
2.7.	Food to be purchased from local farmers	OPM-DDRM
2.8.	Communication Strategy developed/facilitated	MICT still to come on board
2.9.	Gobabis Hospital to be properly equipped	→ Response *Plan (MHSS Section)*
2.10.	Previous Reports to be availed and studied	→ Desk Review (p. 6)
2.11.	Establish proper M&E for better planning	→ *Coordination & Monitoring* (p. 26)
2.12.	Ensure constant food parcel supply to out-patients	→ *Post-Discharge Strategy* (p. 12)
2.13.	Derive Post-Discharge-Strategy	NAFSAN, MHSS, CHWs CoHeNa, DAPP + UNICEF (?)
2.14.	Health Personnel seconded – when? (time frames)	MHSS
2.15.	Lack of demonstration of financial support needed from the Office of the Governor	Office of the Governor → *No. 5.25 = 'Costing of Recommendations'*
2.16.	Identified/registered beneficiaries (970+) to receive food parcels	Governor's Office, RC, OPM + NDF → *No. 1.1 (above)*
2.17.	Costing of enhanced food parcels	Governor's Office
2.18.	Identify components of nutrition food packages	NAFSAN (pp. 33-37) + MHETI (?)
2.19.	Include blended maize in drought relief food	OPM-DDRM, Governor's Office
2.20.	Conduct regional assessment	→ *Rapid Assessment*

2.21.	Contract additional nurses (see: *No. 1.2.)*	MHSS
2.22.	Ensure input from Regional Councillors	Governor's Office
2.23.	Ensure numbers and timeframes are included.	→ *Rapid Assessment & This Report*
2.24.	Task Team to assess situation on the ground to improve quality of intervention	→ *This Report* + NPC + OPM (NFNS)
2.25.	Costing of recommendations	→ *Response Plan* + ongoing
2.27.	Conduct National assessment on Malnutrition	MHSS (Namibia Demographic Health Survey to be conducted) + NSA. NPC (NFNS WG: Operation Research) OPM FNS-IASC + FNS Secretariat
2.28.	Initiate a country wide program for malnutrition.	OPM to coordinate implementation of NFSN Policy and its Action Plan.

Coordination Structures and Capacities

This intervention brought to light the insufficiency or lack of properly established coordination structures on food and nutrition security at regional levels, as ought to have been established as per the revised NFNS Policy of 2021.

In addition, the need for efficient coordination through a properly placed and well-capacitated national FNS Secretariat as the 'engine' of this NFNS policy under OPM also became visible. This was already something that members of the technical team who revised the FNS policy in 2018-21 pointed out *(→ Reasons & Motivation for transfer of the NFNS Secretariat to OPM*, August 2032), and which was also discussed during the intervention because of the severe implications this lack of proper coordination has on the situation in this and in other regions.

Discussions repeatedly highlighted that coordination (and the time, skills and efforts that it requires) are often seriously undervalued. It is a common but harmful practice to just assign additional coordination roles to people who already have other full-time positions, jobs, and assignments, assuming *'they can just coordinate on the side'*. This is a very harmful assumption and practice that leads to, last-minute coordination efforts, no good working relationships established, substandard outcomes, costly duplications of efforts, lack of alignment/synergies, missed opportunities for collaboration, and it will result in us continuing to operate in silos.

Hence, the revised NFNS Policy 's Coordination Structures (→ No. 2.2.4.3., page 13) requires at least three (3) full staff members assigned to the FNS Secretariat purely for coordination, which should – given the multisectoral nature of this policy - should ideally be composed of a multi-disciplinary team.

Key Recommendations:

1) The Rt. Hon. Prime Minister, as custodian and responsible coordinator of the revised NFSN Policy (2021) to request an amendment to the NFSN policy by Cabinet so that the **National FNS Secretariat** (the 'engine' of this policy) is **moved from MAWLR to OPM** to ensure sufficient convening power for effective coordination and oversight.

2) The **FNS Secretariat** to consist of a **multi-disciplinary team** within OPM (additional staff to be seconded by other government ministries, development partners and other technical partners), and to **allocate sufficient technical and financial resources** for it to efficiently coordinate the implementation of the NFNS policy, and for it to ensure synergies between all relevant programmes, policies and stakeholders on national level.

3) The new National FNS Secretariat to proactively guide the **establishment of regional FNS coordination structures** as per the revised NFNS Policy, whereby the following already established structures may provide suitable entry points:

RACOC (= Regional AIDS Coordination Committees, in future maybe: 'Community Health')
→ Regional Working Groups on ***"Nutrition"***

WATSAN Forums (= Water and Sanitation Forums, under MURD)
→ Regional Working Groups on ***"Water, Environment and Sanitation"***

4) The Office of the Governor in Omaheke, in close collaboration with the Regional Council and other stakeholders, to **strengthen and build on existing coordination structures**, such as the Malnutrition Task Force, hereby closely liaising with the National FNS Secretariat and local CSO-Hubs on 'Nutrition' and 'Food Security', for Omaheke to serve as a possible model for how future regional FNS Structures maybe established effectively.

Response Plan (Way Forward)

A comprehensive and costed 'Response Plan' that is going to include all recommendations from this report is work-in-progress, as it still requires essential input from key stakeholders who – by the time of this report having to be finalized - unfortunately were not able to contribute yet.

Difficulties in getting all the necessary stakeholders to avail themselves is indeed a phenomenon that forms a key part of the problem that needs to be addressed by putting suitable coordination structures and capabilities in place.

The Response Plan, which is expected to be finalized during March 2024, will then also include various recommendations already made during previous investigations (→ Desk Review, p. 6).

Given the need to provide timely feedback on the findings from the multi-stakeholder visit to Omaheke in February, it seemed most advisable to not delay the submission of this report any further while much needed details for the completion of the response plan are still pending.

Any feedback and comments on this report by early March 2024 can then of course also be included and reflected in the Response Plan.

Appendices

List of Participating Stakeholders

Surname	Name	Institution	Position
Dumeni	Anna	OPM	Directorate Disaster Risk Management (DDRM)
Erastus	Anna	WHO	Officer: Quality of Care & Service Delivery
Filemon	Cherie	MGEPWS	…
Hewicke	Jennifer	Omaheke, Office of the Governor	Executive Secretary
Kandjungu	Maria	NAFSAN	Head of Projects
Karukirue	Tjijenda	Regional Council	Director
Kavezepa	Ivonne	Gobabis Municipality	Community Developer
Koupanda	Lea	DAPP Namibia	Regional Coordinator
Letlhagoje	Carmen	NAFSAN	Nutritionist
Mayira	Fulgentia	OPM	Deputy Director: Policy and Programme Coordination
Mberira	Moses	NAFSAN	…
Mukela	Muyunda	NPC	…
Muronga	Elijah	CoHeNa	Programme Manager
Naholo	Elias	MURD	…
Namwandi	Rebekka	MGEPEWS	Dep. Director: Marginalized Comm.
Nanus	Kerishne	Omaheke, Office of the Governor	Malnutrition Task Force
Nganate	Pijoo	Omaheke, Office of the Governor	Governor of the Omaheke Region
Ngwa	Chris	UNICEF	Chief: Child Survival & Development
Nnagula	Shivute	OPM	CPA-DDRM
Schernick	Benjamin	NAFSAN	Director
Shiikwa	Annely	MHSS	Matron: Gobabis State Hospital
Shikulo	Jeremia	MOHSS	Director: Regional office (Omaheke) MOHSS
Shikwambi	Meke	MHSS	National Nutrition Programme
Tibinyane	Patrick	MAWLR-DAPEES	Senior Agriculture Scientific Officer
Tjozongoro	Melba	Gobabis Municipality	Municipal Mayor
Uhepo	Emilia	MHSS	…
Uiras	Wilhencia	NPC	Executive Director
Uusiku	Sarafia	MHSS	National Nutrition Programme

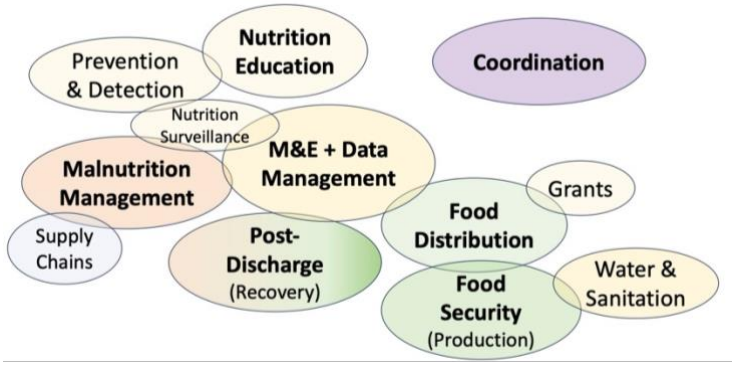
Recommendations - Omaheke's Malnutrition Task Team, OPM - 1 Feb.' 24

- See attached PDF document.

Presentations during the Intervention Period

Tue, 6 February 2024, by NAFSAN

Graphic 2 – ***'Malnutrition Areas of Intervention in Omaheke'***



Tue., 13 February 2024, by NAFSAN at Post-Discharge Meeting

Working Session on Malnutrition Post-Discharge Strategies

Tue., 13 February 2024, by NAFSAN at RCCE Meeting, chaired by MHSS

Introduction to the 'Nutrition-for-Health' Approach and Materials

Thu., 15 February 2024, by MHSS at Task Team Session, chaired by ED NPC

Assessment Report & Initial Draft Response Plan

Thu., 15 February 2024, by NAFSAN at Task Team Session, chaired by ED NPC

Outcomes of Meetings on Developing Post-Discharge Strategies

Thu., 15 February 2024, by NAFSAN at Task Team Session, chaired by ED NPC

Overview & Updates on National and Regional NFNS Coordination Structures

Fri., 16 February 2024, by UNICEF & WHO at Task Team Session, chaired by ED NPC

Stakeholders Meeting in Omaheke Region on Malnutrition: UN Support

Farme Nuwe Hoop – Concept Note

Concept Note on setting up a constituency food security centre on Farm Nuwe Hoop

Introduction

Farm Nuwe Hoop is a property of the Municipality of Gobabis situated 2.11 km south of the Gobabis weighbridge on the Gobabis–Aminuis road (C22). The municipality has agreed to grant the Office of the Governor of Omaheke access to and usage of 250 ha of the farm and associated infrastructure for agricultural production.

This agreement was reached in light of the malnutrition and subsequent infant mortality crisis prevalent in the Omaheke Region. A total of 45 infants have lost their lives due to food insecurity between January and June 2023 in the Region. This situation calls for immediate interventions to drive these figures down to zero.

Current interventions such as soup kitchens, community gardens, and malnutrition rehabilitation programmes have mitigated the effects of malnutrition in the high-density communities, but are all in need of a steady supply of raw materials.

Site Description

Farm Nuwe Hoop is situated 2.11 km south of Gobabis on the Gobabis–Aminuis road (C22) at 22°27’11.4”S and 19°01’22.5”E.

The water infrastructure available is two boreholes of an approximate depth of 60 m with the water table at 20 m depth. The northern borehole is currently functional and is powered by a windmill in need of maintenance. The southern borehole lacks a submersible pump, electric cable and secure casing and thus needs rehabilitation. The functioning borehole supplies a 5 m^3 water tank on a stand and two reservoirs.[7]

[7] Borehole: Borehole database (2010) - Namibia — SADC-GIP

The said reservoirs, of approximately 127 m^3, are made of concrete flooring, Zinc sheet walls and need rehabilitation. The pipelines linking the northern borehole to both reservoirs need replacement if not repair.

There is a dilapidated building that is reported to have acted as a milk parlour, also electrified, but in need of restoration. East of the milk parlour is the main house.

A space of 10 ha has been debushed and is reported as having been previously used for dryland crop production of white maize (*Zea mays*) and omakunde (*Vigna unguiculata*). Soil fertility tests have been performed during the previous cropping season of 2022/23.

Objectives

The supply of the soup kitchens and other food security interventions to be sourced from Farm Nuwe Hoop. A well laid-out crop production plan will facilitate an intensive agricultural production system that integrates crop production and animal husbandry.

Activities

- A portion of the debushed land is to be used for dryland grains such as white maize, mahangu (*Pennisetum glaucum*), or mabele (*Sorghum bicolor*); the latter two being drought tolerant, indigenous, gluten-free, and not prone to theft.
- Omakunde shall be intercropped with the grains on rainfed agriculture as well, thus maximising productivity per hectare of land used. Being the most efficient nitrogen fixer in terms of energy-fixation ratio, will be well-suited as an intercrop. Indigenous cucurbits shall be introduced in subsequent cropping seasons as a replication of the Mexican three sisters cropping system under an eventual no-till system.
- Horticultural crops under cover shall be produced under drip and sprinkle irrigation east of the eastern reservoir. A portion of the cleared land may be dedicated to this by setting up a nursery and shade house for leafy greens, root crops, fruiting crops, and herbs.
- Fruit trees will be planted along North-eastern edge of cropland.
- *Acacia erioloba* trees to remain along the south western border of the crop lands as a means of slowing down prevalent North-easterly wind erosion and evapotranspiration
- The rehabilitation of the milk-parlour will be timeous during a time the Region has committed to increase and fortify local dairy value chains, albeit at an initial small scale. The lactating cows shall have their feed supplemented from silage made from stover.
- Rabbit and pig rearing shall be incorporated into the enterprise to serve as source of animal proteins for the aforementioned intervention centres. The two reservoirs may also be retrofitted to accommodate fish. Rabbits and pigs shall have their feed supplemented from the waste generated from the horticultural enterprise.
- Animal and crop waste will be used in the production of compost and vermicompost for use in the horticulture system as a means of building up soil organic matter.
- Debushing waste to be turned into biochar to build artificial soils (*Terra preta*) with compost.

Expected Outcomes

Food insecurity in the high population density areas of Gobabis will be reduced and eventually eliminated by Farm Nuwe Hoop providing a steady stream of food to intervention centres.

Alcoholism and other forms of delinquency will be redressed by food security and meaningful employment of communities on the farm. Intensive agriculture demands high capital inputs as well as much labour thus leading to the employment of many rural youth in Gobabis and peri-urban areas. Complementary programmes such as food-for-work and/or food-for-cash may finance temporary labourers on Nuwe Hoop. During the expansion of the agro production systems, further debushing of the land will be necessary, thus creating more temporary employment opportunities for the youth.

Students from primary and secondary schools will have an agri-enterprise in close proximity to town to engage in practical agricultural activities. Tertiary institutions may also have students do their in-service training here.

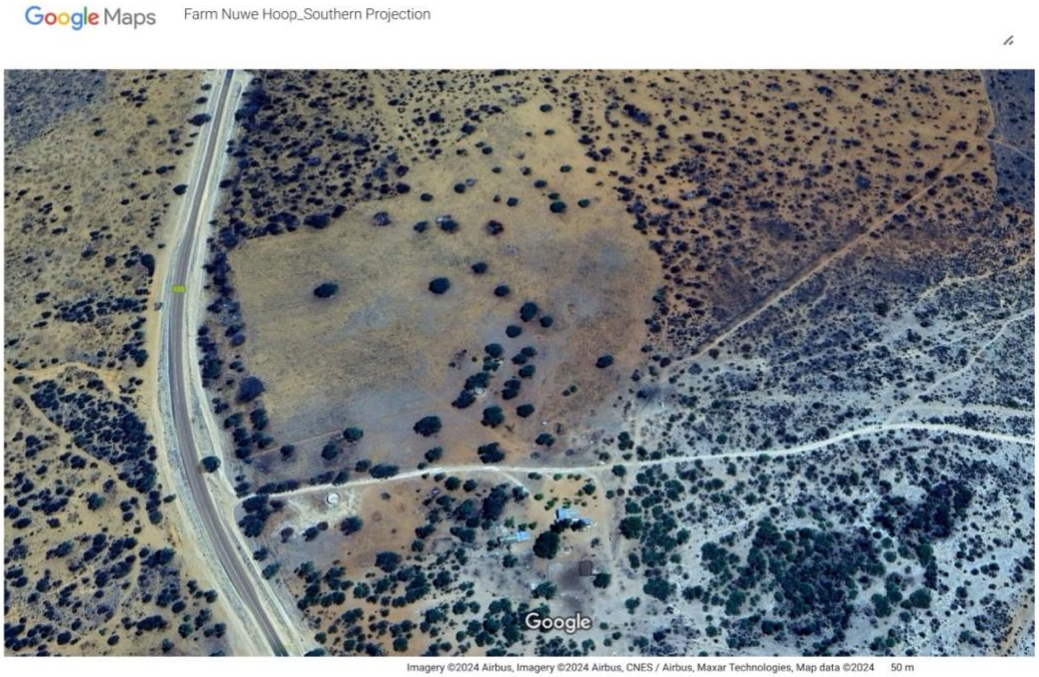
The milk parlour shall ensure that every vulnerable child has a glass of milk per day in the constituency. It also may become a milk collection centre for the region.

The effective implementation of the production systems on Nuwe Hoop may further be replicated into the six other constituencies within the region.

Conclusions

The name Nuwe Hoop means “New Hope”, and is aptly so due to the numerous changes an intensive and integrated farm may bring to booth man and his environment. The holistic approach to agriculture applied on-site provides a means of implementing innovations not yet explored elsewhere in the country, while simultaneously addressing a pressing matter in the region – malnutrition.

Malnutrition that takes away the hope of a young mother by destroying the dreams that she had for her child. All this may be addressed by effective coordination between developmental partners and stakeholders in Omaheke Region to realise the vision of Nuwe Hoop.



Meal Plan for Soup Kitchens in Omaheke Region

Draft V. 1.0. – 22 February 2024

Food Groups & Options:

Staple Foods	Proteins	Vegetables & Fruits	Oils/Fats & Sugar/Salt
Maize flour	Red speckled beans	Butternut	Cooking Oils
Mahangu flour	Lentils	Carrots	Butter/Margarine
Bread (brown)	Canned Fish	Cabbage	Peanut Butter
Oats	Eggs	Spinach	Salt
Weet-Bix	Mince	Onions	Sugar
Pasta/Macaroni	Milk	Tomatoes	Spices / Instant Soups
Rice (brown)	Beef stew	Beetroot	Broth /Bones (to cook)
Samp	Boerewors	Broccoli/Cauliflower	↑ *All the above* ↑ *should be used* ***in moderation*** = *as little as possible, esp. sugar and cooking oil.*
Potatoes	Chicken	Mixed Vegetables	
Cornflakes	Peanut Butter = *rich in proteins and fats*	+ **Fruits:** Apples, Oranges, Bananas, Mangoes, Guavas etc.	

More Information: www.nafsan.org/N4H

Fruits:

Bananas can easily be cut in half (½ for each child), so they can easily be peeled and eaten.

Oranges & Apples can be cut in quarters, to be easily eaten, 1-2 pieces per child.
Please note that apples should be washed beforehand!

Please note that ***Seasonal Fruits*** *(such as watermelons, mangoes etc.) should be* ***prioritized*** *and bought whenever they are available and will then replace the above-mentioned ones.*
The same applies to ***Vegetables*** *whenever they are* ***seasonal*** *and* ***can be sourced locally!***

Beverages/Drinks:

Water = preferred drink of choice

Tea (Rooibos) = prepared in a big pot (using fewer tea bags), yet with minimal sugar added!

Oros = to be mixed with water and must not be too sweet.

Fruit Juice = should always be 50/50 (half/half) mixed with water

Milk = to be taken or cooked with the breakfast, e.g. cornflakes or oat meals

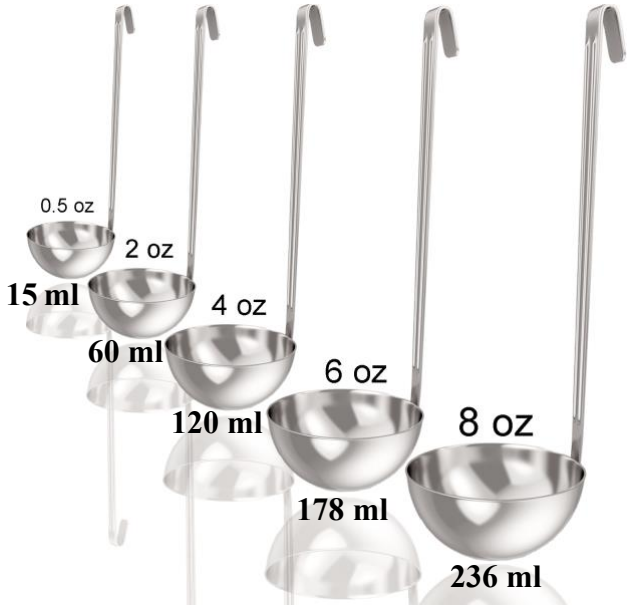
WEEKLY MENU / PLAN

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast	***Meal***	Oatmeal (Porridge) with Milk + Fruit: Orange	Brown Bread with Peanut Butter & Jam + Fruit: Banana	Weet-Bix with Milk (warmed in winter) + Fruit: Apple	Brown Bread with Peanut Butter & Jam + Boiled egg + Fruit: Orange	Soft Porridge (Mahangu or Maize) with Milk & Butter + Fruit: Banana	Brown Bread with Peanut Butter & Jam + Fruit: Apple	Oatmeal or Cornflakes with Milk + Any Fruit, depending on availability
	Drink	**Water** or **Tea**, especially in winter, with as little as necessary sugar!) **+ Milk,** if available, is a good source of protein and could be offered on days where no porridge is served.						
Lunch	***Meal***	Pasta with Soy-Mince & Tomatoes as Sauce	Samp with Beans and Cabbage	Pap with Canned Fish and Spinach	Rice with Lentils and Carrots as Soup/Sauce	Potatoes with Beef Stew & Butternuts or Mixed Vegetables	Pap with Chicken and Spinach	Rice with Boerewors & Beetroots or Broccoli / Cauliflower
	Drink	**Water** (or Oros/Juice, diluted with water as much as possible to reduce sugar!)						

Recommended Intake, per child per meal:

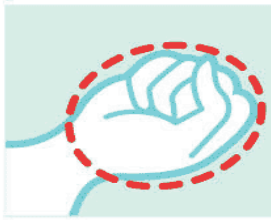
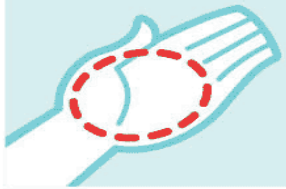
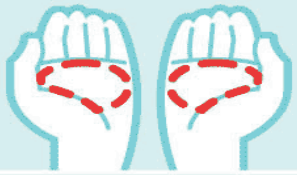
Food type / food group	**Portion size** (depending on the child's age)	**Measurements in milliliter / grams**
Staples (Pap, pasta, rice, potatoes, oats etc.)	½ - 1 cup	125ml - 250ml
Bread	1 - 2 slices	30g - 60g
Proteins (Legumes: peas/beans, Fish or Meat)	¼ - ½ cup	20g - 40g *(use hand-method, see below)*
Eggs	1	n/a
Peanut Butter	1 -2 tablespoons	5 -10ml
Milk	½ - 1 cup	125ml - 250ml
Vegetables + *at least one **Fruit** a day*	½ - 1 cup	125ml - 250ml
Oils/Fats, Sugar and **Salt** (iodized)	Be careful, don't use too much. Only use as little as necessary!	
Drinks – Ideally Water: at least 6-8 glasses a day …and at times generously diluted juices (only as sweet as absolutely necessary)		

Measuring instruments – *recommended for soup kitchens have these:*



Ladles of different sizes with estimated ml

Measuring Cups

Hand Symbol	Equivalent	Foods	Calories
	**Fist** 1 cup	Rice, pasta Fruit Veggies	200 75 40
	**Palm** 3 ounces	Meat Fish Poultry	160 160 160
	**Handful** 1 ounce	Nuts Raisins	170 85
	**2 Handfuls** 1 ounce	Chips Popcorn Pretzels	150 120 100
	**Thumb** 1 ounce	Peanut butter Hard cheese	170 100
	**Thumb tip** 1 teaspoon	Cooking oil Mayonnaise, butter Sugar	40 35 15

FIST

ONE CUP

CUPPED HAND

HALF CUP

THUMB

ONE TABLESPOON

PALM

THREE OUNCES

M&E Suggestions for Soup Kitchens in Omaheke region

Meal Distribution Records:

- Request records of meal distribution, including the number of children served, dates, and times.

Anthropometric measurements:

- Request for anthropometric measurements to be conducted on the children. This could include height, weight and MUAC. At the end of every week or second week.

Photos and Visual Documentation:

- Request visual documentation, such as photographs or videos, showcasing meal preparation and or final meal after cooking and food distribution.

Social Services:

- What type of psycho-social support services do the children and/or their parents need?
- Information about and linkages to social services and social workers should be provided.

\+ + +

Ensure basic hygiene standards are met and children are taught about and practice basic hygiene measures.

+ Assess potential for possible future development of the soup kitchen, e.g. gardening, early childhood development, income generation…