REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

CONCEPT NOTE

for the

P I L O T

of an

Integrated Post-Discharge Strategy

to address **Re-Admission for Malnutrition**

in the **Omaheke Region**

Draft Version – 22 July 2024

List of Abbreviations

CHWs	Community Healthcare Workers
CSO	Civil Society Organisation (
CoHeNa	Advanced Community Health Care Services Namibia
DAPP	Development Aid from People to People
GIZ-F4R	German Development Cooperation: Farming-for-Resilience Project
MAM	Moderate Acute Malnutrition
MHSS	Ministry of Health and Social Services
NAFSAN	Nutrition and Food Security Alliance of Namibia
NFNS	National Food and Nutrition Security (Policy)
NPC	National Planning Commission
PDS	Post-Discharge Strategy
RACOC	Regional Aids Coordination Committee
SAM	Severe Acute Malnutrition
SUN	Scaling Up Nutrition (Global Movement)
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Table of Contents

1. Background ... *4*

2. Proposed Approach ... *5*

2.1. Overview & Introduction ... 5

2.2. Objectives of the Integrated Strategy ... 6

2.3. NFNS Policy Alignment ... 7

3. Key Steps & Actions ... *9*

3.1. Essential Preparations ... 9

3.2. Specific Activities per Intervention Areas ... 11

3.3. Monitoring and Evaluation ... 12

3.4. Costs – Funding Mostly Secured ... 13

Appendices ... *14*

PDS Process Visualizations ... 14

Key Roles & Responsibilities ... 15

Monitoring Aid for CHWs ... 17

Cabinet Endorsement of NAFSAN’s Role within the NFNS Policy ... 20

1. Background

Over 43.3% of Namibia's population live in multidimensional poverty[1], while as from July 2024 more than 75% of the population are projected to not be food secure[2]. National stunting rates are estimated to be as high as 34.4% according to Namibia's COHA Study (NPC, 2022)[3] which significantly impedes the country's overall socio-economic development.

While Namibia faces the 'triple-burden of malnutrition' where overnutrition (overweight/obesity) coexists alongside undernutrition (stunting/wasting) and hidden hunger (micro-nutrient deficiencies), undernutrition has emerged as the most pressing health challenge resulting in several hundred malnutrition-related deaths of children under the age of five every year. The *Vulnerability Assessment and Analysis Report* (OPM, 2023*)* reports a 66% increase in hospital admissions of children under five years with severe acute malnutrition.

Hence, from 2018 until 2021, the **National Food and Nutrition Security Policy**[4] (NFNS) has been revised and was officially launched by the Right Honourable Prime Minister in December 2021. The NFNS promotes a multi-sectoral approach, aligned with the global Scaling-Up-Nutrition (SUN) Movement, of which Namibia is a member since 2011, and the NFNS consists of an Implementation Action Plan and envisioned (yet not fully functional nor established) Coordination Structures on national and subnational levels.

The Nutrition and Food Security Alliance of Namibia (NAFSAN – www.nafsan.org) is Namibia's SUN Civil Society Alliance and recognised technical partner within the NFNS structures, representing civil society, academia and temporarily also the private sector until an independent Namibian SUN Business Network has been formed.

Omaheke is one of the regions hardest hit by malnutrition, with increasing cases of admissions and deaths. Contributing factors to malnutrition in Omaheke include lack of access to food coupled with poor knowledge of proper complementary feeding and caring practices, poverty, high unemployment, alcohol abuse and insufficient provision of psychosocial support services.

Since 2021, Omaheke was repeatedly visited by national MHSS staff, together with UN agencies and NAFSAN, leading to several reports, recommendations and interventions. After an official letter by the Omaheke Governor in November 2023, a high-level meeting with the Prime Minister, Rt Hon Saara Kuugongelwa- Amadhila, was convened on 1 February 2024.

During this meeting the situation was discussed, and support was requested from the National Government to urgently address the situation. Among the key recommendations made during this meeting was the development of a **Post-Discharge Strategy (PDS)** aiming to reduce high rates of admissions and re-admissions of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) cases among children under five, whereby members of the San communities being disproportionately affected.

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[1] *Namibia - Multidimensional Poverty Index* (MPI), Report 2021 (NSA, 2021): https://ophi.org.uk/node/3431

[2] Integrated Food Security Phase Classification (IPC), Namibia, April-September 2024 Report: https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1157090/?iso3=NAM

[3] *Cost of Hunger in Africa (COHA) - The Social and Economic Impact of Child Undernutrition in Namibia*. (NPC, 2022) www.nafsan.org/wp-content/uploads/2022/06/Final-COHA_NAMIBIA_REPORT-May-22_compressed.pdf

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

On 4 to 16 **February 2024**, a multi-stakeholder team visited **Omaheke** for a **rapid assessment** of the situation, resulting in a comprehensive report by the National Planning Commission[5].

During this visit, NAFSAN volunteered to facilitate a series of meetings with MHSS staff from the regional office, the Gobabis hospital, local clinics, as well as CHWs from both government and civil society organisations (CoHeNa and DAPP) to develop such a Post-Discharge Strategy. All meetings and the outcomes thereof are documented in NPC's Omaheke report that was submitted by NPC's Director General to the Rt Hon Prime Minister on 2 April 2024.

After an initial Post-Discharge Strategy (PDS) was drafted, NAFSAN approached the FirstRand Foundation for additional support to enable piloting of this PDS in Omaheke, with other stakeholders (i.e. UNICEF, WHO, GIZ's Farming-for-Resilience, Capricorn Foundation) already having indicated their willingness to also support such pilot and or a nationwide future rollout.

2. Proposed Approach

> *'We have a situation where the same child is being admitted, treated, discharged and re-admitted just a few weeks or months later. This happens up to 3-4 times, until the small body is simply no longer able to deal with the stress and gives up.'*
>
> Dr. Jonas Garoeb, MHSS-Omaheke, February 2024

2.1. Overview & Introduction

The draft PDS - to be tested and piloted in Omaheke, ideally as from August/September 2024 - focuses on improved and more efficient coordination between hospitals, clinics and a range of multi-disciplinary community services offered by various stakeholders (i.e., ministries, local government, civil society organisations, committed individuals, and private sector initiatives) through strengthening capacities and roles of **Community Healthcare Workers (CHWs)**, and by ensuring effective **local coordination** mechanisms.

PDS ownership will be with the Ministry of Health and Social Services (MHSS) as lead agency, in line with strategies and activities under Objective 1 of Namibia's revised Food and Nutrition Security Policy (2021), as listed on pages 5-6.

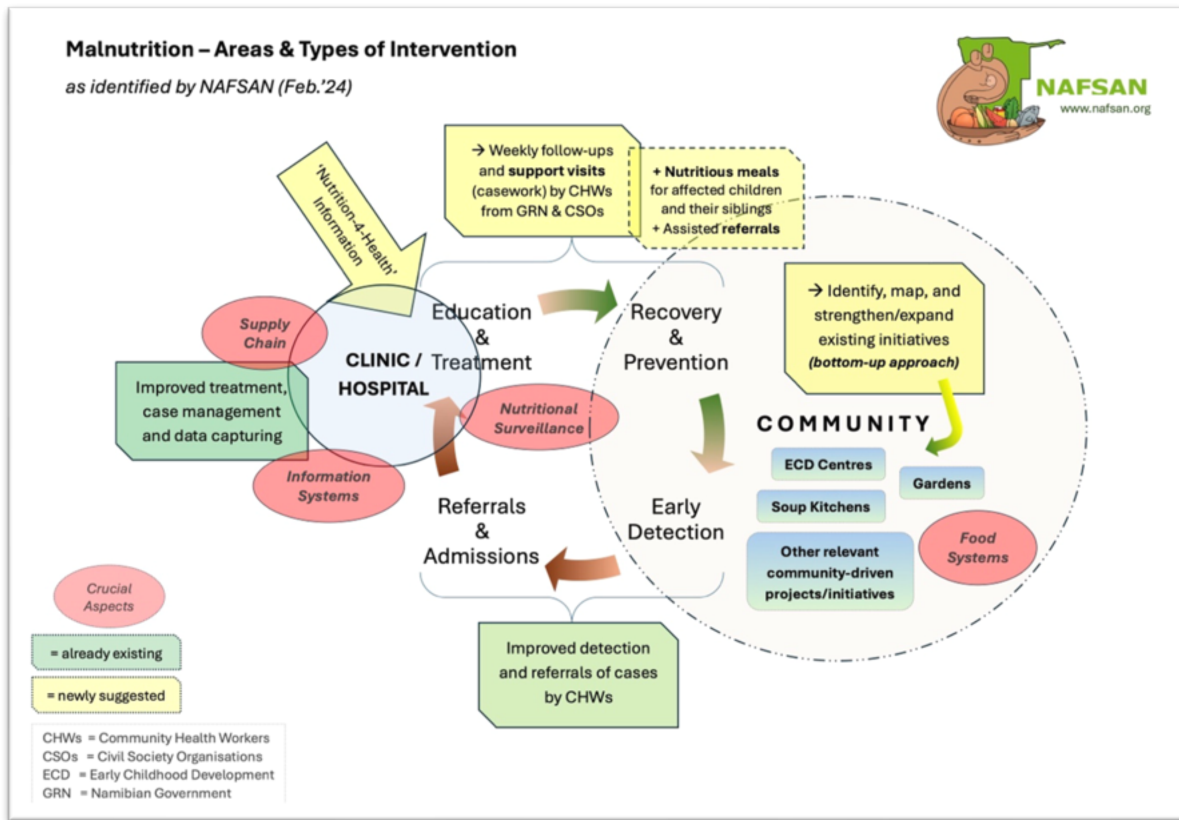
Successful implementation relies on collaborative efforts with other OMAs, local NGOs[6] and NAFSAN, as well as support from UNICEF, WHO and other development partners, such as GIZ - Farming for Resilience (F4R) Project, as well as the involvement of Namibia's private sector.

Based on the outcomes of this pilot and key lessons learned, a **full-fledged strategy will then be developed** and integrated into the MHSS planning and budgeting for country-wide rollout.

[5] www.nafsan.org/wp-content/uploads/2024/05/Report_Omaheke-Feb2024_12Mar2024-submitted.pdf

[6] Which of the several NGOs working in Namibia's health sector is to be involved in a particular region will primarily depend on their respective presence, specific programmatic focus and operational capacities.

Figure 1 –Initial Overview of PDS-Interventions (marked yellow)



2.2. Objectives of the Integrated Strategy

The **Overall Objective** is to:

Reduce rates of malnutrition (= undernutrition) and malnutrition-related deaths among children under five, while improving the nutritional status of families.

This is to be achieved through an integrated multi-sectoral approach that not only links hospital/clinic-based care with community-based support, but that makes good use of and strengthens existing referral systems, while inspiring and facilitating the development of new support systems within the affected communities (in line with regional coordination structures as described in the NFNS Policy).

The **Specific Objectives** are to:

- ✓ Reduce hospital admissions and re-admissions for cases of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM).
- ✓ Enhance capacities of and collaboration among CHWs (both from GRN and NGOs) to provide nutrition-related education and services in communities and facilities.
- ✓ Improve levels of detection of and early interventions for cases of malnutrition.
- ✓ Empower families with knowledge and skills to maintain healthy eating practices., with a focus on breastfeeding and complementary feeding ('first foods').
- ✓ Expand referral networks and support the increased availability of services and material resources related to food and nutrition security in communities.

2.3. NFNS Policy Alignment

The following strategies and activities from the revised **Food and Nutrition Security (NFNS) Policy's Implementation Action Plan** are directly addressed through the Integrated Post-Discharge Strategy:

No.	Activity
Strategy 1.1	**Increase coverage of evidence-based high impact nutrition-specific interventions aimed at preventing all forms of malnutrition**
1.1.3	Ensure equitable access to optimal feeding and hygiene practices for infants and young children.
1.1.4	Promote increased intake of micronutrients by infants and young children through consumption of diversified diets, food fortification, home fortification, and micronutrient supplementation.
1.1.5	Promote and create access to available, affordable, and nutritionally adequate complementary foods for children aged 6–24 months.
1.1.6	Foster partnerships to expand the scope of actors and implement Multi-Sectoral Nutrition approach towards improving child feeding practices.
Strategy 1.2	**Increase coverage of interventions for the management and treatment of acute malnutrition by documenting and sharing best practices at national, regional and global levels.**
1.2.1	Scale up high quality health and nutrition services to detect, treat and prevent the occurrence of acute malnutrition among children under the age of five years.
1.2.2	Promote and support community-based approaches for active identification and effective management of acute malnutrition.
1.2.3	Enhance the institutional and operational capacity to manage moderate and severe acute malnutrition within health facilities and communities.
1.2.4	Strengthen and scale up the prevention and treatment of acute malnutrition and the nutritional management of men, women, and children in hospital setting.
1.2.5	Ensure that operational tools for the policy implementation include guidelines and key messages, norms, and standards for essential strategies such as Management of Acute Malnutrition.
Strategy 1.3	**Implement growth monitoring and promotion programmes**
1.3.1	Strengthen capacity of health workers at health facilities and outreach services to monitor infant and child growth of children under the age of five years.
1.3.2	Sensitise mothers and women of reproduction age on pre-conditions and enablers for optimal growth.
1.3.3	Scale up growth monitoring and promotion services via Community Health Workers at community and household level.
1.3.4	Reinforce information on the use and interpretation of anthropometric indices, cut-off points, and summary statistics used to establish progress on optimal growth.
Strategy 1.5	**Promotion of optimal maternal nutrition**
1.5.3	Strengthen community mobilisation to increase access to and use of antenatal care services by women.
1.5.6	Strengthen interventions to ensure that pregnant and lactating adolescent mothers are adequately nourished.
1.5.8	Improve the system of social safety nets to ensure all vulnerable women of reproductive age and their family members have adequate nutrition.
Strategy 1.7	**Promotion of optimal nutritional care for people living with HIV, TB, and other infectious diseases**
1.7.1.	Increase access to appropriate nutritional assessment, care and support for people living with HIV & AIDS and TB.
1.7.3	Strengthen the community HIV programmes nutrition support capacity.

Strategy 1.8	**Promotion of universal access and utilisation of quality primary health care services to all people**
1.8.1	Promote and support health and nutrition education to increase the level of awareness of good nutrition.
1.8.2	Promote integration of nutrition services in all routine and outreach health services and programmes targeting children and mothers.
1.8.3	Promote and support breastfeeding policies, programmes, and initiatives.
1.8.4	Promote and support appropriate complementary feeding practices.
1.8.5	Promote utilisation of antenatal and postnatal care services among all pregnant and lactating women to monitor child growth, and the health and nutrition status of both mother and child.
Strategy 1.9	**Develop nutrition preparedness and response plans for emergency situations interventions** [7]
1.9.1	Ensure that policies, strategies and practices in emergencies and humanitarian crises promote, protect and support breast-feeding and cater for non-breastfeeding mothers.
1.9.2	Ensure implementation as per national guidelines for infant feeding in emergencies.
1.9.4	Improve supplementary feeding programs for infants and young children in emergency situations.
1.9.5	Ensure screening mechanisms are in place for targeting of nutrition and its related services to un-derserved communities and vulnerable groups in humanitarian situations.
1.9.7	Carry out sensitisation programmes for communities to raise their awareness of prevention, miti-gation and response to risks of malnutrition during emergencies.
1.9.8	Strengthen early warning systems on food and nutrition information from community to national levels.

Figure 2 – RightStart logo

In addition, reviving and maintaining **RightStart** as a vibrant platform for multi-sectoral collaboration and resource hub around the First 1,000 Days, Early Childhood Development (ECD) and Parenting, will significantly contribute to:

1.1.7 - Create a national campaign on "1,000 Days" that promotes awareness messages on the multiple causes of stunting, its negative consequences, services, and practices for its prevention.

If sustained for 20+ years, RightStart will become a household name for Namibian parents and caregivers, hereby offering multi-generational solutions for multigenerational problems, such as stunting.

There are also linkages to other strategies and activities within the **NFNS Policy** for which other ministries are responsible for in terms of implementation. Yet only those that MHSS is directly responsible for implementing and reporting under the **Nutrition Working Group** within the **NFNS Coordination Structures** have been listed here.

In addition, there are certainly other national policies to which the PDS will contribute.

[7] On 22 May 2024, President Nangolo Mbumba declared a **state of emergency** regarding the current drought.

3. Key Steps & Actions

As narrated in much more detail in the 'Post-Discharge Strategy' section of NPC's Omaheke Report (February 2024, pp. 12-18), various role-players working in key areas (i.e., hospital, clinics and communities) must be actively involved in the PDS, especially doctors, nurses, CHWs, social workers, and a designated coordinator.

Provision of sufficient resources for coordination is crucial to ensure multidisciplinary cooperation works, so that the **Expected Outcomes** can be achieved:

1. Provide nutrition education to parents and caregivers at the hospital and clinics.
2. Enable and encourage playful activities for patients to enhance the recovery process and to support early childhood development.
3. Involve social workers in malnutrition-related cases to ensure access to social grants and other psycho-social support systems, as needed and applicable.
4. Successfully trace and follow-up with paediatric patients and their parents/caregivers after they have been discharged.
5. Provide nutritious food (for a bridging period of 12 weeks) together with practical advice on healthy diets, food preparation, and complementary feeding practices ('first foods').
6. Identify nutrition-related challenges in the patients' and their caregivers' environments and make appropriate referrals to psycho-social and livelihood support services.
7. Monitor and evaluate discharged paediatric patient and their parents/caregivers, as well as possibly their siblings, too.
8. Detect infants/children at risk of being malnourished, engage caregivers on preventative measures, and refer cases of moderate malnutrition to health services for timely intervention to prevent them from becoming severely malnourished (= reduce risk of death).
9. Reduce hospital re-admissions of children with undernutrition, especially with SAM.
10. Report key issues and malnutrition hotspots to relevant coordinating bodies at regional and national level to inform/enable multi-sectoral responses and long-term solutions.

3.1. Essential Preparations

a) Stakeholder Consultations & Commitment to the Process

- ✓ Securing funding support from the private sector for:
  - Therapeutic food (= RUTFs) and nutritional supplement (= high protein meals) from Capricorn Foundation in November 2023 over a total of N$ 291,000
  - Nutritional food supply (on a weekly basis), coordination and administrative support from FirstRand Namibia Foundation in over a total of N$ 300,000
- ✓ Initial concept development and participation in joint assessment visit in February 2024, including facilitation of two meetings with regional MHSS staff, local CSOs and CHWs on 7 and 13 February in which the PDS was developed (see minutes).
- ✓ Several further meetings with regional and national MHSS staff and CSOs, as well as with WHO, UNICEF and GIZ-F4R, to ensure buy-in and commitment to support.

b) Training and Capacity Development

- ✓ Collaborative development of Nutrition-for-Health (N4H – www.nafsan.org/N4H) finalised, and printing of nutrition training and education materials in progress.
- ✓ Training of ± 50 CHWs (from MHSS and CSOs) on N4H scheduled for August 2024, in collaboration with WHO and with support from the Government of Japan.[8]
- ✓ Providing CHWs with tools and resources to effectively monitor growth and recovery during home visits, and when engaging with the community at large.
- ✓ Enhance nutritional knowledge and practices among parents/caregivers through facilitation of N4H sessions by trained CHWs at the hospital and at health clinics.
- ✓ Integrate N4H-education into follow-up visits of patients and caregivers at home, focusing on healthy diets, practical food preparation, promotion of breastfeeding, and appropriate complementary feeding practices ('first foods').
- ✓ Establish hospital gardens and provide basic horticulture training to parents and caregivers, hereby promoting own food production (including provision of seeds) in collaboration with GIZ-F4R and possibly MAWLR and/or other stakeholders.

c) Coordination & Linkages to Community-based Services and Initiatives

- ✓ Patients' details are appropriately captured in detail to allow post-discharge tracing, which requires good communication between nurses and CHWs.
- ✓ Parents/Caregivers are engaged and educated on key nutrition topics by CHWs while at the health facilities, with additional support by a GIZ-F4R nutritionist. They are also offered gardening trainings by GIZ-F4R gardening consultant/trainer.
- ✓ Patients are enabled and encouraged to play to develop their muscles and brains in suitable child-friendly rooms that are still to be established at health facilities.
- ✓ Connect parents/caregivers to social workers for assessment and possible support in close collaboration with the responsible CHWs (= joint casework).
- ✓ Ensure seamless transition from hospital care to CHWs-led home-based support.
- ✓ Regular (weekly) follow-up visits to monitor growth and recovery, incl. delivery of nutritional food items and nutrition advice during the bridging period (12 weeks).
- ✓ Identify key livelihood challenges or other factors that led to the child (patient) becoming initially malnourished and link the case to relevant available services.
- ✓ Liaise with community-based initiatives and/or regional stakeholders that may be able to provide additional support services, hereby fostering improvements and further development of existing support mechanisms.
- ✓ Assist in establishing well-functioning regional Working Groups on 'Nutrition' (e.g. the 'Malnutrition Task Force' under RACOC → 'Community Health') and 'Food Security', as per NFNS Policy's Coordination Structures[9] to effectively and sustainably address food insecurity at community-level, as a main root cause of malnutrition.

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[8] The WHO and Japanese-funded project *"Increasing Access to Nutrition Interventions to Prevent and Manage Malnutrition Among Women and Children in Their Immediate Communities"* will ensure training of ± 140 CHWs in Omaheke, Kunene and Khomas regions on Nutrition-for-Health (N4H) from August to November 2024. It will include ongoing mentoring and support through an innovative 'Nutrition Hotline' (081 - 555 3888).

[9] Access to this NFNS Policy document: www.nafsan.org/wp-content/uploads/2022/01/FNS-STRUCTURE.pdf

3.2. Specific Activities per Intervention Areas

The following is an overview of key PDS-activities as per area of intervention. An overview of roles and responsibilities as per the **different professions** is in the appendix on pages 13-14.

1) In the Community:

During regular community engagements and home visits, CHW should conduct nutrition assessment on children, especially under-fives who are showing signs of being underweight. This will ensure early detection and early interventions.

When CHWs detect SAM-cases in children they refer them to the hospital, while MAM-cases in children are being referred to the clinics.

2) At the Clinic:

Any SAM-cases are further referred to the hospital for more specialised health interventions that cannot be provided at clinics.

MAM-cases are managed and discharged at clinic-level, while making sure that each patient is linked with a CHW from that location for continued follow-up.

3) At the Hospital:

SAM cases are **admitted** (+ capturing all details necessary for follow-ups) and treated.

During weeks of treatment, each patient is linked to a **designated CHW**, ideally from their respective location. This CHW is introduced to the parent/caregiver by the nurse, so CHW gets to know them and the patient already in hospital and possibly also visits their home while the patient is still in the hospital. This helps to have a clearer understanding of their life circumstances, which is key for attending to the patient's social and livelihood-related needs that led or contributed to the patient's hospitalization.

The parents/caregivers (fathers also to be involved as much as possible) are assessed to by a **Social Worker** to help understand all the factors that lead to malnutrition and to identify possible grants and necessary psycho-social support to be provided.

Social Worker will liaise with and advise the designated CHW on each patient (= joint casework) and agree on a **recovery plan** that covers both nutritional and social aspects. This recovery plan will be discussed with the caregivers before the child is discharged,

While the patient is admitted, caregivers receive **nutrition education and awareness** in form of short interactive Nutrition-for-Health sessions at the hospital, facilitated by CHWs with support from a Nutritionist (under GIZ-F4R). The Nutritionist will also provide practical cooking demonstrations at the hospital to the caregivers.

A **Gardening Trainer** (under GIZ-F4R) will lead joint efforts in establishing a hospital garden and train caregivers on horticulture while their child is admitted. As far as possible, seeds will be provided to caregivers for them to start their own gardens at home.

A **child-friendly room** is to be established (renovated and equipped with suitable toys through private sector engagement), so that children can rebuild muscles and improve their motor skills and their cognitive abilities through active play, while parents learn about the importance of play in the context of early childhood development. Existing ECD initiatives (e.g. from CSOs, such as Development Workshop Namibia[10]) and other resource persons (e.g., occupational therapists) to provide support on a regular basis.

4) **After Discharge:**

CHWs conduct **weekly follow-up visits**, including nutritional assessments and anthropometric measurements as per Malnutrition Monitoring Aid (see pages 15-17).

CHWs also follow-up on social aspects and interventions, as per recovery plan. Social Worker is to be updated monthly and major adjustments are to be discussed jointly.

During the 'bridging period' of 12 weeks (= three months), **nutritional food items** are provided by the CHWs on a weekly basis, together with practical advice on nutrition and food preparation, as well as on breastfeeding and complementary feeding. The PDS Coordinator helps regarding logistics around buying and delivering of food items.

Progress on **nutritional and social aspects** is being **measured and reported**, with assisted referrals to projects, institutions or other services being done as needed by CHW and/or the Social Worker. The Gardening Trainer (or other relevant resource persons) may be able to conduct home visits and give onsite gardening advice.

Full **nutritional recovery** is expected **after three months**. Thereafter follow-up visits will become less frequent yet remain necessary to monitor the situation and prevent re-admission.

3.3. Monitoring and Evaluation

The PDS Coordinator[11] for this pilot has been employed by NAFSAN on a part-time basis, with funding from FirstRand Foundation. She is envisioned to work closely together with the Family Health Programme Officer, who is heading the implementation of the strategy with support of the Primary HealthCare Supervisor and the Risk Communication and Community Engagement Officer. Regional coordinators from CoHeNa and DAPP are also actively involved.

Oversight of the monitoring of all cases is done by the PDS Coordinator in close collaboration with regional MHSS and local CSOs, while the evaluation of the overall pilot intervention will be conducted by national-level MHSS and NAFSAN with support from development partners.

Some of the key **quantitative indicators** are:

- Number of hospital admissions of cases of SAM (and possibly even MAM),
- Number of re-admissions during the pilot period,

[10] Homepage for DW-Namibia's Early Childhood Development Programme: https://dw-namibia.org/ecd.php

[11] Ms. Belinda Thanises, with years of experiences in the context of community development, especially livelihood projects in Omaheke, where she worked with CSOs and government in various multi-stakeholder fora.

- Number of patients linked with CHWs and successfully followed-up on,
- Number of Recovery Plans developed jointly by CHWs with Social Workers,
- Number of assisted referrals, and number of support services actually received,
- Nutritional measurements per patient over time during recovery at their homes,
- Number of caregivers participating in nutrition education sessions at facilities,
- Number of caregivers participating in horticulture training at the hospital, and number of those caregivers who then started their own home garden afterwards.
- Early detection of MAM/SAM-cases and referrals made, based on community engagements and home visits (= prevention and early interventions).

Some of the key **qualitative indicators** are:

- Level and quality of collaboration between facility staff and CHWs, as well as between different professions and organisations involved in this pilot.
- Assessments patients and caregivers in terms of malnutrition causes and solutions, including quality of recovery plans and level of success in terms of implementation.
- Types of referrals and reasons for successful linking with available support services.
- Feedback from nutrition education sessions, horticulture trainings, utilisation of the child-friendly room, as well as the hospital garden and gardens at patients' homes.
- Human Impact Stories & Lessons Learned (via individual and focus group interviews)

3.4. Costs – Funding Mostly Secured

NAFSAN was able to **secure funding** from the EU, WHO (+ Japan) and the Namibian private sector (namely Capricorn Foundation and FirstRand Namibia Foundation) to support the piloting of the post-discharge strategy **over a 6-month pilot period**, whereby staff time is being volunteered (unpaid) for developing and fine-tuning of the PDS and getting it approved.

The available funding allows for the necessary capacity building of CHWs (using the already developed Nutrition-for-Health approach, also to be integrated into the updated curriculum), provision of weekly food items for discharged patients and their immediate families during the bridging period (12 weeks per patient) delivered by CHWs during weekly follow-up visits, as well as transport, communication, coordination and monitoring of this pilot.

GIZ's Farming for Resilience project, as key development partner who spearheads the integration of nutrition into Namibia's agricultural sector (including developing materials and implementing trainings across the country), is committed to complement this PDS pilot by offering educational materials and capacity building support around nutrition and horticulture, including establishing a garden at the hospital and possible provision of seed to caregivers.

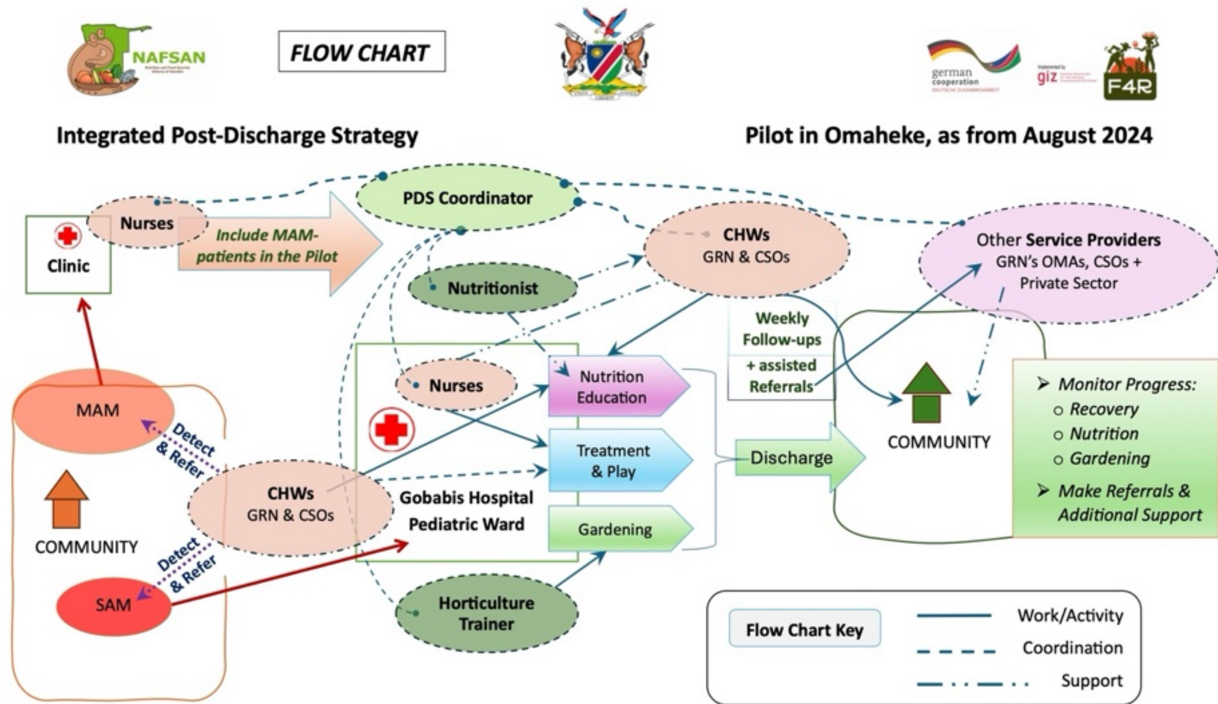
All costs related to starting with the PDS Pilot are therefore covered.

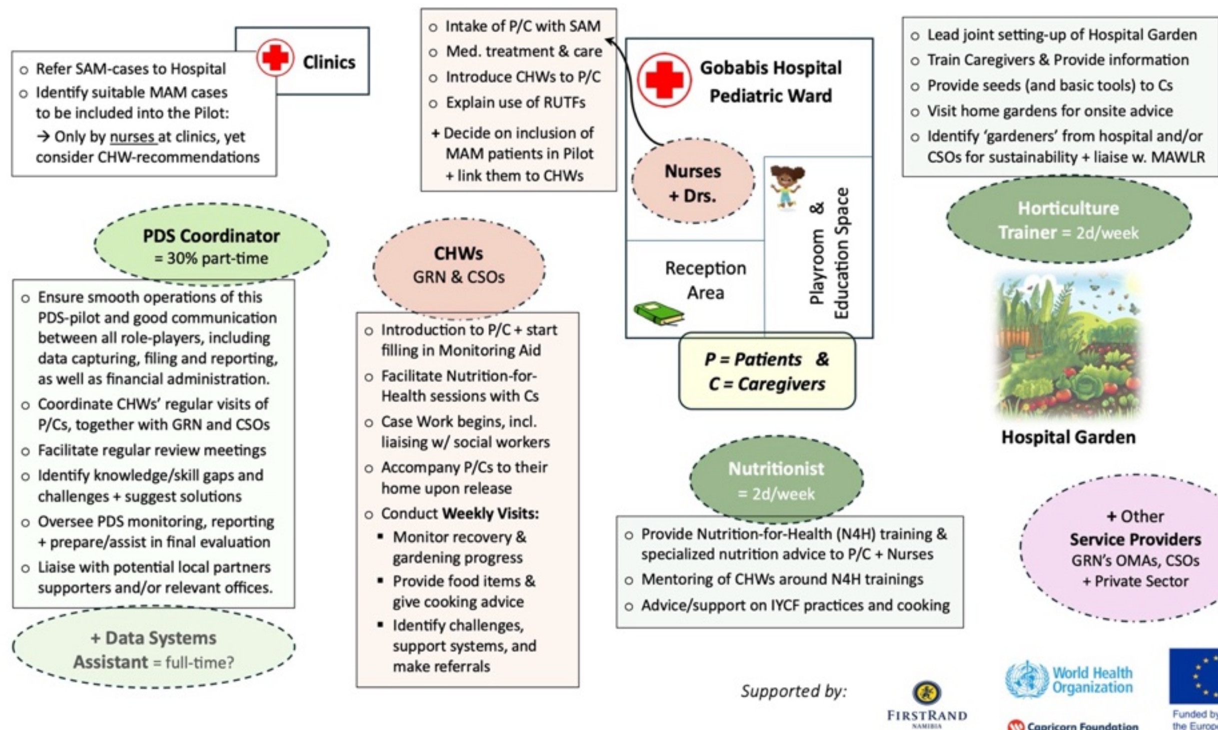
However, some anticipated future costs are not yet fully covered, for instance:

- Costs for a comprehensive (external) evaluation of this pilot after six months,
- Transport for areas that are hard to reach including farms and those without CHWs,
- Employing additional Community Healthcare Workers for yet unserved communities.

Appendices

PDS Process Visualizations





Key Roles & Responsibilities

PDS Coordinator:

- Ensure smooth operations of the PDS-pilot and good communication between all role-players, including data capturing, reporting, and financial administration.
- Coordinate CHWs' regular visits of parents/caregivers, together with GRN and CSOs.
- Facilitate regular review meetings among key stakeholders.
- Identify knowledge/skill gaps and challenges and suggest solutions.
- Oversee PDS monitoring, reporting and prepare/assist in final evaluation.
- Liaise with potential local partners, initiatives, supporters and/or relevant OMAs.
- Purchase food items and prepare them for CWHs to deliver the to patients' homes.

Nurses (at Hospital):

- During admission: note exact location and landmarks of patients
- Introduce CHWs and their role to the parents/caregivers
- Provide key nutrition information (with CHWs) and encourage play
- Ensure CHWs are informed before/when patients get released
- Include MAM patients into the pilot and link them to CHWs

Nurses (at Clinics):

- Refer SAM cases to the Hospital
- Identify suitable MAM cases to be included in the pilot

Nutritionist (at Hospital, part-time, two days per week):

- Provide N4H-training, support and specialized nutrition advice to Nurses and CHWs,
- Provide cooking demonstration sessions for parents and caregivers.
- Mentoring of CHWs for facilitating N4H-training for caregivers.
- Advise on breastfeeding and complementary feeding.

Gardening Trainer (at Hospital, part-time, two days per week):

- Lead joint setting-up of garden at the Hospital
- Train caregivers & provide information/materials (+ seeds?)
- Visit home gardens for onsite advice (if possible)
- Identify future 'gardeners' from within the Hospital and/or liaise with MAWLR and local CSOs for sustainability of the garden site.

Social Worker (MHSS)

- Counseling and assessment of parents/caregivers and patients.
- Liaise with CHWs on patients and caregivers, and give input to each recovery plan
- Ensure that all psycho-social support requests done by CWHs are being attended to.
- Follow-ups on referrals to ensure that families receive the assistance they need.

Community Health Workers (CHWs) - at Hospital/Clinics:

- First contact with the patient and his/her parents/caregivers:
  → Introduce the process & fill in the necessary details in the 'Monitoring Aid'
- Facilitate Nutrition-for-Health (N4H) sessions for caregivers at the health facilities,
- Case Work begins: Involve the Social Worker in developing individual Recovery Plans

Before/at discharge:

- Confirm contact details & ensure 'Monitoring Aid' is properly filled in.
- Buy and provide the first weekly package (= basic yet nutritious food items)
- Accompany the patient and his/her parents/caregivers to their home, if possible.

Community Health Workers (CHWs) - in Communities:

- Weekly visits to:
  - ✓ Monitor growth/recovery (use Monitoring Aid) and progress regarding social aspects + possibly home gardening, too.
  - ✓ Provide Basic food items, incl. food preparation tips.
  - ✓ Take note of challenges, successes, support systems etc.
- Liaise with Social Workers & make assisted referrals as needed

→ *After three months, visits to patients' homes become less frequent.*

Responsibilities of other OMAS, outside the mandate of MHSS:

Ministry of Gender Equality, Poverty Eradication and Social Welfare (MGEPESW):

- Register children/families for vulnerability grants based on recommendations by CHWs and proper assessment by a social worker.
- Register them for food aid/vouchers, where they cannot qualify for grants
- Assist with placing/referring these children or entire households to soup kitchens
- Provide safe shelters and psycho-social services for neglected or abused children

Ministry of Agriculture, Water and Land Reform (MAWLR):

- Assist with agricultural knowledge and skills to set up backyard gardens, which may include the provision of seeds or basic tools to qualifying households.
- Support monitoring and continued support to those who take up gardening
- Together with the local authorities (e.g. municipality), address issues around water and the provision of land for food production purposes.

Governor's Office:

- Assist PDS Coordinator with the bulk purchasing of food items from local stores
- If needed, assist CHWs with the delivery of food packages to families.
- Source and provide additional food parcel for affected communities, in response to referrals or direct requests based on information gathered during the PDS Pilot.
- Support soup kitchen with food, and approach local private sector for more support.

Monitoring Aid for CHWs

Malnutrition - Monitoring Aid *(12 Weeks)*

CHW's Name: ______________________ **Start Date:** __________ **End Date:** _________

Discharged & Recovering from **Severe Malnutrition?**	O	Case of **Moderate Malnutrition**	O

Name of Child	**Surname of Child**	**Date of Birth**

Child's Biological Sex	O Male	O Female	**Age** = in years & months, at the start of measuring	

Names (+ Relationship) **of Parent/Caregiver 1**		**Contact** = Cell No.
Names (+ Relationship) **of Parent/Caregiver 2**		**Contact** = Cell No.
Address / Location		

As a parent/caregiver, I hereby give consent to the monitoring of my child:	O **No**	O **Yes**	*Signature*

Anthropometric Measurements				
Height / Length *(in cm)*	At the **start** (week 1):		At the **end** (week 12):	
Weight *(in kg)*	At the **start** (week 1):		At the **end** (week 12):	
Head Circumference *(in cm) – for children 0-3 years*	At the **start** (week 1):		At the **end** (week 12):	

For Children 0.5 - 5 years:	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**
Date						
MUAC[1] *(in cm)*						
	Week 7	**Week 8**	**Week 9**	**Week 10**	**Week 11**	**Week 12**
Date						
MUAC *(in cm)*						

[1] **Mid-Upper Arm Circumference** = measurement done with a MUAC-tape, only for 6-59 months old children.

General Observations

General Living Conditions, incl. access to Water & Sanitation?

____

____

Hygienic Conditions of the Child? Any Warning Signs of Abuse or Neglect

____

____

Parent/Caregiver background, including employment history and status, sources of income etc.

____

____

____

____

____

Referrals made to Social Workers for Social Services or Grants? Which Office? Any Results/Follow-ups?

____

____

____

OTHER HEALTH-RELATED ASPECTS:

TB screening? No O / Yes O – If yes, results/actions: ______________________________

____

HIV testing? No O / Yes O – If yes, results/actions: ______________________________

____

Other observations/comments/recommendations:

____

____

____

WEEKLY - Malnutrition - Monitoring Aid

Assessment of Current Diet at Home: 7-day recall ***Please do not just tick but indicate what kind of food...***									
Dietary intake:	**Breast -milk**	**Diary: Milk, Yogurt, Omaere**	**Grains/Cereals: Bread & Pap**	**Meat, Fish, Chicken, Eggs**	**Legumes, Beans/Peas**	**Fruit & Vegetables**	**Fats & Oils**	**Snacks:** (Sweets & Chips)	**Any Other Drinks:**
Day 1 - Breakfast									
Day 1 - Lunch									
Day 1 - Dinner									
Day 2 - Breakfast									
Day 2 - Lunch									
Day 2 - Dinner									
Day 3 - Breakfast									
Day 3 - Lunch									
Day 3 - Dinner									
Day 4 - Breakfast									
Day 4 - Lunch									
Day 4 - Dinner									
Day 5 - Breakfast									
Day 5 - Lunch									
Day 5 - Dinner									
Day 6 - Breakfast									
Day 6 - Lunch									
Day 6 - Dinner									
Day 7 - Breakfast									
Day 7 - Lunch									
Day 7 - Dinner									

Cabinet Endorsement of NAFSAN's Role within the NFNS Policy

REPUBLIC OF NAMIBIA

REPUBLIC OF NAMIBIA

OFFICE OF THE PRIME MINISTER

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Private Bag 13338
WINDHOEK

23 September 2021

Mr. Ben Schernick
Director of NAFSAN
P.O. Box. 40723
Windhoek
Namibia

Dear Mr. Schernick,

RE: APPROVAL OF THE REVISED NATIONAL FOOD AND NUTRITION SECURITY POLICY, ITS IMPLEMENTATION ACTION PLAN AND COORDINATION STRUCTURE

1. Our ongoing discussion on the above-mentioned subject matter bears reference.

2. Kindly be informed that Cabinet approved the revised Policy, its Implementation Action Plan and Coordination Structure. Cabinet also endorsed the role of the Nutrition and Food Security Alliance of Namibia (NAFSAN) to serve as technical partner on aspects of food and nutrition security.

Yours Sincerely,

I-BEN NATANGWE NASHANDI
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director