Increasing Access to Quality Nutrition and Protection Services for Vulnerable Populations

FINAL REPORT

9 December 2024






Implementation Period:

1 May – 30 November 2024

-By **Nutrition and Food Security Alliance of Namibia (NAFSAN)**
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1. Introduction

The *Increasing Access to Quality Nutrition and Protection Services for Vulnerable Populations* project was designed to enhance nutrition awareness and good practices within targeted communities. Implemented through a network of Community Healthcare Workers (CHWs) in three regions – Khomas, Kunene, and Omaheke – the project focused on critical community health outcomes. These included:

- **Nutrition Education at Community Level:** Providing comprehensive information on balanced diets, breastfeeding, complementary feeding, and hygiene practices.
- **Household Visits:** Conducting regular home visits to assess the nutritional status of children under five and their caregivers, and to offer tailored advice and support.
- **Direct Interventions**: Implementing targeted interventions for children under five who are identified as malnourished or at risk of malnutrition.

This report presents a detailed analysis of the training and activities undertaken by NAFSAN and by the trained CHWs across the three regions, highlighting key achievements, challenges encountered, and recommendations for future improvement.

All preparatory activities during the first months of the project are captured in NAFSAN's **1st Interim Report**, see: www.nafsan.org/wp-content/uploads/2024/12/1stReport-03Aug24.pdf

The roll-out of the *Nutrition-for-Health* training to 138 CHWs from government (MOHSS) and Civil Society Organisations (CSOs) is documented in detail within the **2nd Interim Report** that NAFSAN submitted to the WHO Namibia on 25th September 2024: https://www.nafsan.org/wp-content/uploads/2024/11/WHO-NAFSAN_2nd-Interim-Report_25Sep.pdf

2. Approach & Methodology

2.1. Training of Community Healthcare Workers (CHWs)

To equip CHWs with the necessary knowledge and skills to implement the project effectively, a comprehensive 3-day training program was designed and delivered during August and September 2024. The training focused on the following key areas:

- **Nutrition Training:** A total of 146 CHWs (out of 148 targeted)[1] were trained on the Nutrition for Health approach[2] (aligned with latest WHO guidelines and the 'First Foods Africa Initiative' by UNICEF), which is a highly interactive an participatory in nature, building upon their existing knowledge of nutrition. The training aimed to enhance their understanding of malnutrition, balanced diets, breastfeeding, hygiene practices, food safety and basic gardening, while also providing them with additional tools, participatory methods and skills for actively engaging communities.

[1] These numbers include eight (8) CHWs employed by MoHSS that were trained by GIZ Namibia's Farming-for-Resilience project in April 2024 (within the project period, counting as 'CHWs trained'.

[2] For more information: www.nafsan.org/n4h + Access to all materials: www.nafsan.org/n4h-materials

- **Training Materials**: Through this project, the following Nutrition-for-Health training material could be printed/procured and provided to the trained CHWs in the regions:
    - 200 x Nutrition-for-Health (N4H): Facilitator's Manuals [108 pages]
    - 60 x laminated cards in boxes [126 Namibian food items for Food Group Exercise]
    - 60 x Slides [A2-sized, with 3 x flip charts on stand per set], incl. durable carry bags
    - Handouts: Available to **download** here: **www.nafsan.org/n4h-materials**
        - 15,000 x 'Nutrition for Health' – Brochure (key information)
        - 15,000 x 'Food Safety and Nutrition' – Information & Guidelines
        - 10,000 x 'Nutrition during Pregnancy and Breastfeeding' (English)
        - 5,000 x 'Nutrition during Pregnancy and Breastfeeding' (Otjiherero)
        - 10,000 x 'How to Breastfeed your Baby' (English)
        - 5,000 x 'How to Breastfeed your Baby' (Otjiherero)
        - 10,000 x 'How to Feed a Baby after 6 Months' (English)
        - 5,000 x 'How to Feed a Baby after 6 Months' (Otjiherero)
        - 15,000 x 'Food Groups, Meal Planning & Food Hygiene'
        - 15,000 x 'Step-by-Step Gardening Guide'
        - 15,000 x 'Composting Posters' (A5)

- **Data Collection and Reporting:** During the 3-day training workshops, CHWs were also introduced to standardized data collection tools and Monitoring and Evaluation (M&E) forms that were specifically designed – together with the Ministry of Health and Social Services - to capture essential information on household visits, community sessions, direct interventions for children under 5, and the *Nutrition Hotline* usage.

A **comprehensive training report** was already submitted in Sept.'24, and is accessible here: www.nafsan.org/wp-content/uploads/2024/11/WHO-NAFSAN_2nd-Interim-Report_25Sep.pdf

2.2. Implementation & Data Collection

This project covered the initial training and provision of training materials, followed by the first few months of CHWs applying their newly acquired skills, methods and tools around nutrition. The data on how CHWs shared what they have learned was primarily collected through the following methods:

- **Community Sessions:** CHWs facilitated nutrition education sessions within their communities, targeting diverse groups, such as pregnant women, caregivers, men, and adolescents. Data on these sessions included:
    - Number of participants, aggregated by gender and age (children under 16)
    - Area (region/community) and Location of the session (e.g., under a tree)
    - Topics covered (e.g., balanced diets, breastfeeding, hygiene)
    - Key outcomes and feedback from a particular session

- **Household Visits:** CHWs regularly conduct home visits, during which they also assess the nutritional status of children under five and their caregivers. During these visits, they collected data on:
    - Measuring the children's weight and height, including MUAC[3] readings.
    - Providing tailor-made nutrition education and advice to the caregivers.

CHWs completed tailor-made M&E forms (Appendix, pp. 18-19) to record data on community sessions, household visits and direct interventions. These forms were submitted to their supervisors and subsequently forwarded to the project manager at NAFSAN.

Community Healthcare Workers (CHWs)

M&E Tool – **Community Engagements**

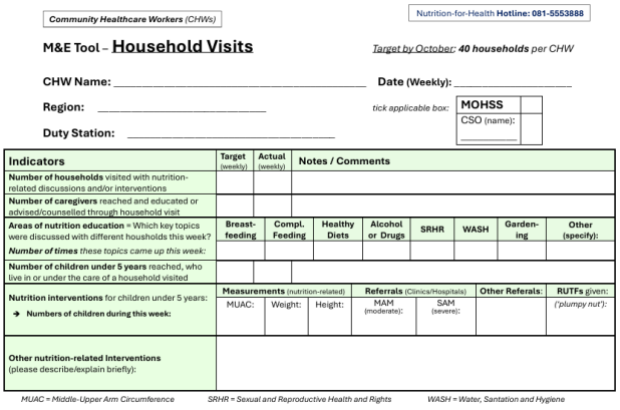
*Target by October: **3-4 sessions** per CHW*

CHW Name: _____ **Date (Weekly):** _____

Region: _____ *tick applicable box:* MOHSS ☐ CSO (name): _____ ☐

Duty Station: _____

Indicators	Figures (weekly)	Notes / Comments
Number of community engagements held on nutrition-related topics (*Nutrition-for-Health*)		
Duration of each engagement (in hours)		
Location of community engagements (list all)		
Number of community members participating in nutrition-related Community Engagements	**Men** (16+ years):	**Women** (16+ years): / **Children** (under 16 years):
Topics covered during community engagements		
Key outcomes and/or **important feedback** or questions/requests from community members		



Community Healthcare Workers (CHWs)

Nutrition-for-Health **Hotline: 081-5553888**

M&E Tool – **Household Visits**

*Target by October: **40 households** per CHW*

CHW Name: _____ **Date (Weekly):** _____

Region: _____ *tick applicable box:* MOHSS ☐ CSO (name): _____ ☐

Duty Station: _____

Indicators	Target (weekly)	Actual (weekly)	Notes / Comments
Number of households visited with nutrition-related discussions and/or interventions			
Number of caregivers reached and educated or advised/counselled through household visit			

Areas of nutrition education = Which key topics were discussed with different housholds this week?	**Breast-feeding**	**Compl. Feeding**	**Healthy Diets**	**Alcohol or Drugs**	**SRHR**	**WASH**	**Garden-ing**	**Other (specify):**
***Number of times** these topics came up this week:*								

Number of children under 5 years reached, who live in or under the care of a household visited								
Nutrition interventions for children under 5 years:	**Measurements** (nutrition-related)			**Referrals** (Clinics/Hospitals)		**Other Referals:**	**RUTFs** given:
→ **Numbers of children during this week:**	MUAC:	Weight:	Height:	MAM (moderate):	SAM (severe):		*('plumpy nut'):*
Other nutrition-related Interventions (please describe/explain briefly):							

MUAC = Middle-Upper Arm Circumference *SRHR = Sexual and Reproductive Health and Rights* *WASH = Water, Santation and Hygiene*

2.3. Data Analysis

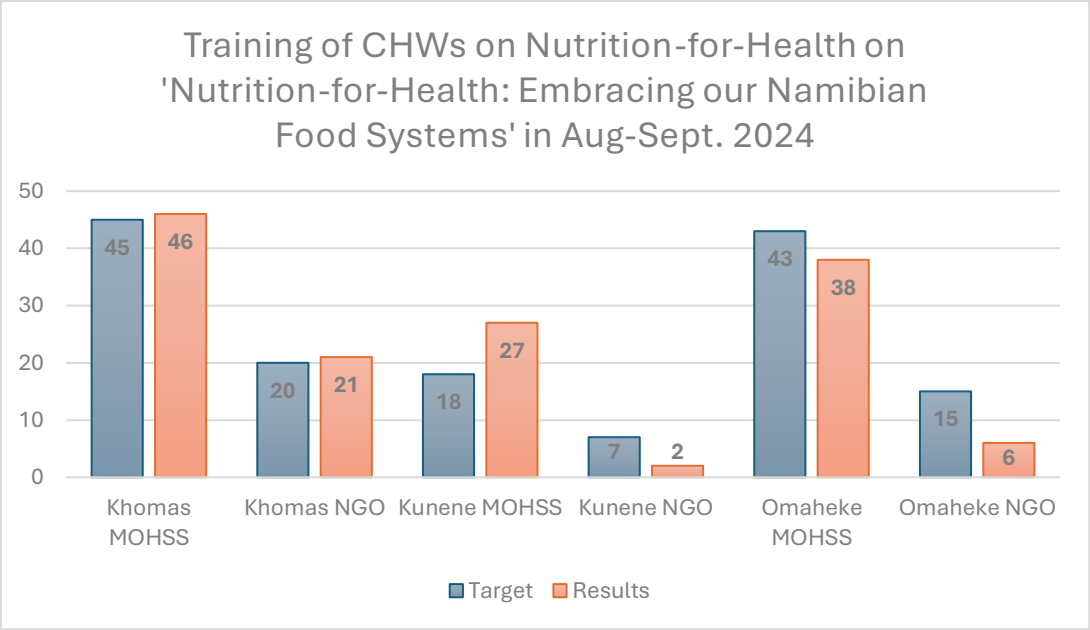
The collected data was analyzed using quantitative and qualitative methods. Quantitative data was analyzed by comparing initial targets and the actual results, hereby using graphs for better visualization. Qualitative analysis involved the thematic analysis of narrative data/feedback from CHWs and community members collected through M&E forms and the *Nutrition Hotline*.

[3] Mid-Upper Arm Circumference (MUAC) measuring tapes are used to identify malnutrition in children and adults (mainly pregnant women).

3. Results and Findings

3.1. Quantitative

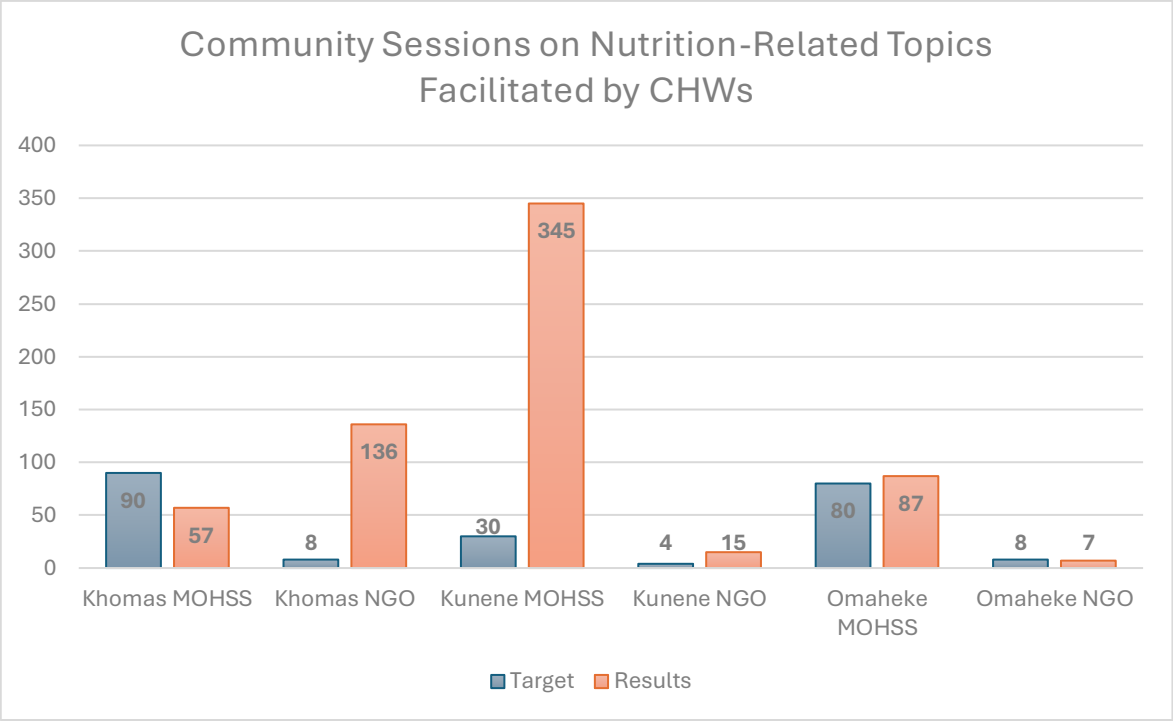
3.1.1 Training of CHWs on Nutrition-for-Health



Analysis:

- In Khomas, both the MOHSS and CSO targets were not only met but exceeded, which may be explained by trainings in Khomas having had more time for preparations.
- In Kunene, fewer CSO-CHWs were trained than originally targeted, due to the limited number of CSOs in Opuwo itself. In addition, Kunene is not one of NAFSAN's target regions, under our current EU-project (which covers most of. NAFSAN's operations), so we have not yet established strong relationships with the CSOs in that area.
- As for Omaheke, CHWs from DAPP (one of the most active Namibian CSOs) were unable to participate in any of the sessions as the program's phase-out in the region.
- In terms of MOHSS-CHWs from Omaheke, eight (8) of them had already received *Nutrition for Health* training from GIZ Namibia's Farming-for-Resilience project in April, and as a result, the MOHSS in this region also fell below the set target. However, these now trained CHWs are counted in the overall number of 146 CHWs in Namibia trained on Nutrition-for-Health, while in this project only 138 were trained.

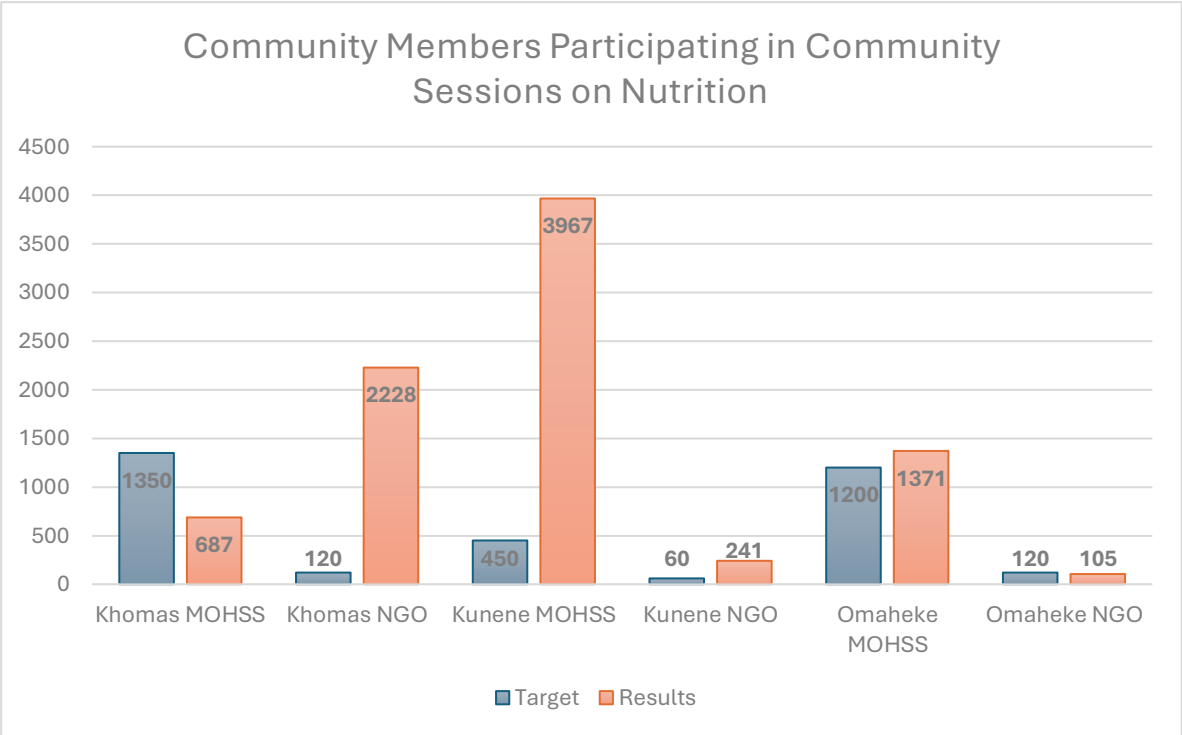
3.1.2 Community Sessions on Nutrition-Related Topics Facilitated by CHWs



Analysis:

- In Khomas, CHWs from the MOHSS fell short of their target, while those from CSOs significantly exceeded theirs. A possible reason for the low results of MOHSS-CHWs in Khomas could be that they were occupied with other duties and attending other trainings, which limited the time they could dedicate to nutrition-related activities, such as community engagements. In contrast, CSO-CHWs were able to integrate a focus on nutrition into their community programmes, as it is closely aligned with their primary areas of work, which is HIV and TB programmes. This alignment may have allowed CSO CHWs to integrate nutrition sessions more seamlessly into their existing responsibilities, contributing to CSO-CHWs exceeding their targets.
- In Kunene, all CHWs greatly surpassed their target, which could be because they had more time for implementation, while the target may also have been set quite low in that region, contributing to CHW's ability to exceed it.
- Omaheke performed well, although in this particular region slightly less CHWs were trained through this project than initially planned. CHWs from the MOHSS slightly exceeded their target, while those from CSOs narrowly missed theirs. A potential contributing factor could be the late delivery of flipcharts to CHWs to that region, which may have impacted the number of sessions conducted.
- CHWs also reported that 'attending workshops' limited their ability to hold community sessions, a challenge particularly noted by CHWs in Omaheke.

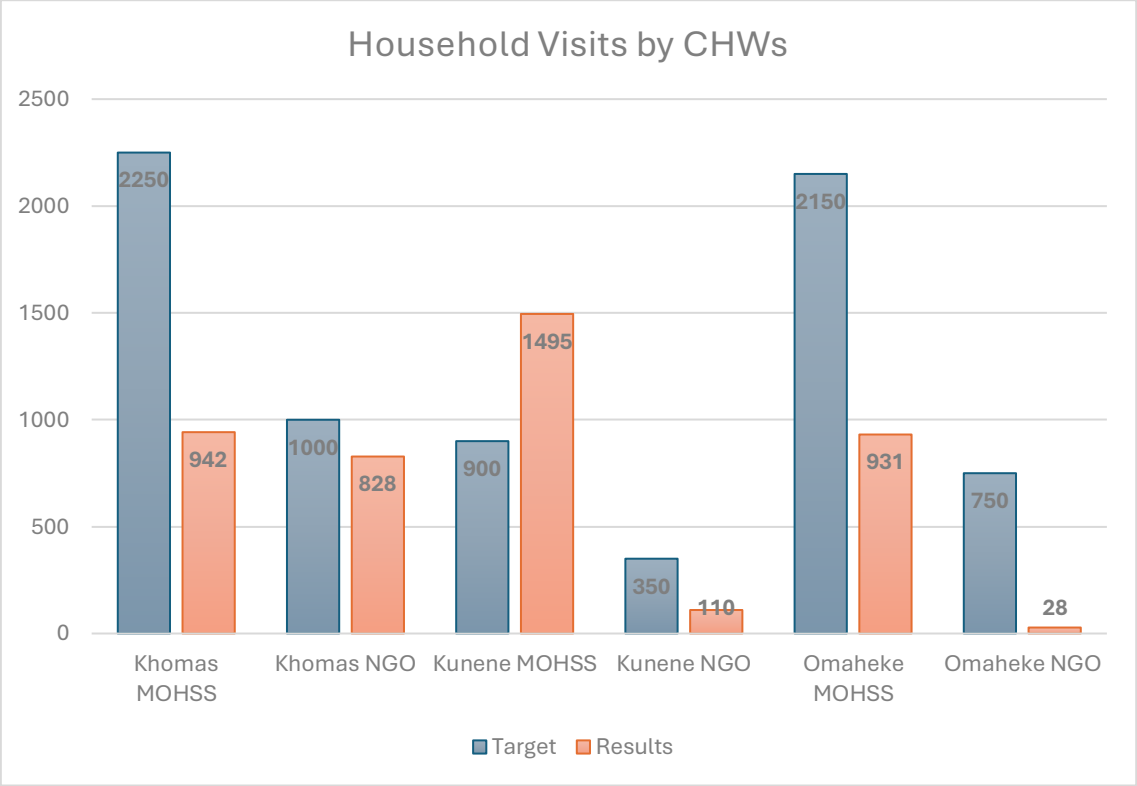
3.1.3 Community Members Participating in Community Sessions on Nutrition



Analysis:

- The CHWs from CSOs in Khomas significantly surpassed their target, reaching over 2,000 community members, likely due to easily integrating nutrition into their existing work on HIV and TB, which allowed them to dedicate more time and effort towards community sessions. Through engaging communities over the years they also developed targeted outreach strategies and established trust through consistent interactions. Plus, they seemed to have had fewer competing prioritie. In contrast, MOHSS CHWs in general have broader responsibilities, which may have spread their efforts thinner across multiple health priorities, limiting the time and focus they could devote to nutrition-related community sessions.
- The high numbers achieved by the CHWs in Kunene could be attributed to several factors. Focusing on just one town, Opuwo, allowed for streamlined coordination and easier mobilization of resources, making it more manageable for CHWs to reach a larger, concentrated population. Additionally, the CHWs in Kunene were the first to be trained, giving them more time to conduct relevant sessions, while the relatively low target made it more feasible to exceed expectations. The region's close-knit community, high need for health services, and effective community mobilization likely also contributed to the success of their outreach efforts.
- In Omaheke, the MOHSS-CHWs exceeded their target, while CHWs from CSOs performed well, coming close to meeting theirs.

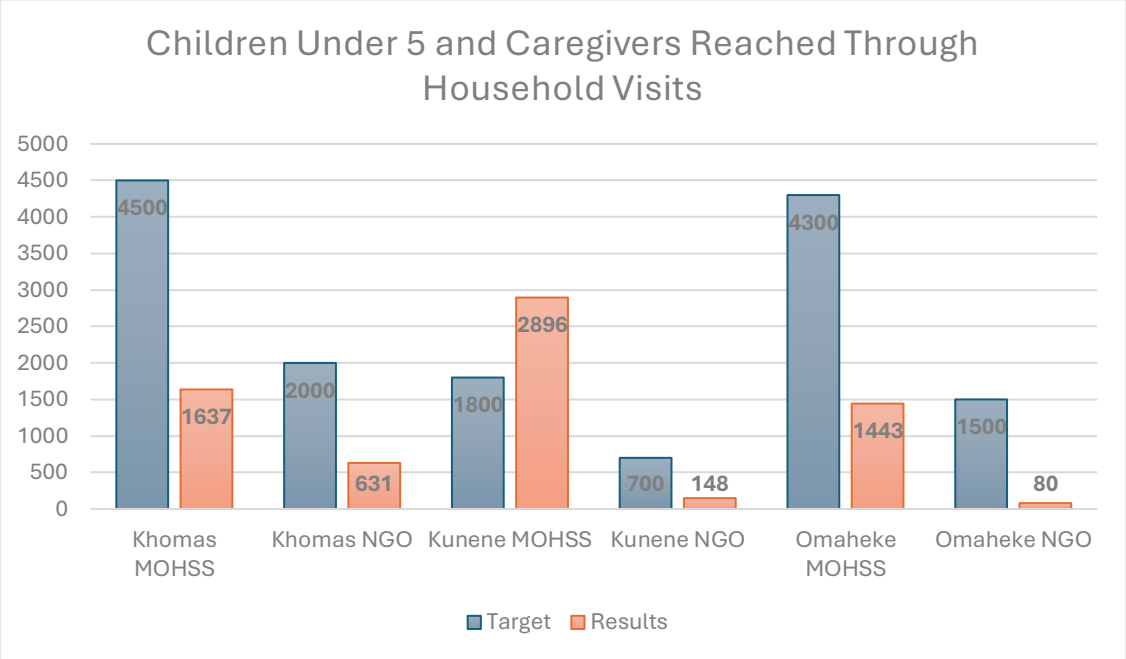
3.1.4. Household Visits by CHWs



Analysis:

- The Household visits by MOHSS-CHWs in Khomas were similarly below target as the community sessions, likely for similar reasons, such as shortest implementation period of all the three regions, CHWs having workshops to attend etc.
- CSO-CHWs' household visit results in Khomas were significantly lower than the community engagements, which can be attributed to CSO's programmes focusing more on community engagements and less on individual household visits.
- CSO-CHWs in Omaheke and Kunene did not reach the targeted number of households for similar reasons. In addition, we learned that they often conduct one-on-one interactions with community members, yet not necessarily visiting the house itself. This limits the number of households reached and is something to be included in future planning for not setting this specific target so high for CHWs from CSOs.
- Additional factors could include logistical challenges, such as transport and time constraints for visiting households, hereby affecting the number of visits conducted.
- Kunene's MOHSS far exceeded their target. Possible reasons for this success could include effective coordination, strong community engagement, longer period for implementation, as well as a relatively low initial target that was easier to surpass.

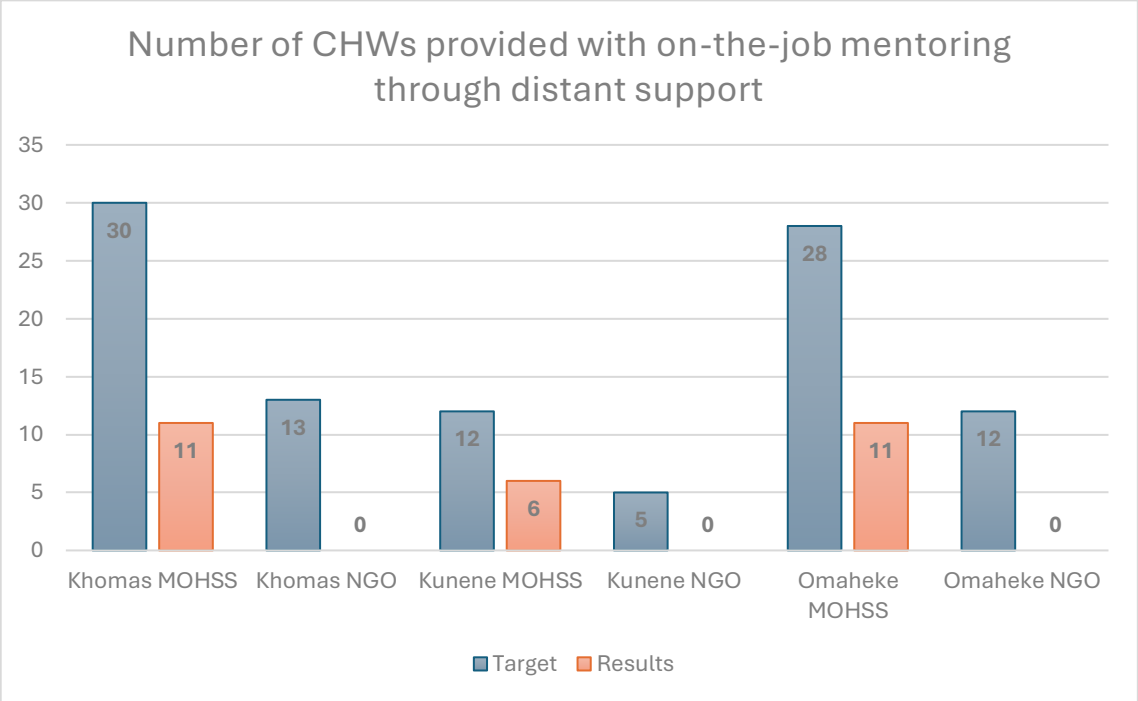
3.1.5 Children Under 5 and Caregivers Reached Through Household Visits



Analysis:

- Both Khomas and Omaheke experienced significant gaps in reaching children and caregivers, particularly among the CSOs (also in Kunene). As already identified under 3.1.4, this is understandable, as CSO's focus is primarily on community engagements and one-on-one sessions with adult clients in the community rather than children.
- In addition, in Kunene, only two CSOs participated, limiting their outreach capacity.
- Kunene's impressive results by the MOHSS-CHWs are attributed to their level of being organized and bigger window period for implementation, yet also because of the relatively low target set, according to the regional coordinator.

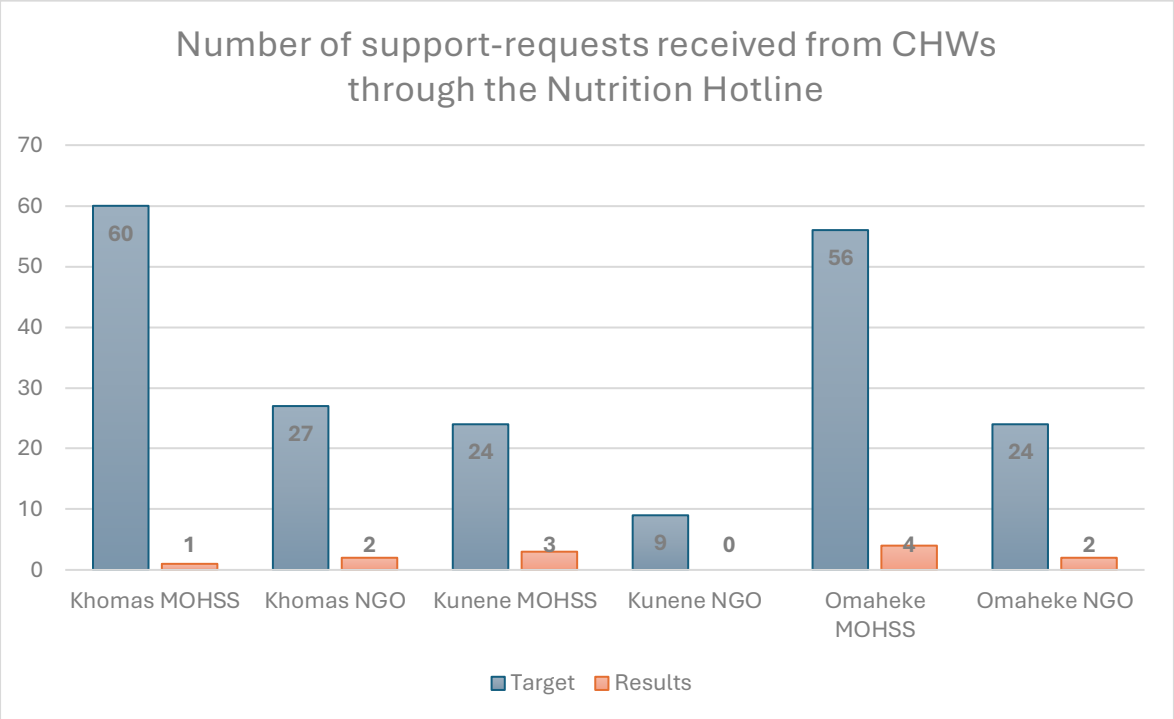
3.1.6 On-the-Job Mentoring via Nutrition Hotline



Analysis:

- **Communication Challenges & Novelty Factor**
    - While efforts were made during and after the training workshops to inform CHWs about the *Nutrition Hotline*, there may have been gaps in fully understanding its purpose, benefits, and how to access it.
    - This may also be because most CHWs are used to having their established reporting structures, while the concept of having such an additional hotline for mentoring and support is a very novel concept in the Namibian context.
- **Capacity, Resources and Workload**
    - Balancing multiple responsibilities, including other programmatic priorities, impacted the ability to dedicate sufficient time to promoting and delivering mentoring via the hotline, i.e. actively approaching and following-up with each and every trained CHWs in all the three regions.
    - From their side, the lack of smartphones or sufficient/continuous airtime or data to reach out to the nutrition hotline could also be a contributing factor.
- **Follow-Up and Coordination**
    - Follow-up and coordination with MOHSS' regional offices and CSOs to confirm participation or address potential barriers were conducted. However, only a handful of CHWs responded. More consistent and frequent follow-ups could have reinforced and strengthened the understanding of the concept and importance of the hotline and encouraged greater engagement.

3.1.7 Support via Nutrition Hotline



Analysis:

- The targets for support requests from CHWs to the nutrition hotline – as a novel model - were not achieved.
- The low numbers are partially because some CHWs - when contacted - did not report any issues requiring assistance.
- This could be due to many CHWs feeling confident in their work and not perceiving a need for additional support, as there are already established reporting and support structures in place.
- It could also be that the concept is new, and it may come across as too 'anonymous' - as well as a lack of active engagement from NAFSAN's side via the nutrition hotline.
- In addition, the implementation period of merely 2-3 months for such a novel concept is rather short and it may be too early to come to an ultimate conclusion on having a Nutrition Hotline.

3.2. Qualitative data

3.2.1 Locations of Community Engagements:

Community engagements took place at the following locations, listed according to how often a place was indicated in the M&E forms:

- Under a tree
- Clinic
- Water pump or water point
- Beer houses or shabeens or bar
- Informal settlements
- Dam
- Community members' homes
- Kindergarten or crèche
- Church
- Soup kitchen
- School

3.2.2 Common Topics During Community Engagements and Household Visits:

- Alcohol
- Breastfeeding
- Healthy diets
- Gardening
- Complementary feeding
- Water, Sanitation, and Hygiene (WASH)
- Mid-Upper Arm Circumference (MUAC) measurements
- Sugar consumption
- Water access and quality
- Malnutrition
- First 1,000 days of child development
- Sexual and reproductive health
- Pregnancy

3.2.3 Time Spent in Community Sessions:

- 15–30 minutes
- 45 minutes to 1 hour
- 1.5 to 2 hours

3.2.4 Nutrition-Related Interventions for Children and Caregivers

- **MOHSS** interventions were comprehensive, including MUAC measurements, weight tracking, referrals for malnutrition treatment, and immunization.
- **CSOs** like DAPP and COHENA, focused more on one-on-one counseling, primarily addressing adults rather than children, with no anthropometric measurements conducted. This is also due to their organizational and programmatic mandate, i.e. to work with people affected by HIV/AIDS and TB.

3.2.5 Types of Nutrition-Related Support Provided via the Nutrition Hotline

1. **Community Challenges with Gardening**:

   Many Community Health Workers (CHWs) reported that when providing nutrition education on gardening, community members often expressed challenges, such as:

   i. Lack of land for gardening.
   ii. Insufficient funds to purchase seeds.
   iii. Limited access to water.

2. **Suggestions for Addressing Gardening Challenges**:

   One CHW proposed a collective solution where community members contribute N$5 each to buy seeds for communal gardening efforts.

3. **Need for Guidance on Monitoring and Evaluation**:

   Some CHWs sought clarification on the proper use of the Monitoring and Evaluation (M&E) form to ensure accurate reporting and assessment.

4. **Addressing Child Neglect and Malnutrition**:

   One CHW encountered a case of child neglect and malnutrition. The recommended course of action was to escalate the issue to their supervisor and to involve the police if the situation would not improve.

5. **Positive Outcomes and Ongoing Challenges**:

   a. One CHW reported a reduction in malnutrition cases in their area, attributed to educating the community about backyard gardening.

   b. However, they highlighted a persistent challenge: due to a lack of shading, many plants are dying in the intense heat.

4. Community Feedback After Engagements:

1. **Financial Challenges**:
    a. Desire for jobs/money to afford nutritious food, as not all food can be grown.
    b. Seeds are expensive, and some lack funds for essential resources like fencing or gardening tools.

2. **Access to Resources**:
    a. Requests for government support to provide fruits, vegetables, or formula milk for malnourished children.
    b. Requests for boreholes, water tanks, and clean water access to alleviate water scarcity issues.

3. **Gardening Barriers**:
    a. Difficulty establishing backyard gardens due to lack of water, stony ground, or insufficient space (especially for those who are renting).
    b. Suggestions for practical demonstrations on gardening techniques.

4. **Cultural Beliefs and Practices**:
    a. Some cultural practices lead to early introduction of solid foods, considering exclusive breastfeeding in the first six months as insufficient.
    b. Concerns about the inability to breastfeed exclusively due to work commitments.

5. **Dietary Challenges**:
    a. Limited access to nutritious food due to high costs or distance from towns.
    b. Some are accustomed to basic diets (e.g., pap and milk) and express no dissatisfaction.
    c. Challenges avoiding processed foods since they are widely available in shops.

6. **Business and Employment**:

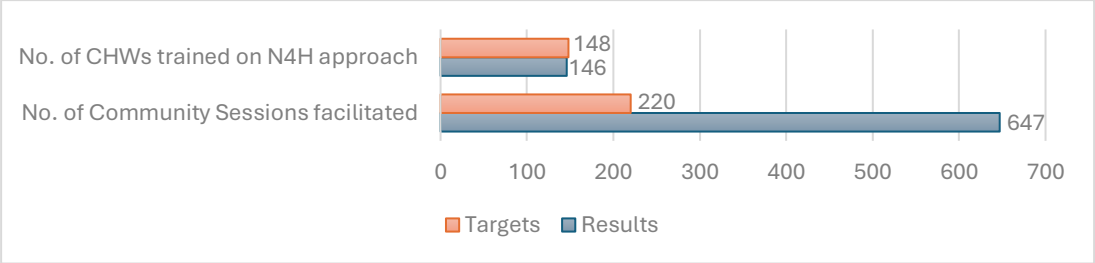
    Requests for support in starting small businesses or accessing guidance for entrepreneurial ventures.

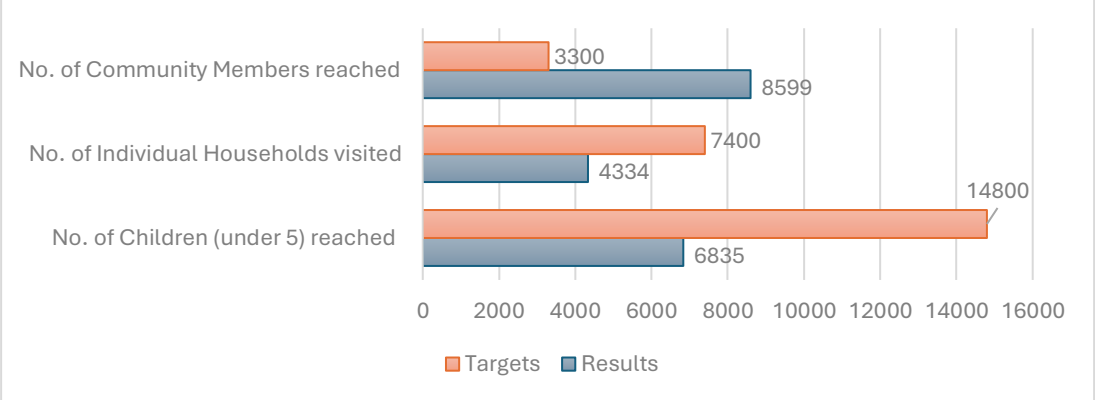
7. **Hygiene Needs**:

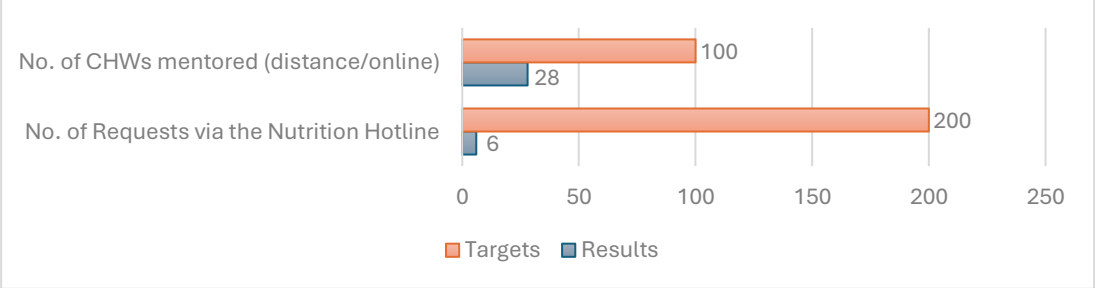
    Interest in tippy taps for handwashing at home.

5. Project Achievements, Challenges and Limitations

5.1. Overview of Project Indicators: Targets & Results







5.2. General Challenges and Limitations

1. **Delayed Project Start:** A delayed commencement of the project delayed the rollout, reducing the time available to produce desired results and fully implement activities.
2. **Late Flipchart Distribution:** The printing of flipcharts and manufacturing of the tailor-made carry bags took longer than anticipated, which is why they could not be provided to CHWs in Kunene and Omaheke during their training sessions. In addition, there were logistical delays with the distribution of the Flipcharts to the regions, which likely delayed the start of community sessions and may have affected the quality and consistency of the work conducted by CHWs.
3. **Conflicting Commitments for CHWs:** Some CHWs were occupied with workshops or other events and interventions/programmes during the monitoring and evaluation period, preventing them from conducting or recording sessions at that time.

4. **Inadequate Integration of CSO-CHWs:** Contact details for CHWs employed by CSOs were by accident not clearly collected, making it difficult to reach all of them for mentoring or support. On the one hand, this could have been better addressed in advance during the planning stage, while it also shows that CHWs from CSOs need to be better integrated into the overall system of providing healthcare for communities.
5. **Competing Priorities & Lack of Incentives:** CHWs from both MOHSS and CSOs are under significant pressure to deliver on a variety of targets and therefore might have competing priorities. They also may have lacked motivation to prioritize the project activities, whereby additional incentives (in addition to "Certificates of Participation" for the *Nutrition-for-Health* trainings) whether monetary or non-monetary, e.g., recognition of efforts or additional opportunities for professional development.
6. **Budgetary Challenges:** NAFSAN and WHO Namibia realized only during the early implementation stages that costs for transport and DSA for CHWs to attend the initial N4H training sessions was not provided for in the approved project budget. After brief discussions, NAFSAN was able to cover local transport for participants and WHO provided additional funding of N$ 201,152.00 to cover DSA for CHWs and MoHSS, so that the training of CHWs could go ahead without any further delays.

5.3. Explanations for Under-Achieved Targets

5.3.1. No. of Individual Households visited

- **Short Implementation Period**
    - Due to delays in formalizing agreements, finalizing and printing of materials, and liaising with MoHSS around logistical arrangements for the trainings, the overall implementation period was significantly shortened. The last of the six training workshops only ended on 7 September, leaving merely only 2-3 months for the implementation of community-based activities instead of the initially envisioned 5-6 months. This limited the time available for CHWs to conduct household visits before the end of the reporting period.
    - With a compressed timeline, CHWs had to balance multiple responsibilities, making it difficult to allocate enough time for household visits.
    - Omaheke and Khomas regions were trained last and therefore had the shortest implementation period among the three regions. The correlation between less time available for implementation and the number of households visited is also clearly reflected in graph 3.1.4. 'Household Visits by CHWs' on p.8 above.

- **Competing Priorities for CHWs (Workshops and other Programmes)**
    - As part of their overall duties, CHWs were required to attend other workshops and training sessions, which - while essential for skill-building and program quality - reduced the time available for fieldwork.

- Attending such sessions often required travel, adding further time constraints. Since CHWs work within a limited number of hours per week, any time spent in training meant fewer household visits could be conducted.
- Especially in the case of CHWs from CSOs, they have partially been involved in multiple projects based on donor-requirements, leading them to having to divide their attention and time across different interventions, making it difficult to meet all nutrition-project target indicators, especially around household visits.

- **Programmatic Focus on Community Engagements Rather Than Household Visits**
  - CHWs from CSOs in Khomas do not typically conduct household visits as part of their standard approach. Instead, they primarily share information with their clients through one-on-one interactions at their facilities or larger community sessions, such as group discussions, awareness campaigns, and workshops.
  - CSOs' strategic focus prioritizes reaching larger audiences through group-based sessions once rather than individualized household visits. The latter usually takes more time and resources per engagement.
  - Since community engagements align more closely with their core programme objectives, fewer efforts were directed toward conducting household visits, resulting in lower numbers in this category.

- **One-on-One Interactions Outside of Households**
  - Many CSO-CHWs in Omaheke and Kunene interact with community members in shared spaces such as community centers, health posts, markets, or public gathering areas rather than at individual households.
  - This approach allows them to provide essential information and services while adapting to cultural and logistical realities. In some communities, direct home visits may not always be welcomed or practical.
  - Because these interactions do not count as formal household visits under the current reporting structure, the recorded numbers appear lower even though CHWs are actively engaging with individuals at other locations.
  - Hence, there is a need to refine future target-setting and data collection methodologies to better reflect the realities on the ground of how CHWs operate in different contexts and how best they reach individual community members.

- **Logistical Challenges (Transport and Time Constraints)**
  - Many CHWs face difficulties accessing remote households due to a lack of adequate transportation. In the rather vast regions of Kunene and Omaheke with dispersed settlements, travel time between visits can be significant, limiting the number of households reached per day.

- Some CHWs rely on public transport, which may not always align with the time needed for fieldwork. In rural areas, transportation options can be infrequent or costly, further limiting mobility.

5.3.2. No. of Children (under five) reached

In general, this indicator is directly linked to "No. of individual households visited", therefore the same reasons apply and only some additional reasons are listed here:

- **Lower Household Visits = Fewer Opportunities to Count Children Under Five**
  - Since children and caregivers were counted during household visits, fewer visits meant fewer chances to record and report engagements with this target group.
  - Any barriers to household visits—such as CHWs' competing priorities, transport limitations, or programmatic focus on community-level engagements—also reduced opportunities to count children and caregivers.
- **CSO-CHWs' Focus on Community Engagements Reduced Household-Based Counting**
  - As discussed earlier, CSOs primarily engage with adults through community sessions or one-on-one interactions at facilities rather than household visits.
  - Since children under five are less likely to be present in these settings, this limited their direct engagement and their inclusion in the reported numbers.
- **One-on-One Interactions Outside of Households**
  - In some cases, CHWs conducted one-on-one interactions with community members outside the home rather than visiting individual households.
  - Since young children are typically at home with caregivers or at ECD centers rather than in public spaces, this approach did not effectively capture the intended target group, leading to underreporting.
- **Caregivers May Not Always Have Young Children Present During Visits**
  - In many households, children under five are in the care of other family members, at daycare, or play outside when CHWs visit, making engagement harder.
  - Even if caregivers are present, they might not always bring their children forward for engagement unless specifically asked about their child's health or well-being.

5.3.3. No. of CHWs mentored (distance/online)

- **Communication Challenges & Novelty Factor**
  - Despite efforts by the nutritionist to introduce and promote the *Nutrition Hotline* during and after training workshops, some CHWs may not have fully grasped its purpose, benefits, and/or how to integrate it into and use it for their daily work.

- The concept of a dedicated hotline for mentoring and support was very new in the Namibian context, and CHWs from both government and CSOs were more accustomed to using their traditional reporting and support structures. As a result, they did not as actively engage with the hotline as anticipated, viewing it as an unfamiliarand only optional tool rather than a routine support mechanism.
- In future, the nutritionist would need to highlight more of the various benefits of the Nutrition Hotline before, during and after community engagement sessions and individual consultations, including practical examples of how to use it. In addition, the Nutrition Hotline as such needs to be introduced to CHW's management within the structures of both government and CSOs, so they are also aware of these additional benefits, can encourage the use of it and can integrate it into the structured support mechanisms and strategies for CHWs.

- **Capacity, Resources, and Workload Constraints**
  - CHWs experienced resource constraints, such as a lack of smartphones, airtime, data or in some regions also limited network to reach out. This further impacted the ability to achieve mentoring targets related to the Nutrition Hotline.
  - The nutritionist, as the lead for this project, had multiple responsibilities beyond managing the hotline, including overseeing other programmatic priorities and ensuring overall project implementation.
  - With limited time available to focus solely on hotline engagement (e.g. reaching out to all ±140 trained CHWs) only a few direct follow-ups with CHWs were possible to encourage participation.

- **Follow-Up and Coordination Gaps**
  - Despite the nutritionist following up with MOHSS' regional offices and CSOs to confirm participation and address barriers, but responses from CHWs remained low. This is likely also due to competing priorities and multiple tasks to be performed by CHWs and their respective managers.
  - Proactive involvement of senior management of government and CSOs may have strengthened awareness and reinforced the importance of using the Nutrition Hotline for mentoring support and nutrition-related advice.
  - Given the nutritionist's broad project oversight role and the number of CHWs trained, additional support or delegation for follow-up efforts could be helpful in future projects to sustain engagement with CHWs and improve hotline usage.

5.3.4. No. of Requests via the Nutrition Hotline

In general, this indicator is directly linked to "No. of CHWs mentored", therefore the same reasons apply and only some additional reasons are listed here:

- **Limited Requests for Support from CHWs**
    - Many CHWs, when contacted, did not report any issues requiring assistance, leading to fewer-than-expected support requests.
    - Many CHWs contacted also said they felt confident in their work and did not perceive a need for additional mentoring or guidance through the hotline.
    - Established reporting and support structures were already in place, and CHWs tend to prefer relying on their usual supervisors and/or colleagues rather than seeking assistance through a new person and not yet familiar system.

- **Novelty of the Hotline and Perceived Anonymity**
    - The Nutrition Hotline, as a new concept, may not have been fully integrated into CHWs' routine support-seeking behavior.
    - Some CHWs may have found the hotline too 'anonymous' compared to the familiar and direct guidance they receive from their usual supervisors and/or colleagues, while they only had a short three days face-to-face interaction during the N4H-training with the nutritionist managing the hotline.
    - It may be helpful in future to develop a 1-pager (flyer) about the hotline, including a picture of who is managing it and a list of possible situations in which to use it, how to use it and what the various benefits could be.
    - Additionally, the level of proactive engagement from NAFSAN via the hotline may have been insufficient to encourage CHWs to make use of it. Without regular reminders or reinforcement, CHWs may not have felt compelled to utilize it.

- **Logistical Barriers: Mobile Network and Airtime Constraints**
    - Some CHWs, particularly those in rural areas, faced mobile network connectivity issues, making it difficult or impossible to contact the hotline consistently, as well as for NAFSAN to contact and get hold of them.
    - Even when network reception was available, a lack of airtime or mobile data posed an additional barrier, preventing CHWs from making calls when they needed support.
    - These limitations may have discouraged CHWs from using the hotline, as they could not rely on it as an easily accessible and convenient support option.

- **Short Implementation Period**
    - The hotline was introduced and implemented over a brief 2–3-month period, which may have been too short for CHWs to fully embrace the new system.
    - Given that behavior change and the adoption of new support mechanisms take time, this limited timeframe may not provide a full reflection of the hotline's potential effectiveness.

- A longer implementation period, coupled with continued awareness and engagement efforts, may be necessary before drawing final conclusions about the viability of the hotline model.

5.4. Specific Lessons Learned & Ways Forward:

A. Nutrition Hotline: Integration of novel approaches

- The introduction of novel approaches and systems, such as the Nutrition Hotline, requires a longer adaptation period before a meaningful uptake is noticeable.
- To expand beyond familiar reporting structures, additional efforts are needed, such as sensitization of and buy-in from senior management, as well as user-friendly information leaflet (including practical info and picture of who is 'behind' the Nutrition Hotline (i.e. responding to requests) to overcome the sense of anonymity of this new support tool.

B. Continuous Engagement, including Senior Management

- Initial training sessions are not enough. Ongoing/occasional follow-ups and positive reinforcement are necessary to ensure CHWs fully understand and utilize the new training materials, as well as the Nutrition Hotline.
- Increased engagement of Senior Management is needed to expand existing reporting and support structure with regards to nutrition awareness and engagement of communities, to ensure better integration of novel support systems like the Nutrition Hotline.

C. Balancing workload and adjusting targets for individual engagements

- CHWs balance multiple responsibilities and have to meet various targets (at times from different projects/programmes), making it difficult to prioritize nutrition-related initiatives and extensive household visits.
- CSOs naturally focus more on community-based engagements with groups and one-on-one sessions at facilities rather than household visits. So, future targets need to be adjusted to include individual consultations outside of households.

D. Longer implementation period for improved effectiveness

- The actual 2–3-month implementation window, and even the initial 5-6 month period was too short to accurately assess the impact of the intervention and also the effectiveness of new support strategies, such as the Nutrition Hotline. Hence, future initiatives should have a longer timeframe to enable proper measurement of impact, especially where behavioral change within communities and among CHWs and their respective management structures (both in GRN and CSOs) is involved.

6. Conclusion and Recommendations

6.1. Conclusion

Overall, the *Increasing Access to Quality Nutrition and Protection Services for Vulnerable Populations* project clearly achieved its targets in terms of training CHWs (146 of 148), who then reached almost triple the number of community members (8,599 of 3,300) through community engagement sessions (647 of 220). However, only approximately half of the targeted households (4,334 of 7,400) and children under 5 years of age (6,835 of 14,800) could be reached during the implementation period. As this capacity building measure will have an ongoing effect and CHWs will continue their work, it is certain that more households, children and community members will continue to be reached beyond this particular project.

The *Nutrition Hotline*, an integrated part of the *Nutrition-for-Health* approach to provide mentoring and support (= to ensure that correct nutritional information is provided by those who were trained as N4H-facilitators), has so far been underutilized. However, it was only possible to activate it over the last two month of project implementation.

Responses showed that the project demonstrated notable achievements in raising awareness about nutrition and improving community health outcomes across Khomas, Kunene, and Omaheke regions. Through training of CHWs followed by targeted community engagement sessions and household visits, the project provided essential information on balanced diets, breastfeeding, complementary feeding, and hygiene practices, as well as practical prevention and interventions for cases of moderate and severe malnutrition/undernutrition.

Despite these overall successes, important challenges were identified, such as delayed project implementation, late delivery of materials, and competing commitments by CHWs, which limited the project's ability to fully achieve its potential. Variations in performance across regions highlighted the importance of consistent communication, robust planning, and effective coordination to address logistical and resource-related barriers.

Differences in programmatic approach and priorities between CHWs employed by MOHSS and by CSOs will also need to be considered more, which will then also influence the setting of future targets, e.g. in terms of community engagements and household visits.

The low uptake of the nutrition hotline, which also provides for on-the-job mentoring and 'fact checking' support when it comes to sharing nutrition-related information, suggests the need for clearer communication of its benefits and ensure greater accessibility.

Additionally, factors such as deep-rooted cultural practices and wide-spread poverty and inequalities at the community level impact the ability to drive sustainable behavioral changes.

However, data collected during this project underscores the critical role CHWs play in reaching vulnerable populations and the value of community-based nutrition interventions. It became evident, that strengthening CHWs' capacity and equipping them with practical tools, innovative methods, skills and support, it is possible address malnutrition-related challenges.

6.2. Recommendations

As this was the first project of this nature, using the comprehensive ***Nutrition-for-Health*** approach and introducing the innovative *Nutrition Hotline*, valuable lessons can be learned to improve the effectiveness and sustainability of future projects, as a **scaling up** of this approach into other regions within Namibia is highly recommended, hereby **considering synergies** with ***RightStart Namibia***. In addition, the following recommendations are proposed:

1. **Strengthen Planning and Coordination:**
   - All partners to ensure that all financial and logistical aspects are reflected in the project budget from the onset, to ensure smooth implementation of trainings and timely distribution of materials to avoid delays in community-based activities.
   - Collect comprehensive contact information for all CHWs (including those from CSOs) at the outset of the project to facilitate communication and engagement.

2. **Set Realistic and Region-Specific Targets:**
   - Work more with local stakeholders to establish region-specific targets that reflect the unique circumstances and resources available by different organisations.

3. **Enhance Communication and Promote the Nutrition Hotline:**
   - Ensure the concept and benefits of the Nutrition Hotline is well understood, and se multiple communication channels (e.g., SMS, calls, WhatsApp groups) to ensure CHWs are aware of it and can easily access helpful resources and support services.

4. **Provide Adequate Incentives and Support:**
   - Offer incentives to CHWs, to motivate participation and improve retention.
   - Provide ongoing support to CHWs, not only through the Nutrition Hotline but also through refresher training and guidance on overcoming challenges in their roles.

5. **Increase Community Engagement:**
   - Conduct hands-on demonstrations for community members, e.g. on gardening techniques, hygiene practices or cooking, to address reported challenges.
   - Increase involvement of ECD Centers and multi-stakeholder platforms, such as the *RightStart Namibia*, to reach children under five and their caregivers more effectively, particularly in regions where significant gaps were identified.

6. **Address Systemic Barriers to Accessing Food:**
   - Advocate for government or donor support to address systemic challenges, such as **access** to clean water, seeds for gardening, and affordable nutritious food - rooted in poverty and inequality - and consider innovative and transformative solutions, like a Universal Basic Income (UBI = https://basicincome.org)
   - Better understand and develop culturally sensitive strategies to address dietary practices and beliefs that may hinder the nutrition-related behaviour change.

By leveraging lessons learned, future initiatives can build on this project's foundation to have even greater impact regarding nutrition and protection services for vulnerable populations.

Community Healthcare Workers (CHWs)

M&E Tool – Community Engagements

Target by October: ***3-4 sessions*** *per CHW*

CHW Name: _____ **Date (Weekly):** _____

Region: _____ *tick applicable box:* **MOHSS** ☐ / CSO (name): _____ ☐

Duty Station: _____

Indicators	**Figures** (weekly)	**Notes / Comments**		
Number of community engagements held on nutrition-related topics (*Nutrition-for-Health*)				
Duration of each engagement (in hours)				
Location of community engagements (list all)				
Number of community members participating in nutrition-related Community Engagements	**Men** (16+ years):		**Women** (16+ years):	**Children** (under 16 years):
Topics covered in community engagements				
Key outcomes and/or **important feedback** or questions/requests from community members				

***Community Healthcare Workers** (CHWs)*

Nutrition-for-Health **Hotline: 081-5553888**

M&E Tool – Household Visits

*Target by October: **40 households** per CHW*

CHW Name: _____ **Date (Weekly):** _____

Region: _____

Duty Station: _____

tick applicable box:

MOHSS	
CSO (name): _____	

Indicators	**Target** (weekly)	**Actual** (weekly)	**Notes / Comments**					
Number of households visited with nutrition-related discussions and/or interventions								
Number of caregivers reached and educated or advised/counselled through household visit								
Areas of nutrition education = Which key topics were discussed with different houeholds this week?	**Breast-feeding**	**Compl. Feeding**	**Healthy Diets**	**Alcohol or Drugs**	**SRHR**	**WASH**	**Garden-ing**	**Other (specify):**
***Number of times** these topics came up this week:*								
Number of children under 5 years reached, who live in or under the care of a household visited								
Nutrition interventions for children under 5 years: ➔ **Numbers of children during this week:**	**Measurements** (nutrition-related)			**Referrals** (Clinics/Hospitals)		**Other Referals:**	**RUTFs** given:	
	MUAC:	Weight:	Height:	MAM (moderate):	SAM (severe):		*('plumby nut'):*	
Other nutrition-related Interventions (please describe/explain briefly):								

MUAC = Middle-Upper Arm Circumference *SRHR = Sexual and Reproductive Health and Rights* *WASH = Water, Santation and Hygiene*