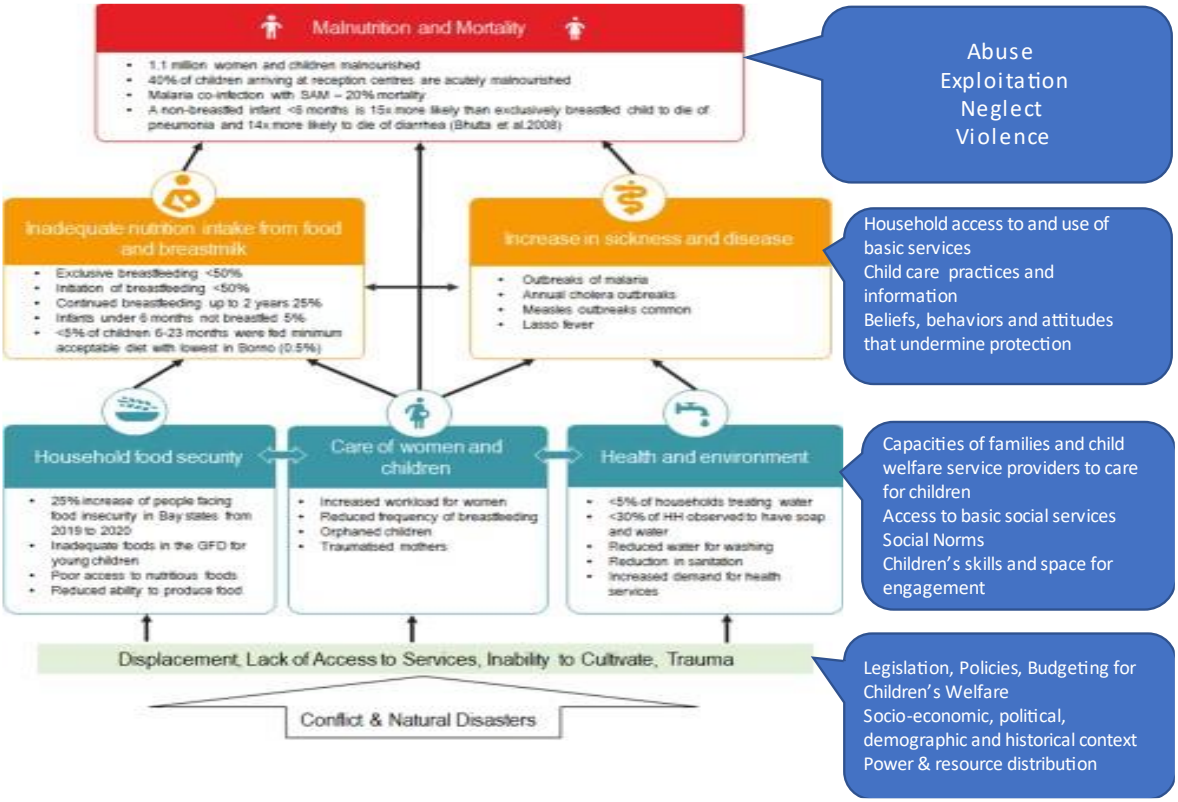
# SOMALIA NUTRITION AND CHILD PROTECTION[1] INTEGRATION FRAMEWORK

## 1. Introduction: Why integrate Child Protection in Nutrition?

During emergency situations, children are often vulnerable to malnutrition because they are dependent on others for their nutrition, care and wellbeing. Girls and boys face an increased risk of violence, abuse, neglect, and exploitation. Imbalances and discriminatory practices in terms of access to food and harmful traditional practices can be aggravated in times of crisis. For example, children in abusive families may be prevented from accessing food as a means of psychological abuse and/or punishment. Unaccompanied and Separated Children (UASC) without caregivers may face difficulty in managing their food, such as selling it for other goods, or not knowing how to cook hygienically and properly. If the needs and risks of children are not considered in nutrition programs, children may be at further risk of harm, abuse, neglect, and exploitation as they try to obtain access to food and nutrition. It is therefore important that all Nutrition workers are aware of the specific needs and risks of children and carry out their activities in a way that protects children and does not put them at risk of any further harm.

## Causes of Malnutrition & Linkages to Child Protection




### 1.1 Common Risks for Girls and Boys in Nutrition Programming

Common reasons why vulnerable children lack access to nutrition services and protection concerns that put vulnerable children at greater risk of malnutrition include:

- Mothers may not be able to breastfeed if there is no adequate safe and private space.
- Mothers may have difficulties breastfeeding their children due to their own psychosocial stress, infections, or other reasons.
- Lack of preventive actions to reduce the negative effects of unsolicited and unmonitored distribution of breast milk substitutes.
- Lack of appropriate and sustainable solutions for infants for whom breastfeeding is not an option.

[1] Based on "*Minimum standards on Child Protection in Humanitarian Action, Global Protection Cluster, Standard 22", p. 186*

- Unaccompanied infants (0-6 months) may not be breastfed and thus suffer acute malnutrition.
- Children may be exposed to further distress or abuse when handled by nutrition staff who are not trained on how to communicate appropriately with children, e.g., during therapeutic/supplementary feeding sessions.
- Children who are at risk, including those with disabilities, unaccompanied and separated children, children living in child-headed households, and children living in and working on the streets or in residential care, may not be included in nutrition activities that rely on parents/caregivers to access the programs.
- Children of family members who are sick, injured, or with disabilities may lack access to vital nutritional foods, income, and information on where to seek help.
- Children, especially those who are unaccompanied or living in child-headed households, may not consume foods provided by nutrition programmes because they do not know their important nutritional value or how to prepare the food.
- Food and nutrition priority needs of adolescent/teenage or child mothers are not often strategically addressed in targeting or service delivery.
- Children may be exposed to abuse or other forms of violence while left unattended as their mothers participate in nutrition program activities such as trainings or when in taking care of other sick children in nutrition treatment centres.

Child Protection is "the response to and prevention of abuse, neglect, exploitation, and violence against children". Child protection work is guided by the four child protection principles of the UN Convention on the Rights of the Child which include: non-discrimination; devotion to the best interests of the child; right to life, survival and development; and respect for views of the child. Both Nutrition and Child Protection programs aim at achieving these principles. In building strong collaborations between nutrition and Child Protection colleagues, these principles remain at the core of our work. Therefore, this integrated framework allows for actions between Child Protection and Nutrition actors to work together on the safety and well-being of children affected by emergencies in Somalia.

## 2. Common Strategic Objectives:

- Contribute to the right to life, survival, and development of children and their caregivers
- Ensure adolescent/child mothers are supported throughout pregnancy to enhance their psychosocial wellbeing, child caring practices and their protection
- Ensure children at risk and other vulnerable have access to nutritional and protection services
- Children are protected from all forms of abuse, exploitation, violence, and neglect.

## 3. Designing a Child-Friendly and Safe Nutrition Programme

Planning and preparedness actions need to be undertaken to ensure children, adolescents and youth are protected from harm during Nutrition activities and have equal access to vital Nutrition services. Below are some recommended actions, some only target Child Protection or Nutrition actors. Other actions target both child protection and nutrition actors. Note that not all the below actions will be feasible, it is important that you check with your colleagues which actions will be feasible. Boys and girls, especially those most vulnerable, must be consulted during needs assessments and throughout the Nutrition program design/delivery/monitoring/evaluation.

### 3.1 Planning and Preparedness Actions:

- Conduct joint needs assessments to gather relevant Child Protection and malnutrition data; think about joint rapid needs assessment.
- Enhance coordination through information sharing and discussion relevant to the wellbeing of PLW and children under five between the Nutrition Cluster and Child Protection AoR;
- Advocate for inclusion of IYCF approaches and materials in protection policies and guidance material, and vice versa (i.e. PSS guidelines);

- Utilise CHILD PROTECTION and malnutrition data to advocate for the needs of children 0-23 months of age and their caregivers with relevant authorities – conduct joint advocacy for greater impact;
- Ensure that the link between nutrition and child protection is explored in assessments and resources allocation (services, human, financial)
- Formalise information sharing and discussion relevant to the wellbeing of children under five, children in need of protection, and pregnant and lactating mothers, between the two sectors (debrief following assessments, monitoring, or data collection), and ensure time is taken to discuss the implications of this information for child protection;
- Standardise relevant Nutrition and Child Protection messages for this age group, particularly as they relate to care practices and the availability of relevant services. Jointly plan dissemination opportunities in one another's programmes
- Arrange regular meetings between child protection and nutrition staff to ensure that crucial issues, such as priority risk areas and vulnerability criteria are communicated and understood. Ensure nutrition staff regularly communicate with child protection colleagues to ensure the referral mechanisms are working.

### 3.2 Actions for Nutrition Actors:

- Ensure Child Protection staff are aware of which children are the most vulnerable in terms of their nutritional status. Child Protection caseworkers can be provided with MUAC tapes and trained in the screening and referral of acutely malnourished children.
- Ensure Child Protection staff and Nutrition partners know the particular protection concerns children face in your context and are aware of barriers to accessing nutrition services in your specific context.
- Incorporate questions about Child Protection and malnutrition in discussions with pregnant and lactating mothers and caregivers; questions should aim at understanding their needs and support priorities, needs; care and support practices such as traditional feeding practices, food taboos, traditional carers for infants, the role of siblings etc.; challenges they face.
- Ensure child protection staff know the patterns in household food consumption and which person in a household makes decisions about the type of food eaten, by whom it is eaten, and how much.
- Ensure child protection staff and nutrition partners know the nutritional situation of children in different kinds of care arrangements (i.e. children on the streets, children living in child-headed households, children with disabilities, children in residential care, and children in host families).
- Ensure child protection staff and nutrition partners are aware of whether women have difficulties breastfeeding their infants during their first 6 months, if possible, how many have these difficulties and the most common reasons for these difficulties.
- Ensure adolescent girls' nutrition needs (e.g., iron deficiency) are noted in needs assessments, and also provided with appropriate key nutrition messages.
- Where relevant, disaggregate assessment and monitoring data so analysis can be conducted for specific groups: pregnant women, lactating women under the age of 18, children 0-5 years, and children with disability. Review the recording procedures at all stages of the nutrition program; ensure to capture: - the age of the mother or caregiver, the number of children the mother or the caregiver has and marital status. Ensure that the presence or absence of mother/father/caregiver is recorded.

### 3.3 Staff Capacity Building can Include:

Train nutrition staff with a focus on the needs and concerns of children and their caregivers. To ensure that child protection risks are dealt with in a timely and efficient manner, it is crucial that the nutrition staff is educated on the following topics in trainings:

- Child safeguarding including the PSEA code of conduct and or the service provider's child protection policy.
- Appropriate communication with children to avoid further distress.

- Context-specific child protection issues and vulnerability criteria.
- Identification and referral of cases of abuse to child protection actors using established referral pathways.
- How to ensure children's access to nutrition services, particularly for excluded children, such as children living or working on the streets, children with special needs, children living in child-headed households, etc.
- Design/inclusion of Child Protection prevention and response messages in nutrition community outreach (e.g. broadcasting radio messages on protection from sexual exploitation and abuse during nutrition activities).
- Identification and referral of parents and caregivers who might be under psychosocial distress and need support in providing adequate nutrition to their children.
- Psychological first aid

## 4. Programme Implementation: How to Mainstream Child Protection into Nutrition

During programme implementation, it is important that child protection and nutrition field staff are equipped to take the following key programme implementation actions to ensure children are protected from harm during nutrition activities and have equal access to vital services. Nutrition actors should coordinate with the Child Protection actors to work with other clusters, where relevant, to ensure you have all the information needed to plan nutrition actions that keep children safe and with access to life-saving nutrition programmes.

### 4.1 Nutrition Staffing:

- Ensure nutrition staff are trained on the above-mentioned specific child protection issues in your context.
- Assign at least 1 staff member to act as **Child Protection focal point** at each nutrition centre. This can be either be a child protection or a nutrition staff member who is trained on child protection issues. *Ensure both male and female staff are assigned to nutrition centres*.
- Monitor whether children take part in nutrition activities, particularly vulnerable such as children living without adult care, children with special needs, or children whose parents are disabled.
- Educate and support mothers who have difficulties breastfeeding, and refer them to other services if necessary.
- Include discussions related to child protection, including psychosocial support and gender-based violence (GBV), in mother-to-mother nutrition activities. NOTE: *Ensure nutrition staff feels confident in having discussions related to child protection, if not comfortable, invite child protection actors to support with leading these discussions.*
- Ensure nutrition staff feels confident providing parents and caregivers with parenting tips concerning nutritional practices.
- Ensure nutrition actors understand their role in the identification of children in need of protection. They should be able to detect and refer but not intervene if there is a protection issue, which should be managed by a skilled staff.

### 4.2 Nutrition Centres:

- Ensure nutrition centres are at most 1 day's return walk for children from their homes (including time for going, receiving treatment, and returning home).
- Ensure nutrition centres are accessible, particularly for children and adults with special needs.
- Ensure nutrition centres provide adequate space and privacy for lactating mothers to breastfeed their children.
- Ensure the nutritional status of pregnant and breastfeeding women is monitored to ensure that their nutritional needs are being met.
- Ensure nutrition centres provide accurate and child-friendly information about the feeding session schedule. Double-check with children that they understand the schedule, particularly those in child-headed households, as they may not be able to read clocks or words.

- Clearly display the PSEA Code of Conduct and Child Protection Policy at nutrition centres, including in visual form.
- Ensure psychosocial stimulation activities for infants and young children take place.

**4.3 Therapeutic and Supplemental Feeding:**

- Ensure children are breastfed or, as a last resort, appropriate replacement feeding for unaccompanied infants or children whose mothers cannot breastfed. Where possible, these should be community members who have been breastfeeding their own infants.
- Assign a trained breastfeeding counsellor to nutrition centres or establish referral mechanisms for mothers who have difficulties breastfeeding.
- Ensure that, during feedings, children are either fed by or remain near their parents/caregivers whenever possible; this will reduce the child's stress and increase comfort during feeding.
- Ensure that parents/caregivers, not staff, are the ones who handle their children during therapeutic feeding, whenever possible. If no parent or close caregiver is available, staff can administer therapeutic feeding.
- Ensure that nutrition and child protection staff promote and support mothers' exclusive breastfeeding of infants for the first 6 months and continue breastfeeding, with appropriate complementary foods, through at least the second year of life.
- Educate adults and children, especially unaccompanied children, on how to prepare and store supplementary food in a hygienic manner as well as how and when it should be consumed.
- Ensure children know that they will not be penalised for reporting abuse.

**4.4 Referral Mechanisms:**

- Develop clear operating procedures for referral mechanisms between Child Protection and nutrition programmes (as already done but should be more regularly updated);
- Ensure teams have up-to-date information regarding detection and service availability for referral. Ensure referral follow-up with respective teams.
- Train Child Protection staff on active identification of children in need of nutritional support (case finding) and referral to the relevant structure.
- At early stages of an emergency and according to the context, agree on referral criteria and ensure cases that need urgent care are referred to the appropriate structure (e.g. separated children, infants under 6 months not breastfed, malnourished children).

**4.5 Community-Based Outreach**

- Child Protection activities and outreach programmes should consider needs and space for IYCF activities i.e. space for lactating women to breastfeed or mother-to-mother support groups to hold discussions in CHILD PROTECTION spaces;
- Extend community outreach by engaging members of existing community-based mechanisms to identify and refer children 0-23 months in need of case management and/or IYCF support. Ensure that the intervention is only referral and community members are trained to refer for skilled support instead of trying to intervene themselves.
- Train members of existing community-based mechanisms in key CMAM and CHILD PROTECTION topics contextualised according to their roles in the community.
- Whenever possible, organize joint community mobilization programmes particularly at child-mother centres (nutrition or CHILD PROTECTION). Include child protection messages, on prevention and response, as well as referral mechanisms, in activities related to nutrition, community outreach and raising awareness.

**4.6 Child-Friendly Spaces (CFS) and One Stop Centres**

- CFS/OSC can provide safe space for the delivery of nutrition programs, especially in locations that are far away from the OTP or SC's; likewise, OTP's can host a CFS.
- Co-locate Mother-Baby Friendly Spaces (MBFS) with Child friendly spaces.

- Refer siblings to child-friendly spaces while the caregiver attends nutrition programmes in order for children not to be neglected.
- Include nutrition topics into CFS parenting classes and vice versa with relevant Child Protection skills in parenting sessions;
- Work with Child Protection and health colleagues to brainstorm relevant psychosocial stimulation activities for infants and young children in nutrition programmes;
- Propose activities for mothers while their children go to CFS: these can be related to increasing caring skills or awareness; otherwise consider linking mothers with existing outreach or awareness activities such as those organised through the other clusters.

## 5. Monitoring and Evaluation of a Child-Friendly and Safe Nutrition Programme

The below action indicators are suggested but be sure to select from these indicators only those that apply to or can be adapted for your specific context and nutrition programme. You may come up with different indicators based on your specific intervention. These results can be documented and shared as ways to improve your programming and as lessons learnt on child protection mainstreaming. Be sure to disaggregate all data by sex and age.

| Action Indicators | Monitoring Tools |
|---|---|
| **I.** Percentage of supplementary or therapeutic feeding centres with a trained child protection focal point | OTP/SC reports |
| **II.** Percentage of nutrition centres and service centres for child protection activities where appropriate space is provided for women to breastfeed | Consultation with women and nutrition staff, evaluation of surveys |
| **III.** Percentage of nutritional feeding centres in which referral pathways for child protection cases exist and are used. | Program implementation reports |
| **IV.** Number of suspected cases of separation, violence, abuse, exploitation, or neglect identified through nutrition programmes and referred to child protection organisation | Nutrition- Child Protection Referral cards |
| **V.** Percentage of separated or unaccompanied infants placed in care arrangements with families that can continue providing the recommended nutrition support | Child Protection case management reports |

## 6. Proposed activity checklist for the Drought Response in Somalia OPA1 and 2:

- Joint training of Child Protection and nutrition staff conducted (yes/no)
- Child Protection staff oriented on CMAM and IYCF services (yes/no)
- Nutrition staff oriented on Child Protection and Child Protection services (yes/no)
- Referral mechanisms between Child Protection and programmes addressing malnutrition established and staff oriented (yes/no)
- Case Management Assessment forms for children 0-23 months include key questions related to IYCF (yes/no)
- Child-Friendly-Spaces and Mother-Baby-Friendly-Spaces are co-located (yes/no)
- Nutrition/IYCF messages included in child protection messages (yes/no)
- Child protection messages included in IYCF messages (yes/no)
- At least one child protection staff appointed as IYCF champion (yes/no)
- At Least one nutrition staff per OTP or SC appointed as a Child Protection champion/ referral focal point (yes/no)

**Further Resources:**

- Child Protection Working Group, *Minimum Standards on Child Protection in Humanitarian Action*, Standard 26 - http://Child Protectionwg.net/wp-content/uploads/sites/2/2014/03/Child Protection-Minimum-Standards-English-2013.pdf
- The Sphere Project, *Sphere Handbook,* p 139-239 - http://www.spherehandbook.org/~sh_resources/resources/Sphere_Core_Standards_and_CHS.pdf
- ChildFund International, World Vision, IRC, and Save the Children, *Inter-Agency Facilitator's Guide: Applying Basic Child Protection Mainstreaming in Training for Field Staff in Non-Protection Sectors* - http://resourcecentre.savethechildren.se/sites/default/files/documents/5340.pdf
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- Global Protection Cluster, *Protection Mainstreaming Training Package*, 2014 - http://www.globalprotectioncluster.org/_assets/files/aors/protection_mainstreaming/PM_training/1_GPC_Protection_Mainstreaming_Training_Package_FULL_November_2014.pdf
- Save the Children, *Ethical Guidelines – For ethical, meaningful and inclusive children's participation practice*, 2008 - http://childethics.com/wp-content/uploads/2013/09/Feinstein-OKane-2008.pdf
- Save the Children, *Practice Standards in Children's Participation*, 2005 - http://resourcecentre.savethechildren.se/sites/default/files/documents/3017.pdf
- ARC Resource Pack, *Foundation Module 4: Participation and Inclusion*, 2009 - http://www.refworld.org/pdfid/4b55d8d22.pdf