Nutrition and child protection

Children are particularly vulnerable to all forms of under-nutrition in times of instability and crisis, as they are dependent on others, and are often physically fragile. Children’s rights and wellbeing are often disastrously affected when families are forced to make difficult decisions about survival. Children drop out of school to search for food, may be forced into marriages or hazardous child labour, face increased levels of physical and sexual abuse and greater likelihood of abduction and trafficking, or are left behind or alone by parents who are searching for food. Evidence from droughts have also shown an increase in gender-based violence and recruitment into armed forces or armed groups that promise food and other benefits in conflict-affected countries. In addition, nutritional habits, food taboos and discriminatory access to food within the home can differently affect women, men, girls and boys, imbalances that can worsen in times of crisis. Research has shown that adverse childhood experiences can lead to long-term health outcomes and psychological impacts, which in turn may exacerbate and maintain conflict, perpetuate cycles of poverty and reinforce family and community instability. Both maternal and child care can be compromised in situations where caregivers – predominantly women – are unable to find time for care-related tasks as they struggle to secure food supplies, income and health care for their families. Child protection can promote care for both women and children, thereby lessening workload and increasing the time that mothers can devote to their families.
Breastfeeding is an absolute priority in infants under 6 months. However, e.g. young mothers suffering from psychosocial distress due to displacement, experiencing violence and/or loss of family members may experience difficulties in breastfeeding and even connecting to their children (children born as a result of rape are particular at risk). Poor food practices may result in an increase in chronic malnutrition. Child protection actors can help refer breastfeeding young mothers to nutrition programmes and nutrition actors may be able to identify distressed mothers through feeding programs and refer to child protection and GBV services. An integrated sector approach is a model based on inclusion, coordination and complementarity, valid for all sectors, and should be systematically applied.

Child protection concerns are reflected in the assessment, design, monitoring and evaluation of nutrition programmes. Girls and boys of all ages and their caregivers, especially pregnant and breastfeeding women and girls, have access to safe, adequate and appropriate nutrition services.

**Key actions**

**KEY ACTIONS FOR CHILD PROTECTION ACTORS**

22.1. Conduct inter-sectoral assessments followed by joint sector analysis and strategies, or support age and gender disaggregated data in all assessments and surveys conducted by nutrition colleagues. Ensure time is taken to discuss affected population common for shelter and child protection, implications of respective sector information for the other sector, and strategies for intervention for children of all ages;

22.2. Jointly decide coordination and information sharing mechanisms, as well as standard operating procedures including identification and referral mechanisms between child protection and nutritional programmes, including therapeutic feeding services;

22.3. Identify which pre-existing forums (e.g. refugee coordination groups or cluster meetings) are most useful for regular reviews of information on child protection and nutrition;

22.4. Jointly decide on key indicators, including measurement on children's perception and statements of safety;

22.5. Work with nutrition staff in identifying breastfeeding women and/or wet nurses (or, as a last resort, appropriate replacement feeding) for babies with no mother;

22.6. Whenever possible, provide appropriate space for women and girls to breastfeed within or near centres where child protection and caregiver outreach programmes are carried out;

22.7. Refer breastfeeding mothers who are facing difficulties producing milk;

22.8. Work with nutrition staff to identify patterns in household food consumption and those who make decisions about the type of food eaten and by whom it is eaten;

22.9. Whenever possible, run joint programmes with the nutrition sector in terms of community mobilisation, prevention messages and child-mother centres at the nutritional post (fixed or
mobile), including socially and culturally appropriate, technically accurate, messages on nutrition and breastfeeding;

22.10. [27] when appropriate and possible, include infant and young child feeding (IYCF) or supplementary feeding for at risk children in appropriate child protection activities;

22.11. [28] protect, promote and support exclusive breastfeeding for the first six months and then continued breastfeeding, along with age-appropriate nutritious complementary foods, through the second year of life and beyond;

22.12. [29] support families that are being placed in nutritional centres by following-up on temporary care arrangements for the other children while the mother is away; and

22.13. [30] lobby for the link between nutrition and child protection to be explored in evaluations and resource allocation processes such as the Post Disaster Needs Analysis or the Post Conflict Needs Analysis.

KEY ACTIONS FOR NUTRITION ACTORS

22.14. [31] wherever possible conduct inter-sectoral or nutrition/child protection assessments followed by joint sector analysis and strategies. [32] Ensure time is taken to discuss affected population common for nutrition and child protection, implications of respective sector information for the other sector, and strategies for intervention for children of all ages. [33] All assessments should include an analysis of market functionality that meets the Minimum Standard for Market Analysis (MISMA);

22.15. [34] jointly decide coordination and information sharing mechanisms, as well as standard operating procedures including identification and referral mechanisms between nutrition and child protection programmes, including psychosocial support and provision of quality and family based care;

22.16. [35] identify which pre-existing forums (e.g. refugee coordination groups or cluster meetings) are most useful for regular reviews of information on child protection and nutrition;

22.17. [36] identify minimum one trained child protection focal point or social worker within the nutrition programme, and make sure they are trained on identifying survivors of sexual violence, as well as basic psychosocial support, PFA and positive parenting support, etc.;

22.18. [37] monitor unaccompanied and separated children admitted into nutrition programmes;

22.19. include child protection messages, including how communities can respond and where to refer, in activities related to nutrition, community outreach and awareness raising;

22.20. [38] include discussions related to protection, including psychosocial support and gender-based violence (GBV), in mother-to-mother nutrition activities;

22.21. [39] ensure that nutrition programmes and associated livelihood activities take into account the effect that they can have on childcare practices;

22.22. [40] campaign for psychosocial stimulation activities for infants and young children in nutrition, education, early childhood development and child protection programmes;

22.23. [41] when generating community messages, consider the need to support caregivers who are grandparents, living with HIV, single parents, child-headed households or siblings and caregivers with disabilities; and
22.24. ensure that those working in nutrition have signed up to and been trained in a code of conduct or other policy which covers child safeguarding.

Measurement

<table>
<thead>
<tr>
<th>OUTCOME INDICATOR</th>
<th>OUTCOME TARGET</th>
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<tbody>
<tr>
<td>22.1. Percentage of nutrition projects where child safety and wellbeing,</td>
<td>100%</td>
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<tr>
<td>including family unity, are reflected in design, monitoring and evaluation</td>
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<tr>
<td>ACTION INDICATOR</td>
<td>ACTION TARGET</td>
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<tr>
<td>22.2. Percentage of health facilities and nutritional feeding centres for</td>
<td>70%</td>
</tr>
<tr>
<td>which referral pathways for child protection cases exist and are used</td>
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<tr>
<td>22.3. Percentage of separated or unaccompanied infants placed in care</td>
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<tr>
<td>arrangements with women who can safely breastfeed them</td>
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<tr>
<td>22.4. Number of suspected cases of separation, violence, abuse, exploitation or</td>
<td>To be determined</td>
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<tr>
<td>neglect identified through nutrition programmes and referred to child protection</td>
<td>in country</td>
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<tr>
<td>organisations</td>
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<tr>
<td>22.5. Percentage of child protection activity locations where appropriate space</td>
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<tr>
<td>is provided for women to breastfeed</td>
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<tr>
<td>22.6. Percentage of supplementary or therapeutic feeding centres with a trained</td>
<td>80%</td>
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<tr>
<td>child protection focal point</td>
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Guidance notes

22.1. Capacity building

Child protection actors, especially those working at community level in integrated nutrition/CP programmes, should be aware of:

- Appropriate IYCF messages and basic information about the aims and activities of the various nutrition programmes.
- How to measure and monitor the nutritional status of children and women in situations where no nutrition staff are available.
- How to identify mothers (women and girls) with breastfeeding or complementary feeding difficulties, in circumstances where no nutrition staff are available.
- How to identify malnourished and under-nourished children, as well as pregnant and breastfeeding women, in circumstances where no nutrition staff are available.
- How to refer identified cases to appropriate and available services.
Equally, nutrition staff should be aware of:

- How to identify and refer suspected cases of violence, abuse, exploitation and neglect of children, especially how to detect signs within nutrition activities.
- How to ensure access to nutrition services for specific groups of excluded children, such as children living or working on the streets, children with disabilities, children living in institutions, etc.
- How to include child protection prevention and response messages into community nutrition outreach (for example, broadcasting radio messages on protection from sexual exploitation and abuse during nutrition activities, making sure there are adequate numbers of female nutritional promoters, etc.).
- Appropriate ways to handle children – for example, when weighing children, the best person to place the child into the hanging weighing scales is often the mother.
- How to promote psychosocial stimulation for infants and young children.
- How to identify parents and caregivers who might be under psychosocial distress and need support.

To help with timely and appropriate referral, specific standard operating procedures and referral mechanisms should be agreed with child protection and nutrition actors. Preferably, this should be done at an inter-agency level, and at the cross-sector level (see Standard 1).

22.2. Child labour, family unity, and education

Where children and other family members are at risk of or suffering malnutrition, there may be a higher likelihood of children leaving the family, either to access paid work including hazardous labour or to access food (for example through entering residential care where food is provided). Equally, children’s access to other children may be affected as they may drop out of school for related reasons. A further threat to children’s care and to family unity is the splitting of families as caregivers leave to access paid labour. Care must be taken to understand these dynamics and the patterns of choices that families are making, and to ensure that nutrition interventions do not in any way incentivise separation of children from caregivers, for example by delivery of disproportionate benefits to children in residential care.

22.3. Infant feeding

Mothers who are having difficulties in breastfeeding should receive counselling and support to help them continue breastfeeding or to help them produce milk again if this is what is wanted. If HIV rates are high, consider whether finding breastfeeding women is appropriate, taking into account existing HIV guidance. Look at traditional and cultural infant-feeding practices and support and encourage the development of mother or caregiver support groups to promote and support breastfeeding. Infant formula may be given in certain cases for specific infants. Keep to the operational guidance on using infant formula in emergency situations (see References).

22.4. Mother groups

Mother-to-mother groups, developed in a nutrition programme, can be support groups in which sensitive topics such as sexual and gender-based violence or positive parenting can be discussed. By attending a group the main purpose of which is rearing children, a woman may feel free to talk, but...
will not feel labelled and may be protected from stigma. These mother-to-mother groups and peer support networks can help to break down the social isolation that can be caused by forced displacement, and create growing networks of social support. Mother-to-mother groups also provide an ideal forum for older mothers to educate younger ones. They can often help to tackle issues and challenges related to teenage mothers, children born out of sexual violence, etc. It is also important to explore appropriate ways in which to get fathers and other family members, such as grandmothers, involved in these kinds of activities, as these family members often have a say on what is eaten at home, who eats first and most, how long the breastfeeding period should be, and the access to nutritional care of family members.

22.5. Integrated malnutrition treatment and child protection prevention and response programmes

Integrated child protection and nutrition interventions may for instance include therapeutic feeding and supplementary feeding programmes to treat severe, moderate and acute malnutrition, as well as blanket feeding programmes using lipid-based nutrient supplements or fortified blended foods, connected to child protection programmes, such as positive parenting programmes or child friendly spaces. It could also take shape through nutrition and CP connected case management or through essential packages of support, when breastmilk supplements (BMS) are needed, with cooking and feeding equipment, minimum WASH standards, access to healthcare services and the monitoring of appropriate care and a system for referrals for psychosocial support and other services. All therapeutic, supplementary or blanket feeding beneficiaries should meet the admission criteria as set out by national and international procedures on nutrition. Specific efforts should also be made to ensure that:

- Services do not lead to stigma or perceptions of “favouritism”
- Services do not become a pull-factor away from family or community feeding habits.

22.6. Vitamin A

All supplementary or feeding and nutrition programmes should use foods rich in or fortified with vitamin A to strengthen children’s immune systems, reduce the effects of measles and diarrhoea, reduce child deaths in at-risk populations, and help prevent childhood blindness. Specific efforts should also be made to promote improved quality of food given to children, especially those aged six to 24 months, by promoting the use of fortified products such as fortified-blended foods, micronutrient powders or lipid-based nutrient supplements, as well as other nutrient-rich diets in general.

22.7. Social workers

Having specialised child protection focal points or social workers at nutrition sites can help to bolster child protection considerations. These focal points can, for example:

- Help families if a child has died.
- Strengthen efforts to prevent children being separated from their families at the sites.
- Support with positive parenting, psychosocial support and child resilience programmes.
- Help to identify possible cases of separation, violence, abuse, exploitation or neglect of children.
- Help appropriately to refer cases, mediate within families and follow up on cases as necessary.
- Support families with practical help to overcome barriers to accessing nutrition services –
for example, if a mother has to take her child to the nutrition centre at the same time as she collects the general food distribution, by advising on what procedures to follow to enable her to do both activities.

- Support work in raising awareness of child protection issues among nutrition staff as well as caregivers and community members attending sites.

References

[102] IASC (2005), *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. Chap. 4.6
[105] UNHCR (2011). *Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations*
[106] UNHCR Policy Related to the Acceptance, Distribution and Use of Milk Products in Refugee Settings
[111] CPWG (2015?): *A Matter of Life and Death*
[112] Sphere handbook 2018; forthcoming