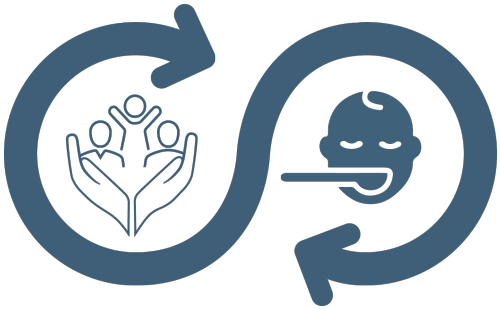
STANDARD 25: NUTRITION AND CHILD PROTECTION

The following should be read with this standard: Principles; Standard 21: Food security and child protection; and Standard 24: Health and child protection.



Nutrition and child protection actors have key opportunities for collaboration, particularly in children's first three years of life and during adolescence. Nutritional habits, taboos and discrimination within the home can affect diverse members of the population differently. Children, particularly pregnant girls, are vulnerable to all forms of undernutrition. Children with disabilities are particularly vulnerable to malnourishment and related impairments. Nutritional imbalances often worsen in times of crisis when caregivers struggle to provide food, income and health care for their families. Mothers' and children's health, rights and well-being are especially vulnerable.

STANDARD

Children and their caregivers, especially pregnant and lactating women and girls, have access to safe, adequate and appropriate nutrition services.

25.1. KEY ACTIONS

KEY ACTIONS FOR CHILD PROTECTION AND NUTRITION ACTORS TO IMPLEMENT TOGETHER

25.1.1. Adapt existing nutrition and child protection assessment and monitoring tools, methodologies and indicators for joint identification,

analysis, monitoring and response to households at risk of malnutrition and/or child protection concerns:

- Collect baseline data on children's nutrition and protection status;
- Include children's own perceptions in all monitoring and assessments;
- Disaggregate data by gender, age and disability, at a minimum; and
- Include measures and verification on children's perception of safety and the status of their care arrangements.

25.1.2. Agree upon the most effective multisectoral mechanism for sharing information generated by assessments, evaluations and analysis.

25.1.3. Identify common areas of concern to both nutrition and child protection through consultation with communities, including children.

25.1.4. Establish joint prioritisation criteria for inclusion of children and households at risk of malnutrition and/or child protection concerns.

25.1.5. Implement integrated response interventions for households at risk of malnutrition and/or child protection concerns for children of all ages throughout all phases of the programme cycle. Interventions may include:

- Community mobilisation;
- Mother-to-mother support groups at health facilities and in communities;
- Psychosocial stimulation activities for infants and young children;
- Therapeutic feeding services; and
- Infant feeding sensitisation programmes.

25.1.6. Document and address any unintended negative consequences where child protection concerns are improving or worsening the nutrition situation.

25.1.7. Coordinate interventions throughout all phases of the programme cycle by:

- Identifying any pre-existing coordination groups; and
- Deciding on the best coordination mechanism to use between the two sectors.

25.1.8. Review at regular intervals the connections and collaboration between child protection and nutrition. Reproduce promising practices.

25.1.9. Ensure an adequate representation of children in decision-making processes and community-based participation structures related to nutrition. (See Principles.)

25.1.10. Include child-friendly (a) child protection messages in nutrition interventions and (b) malnutrition prevention messages in child protection activities.

25.1.11. Train nutrition staff on child protection concerns, principles and approaches so they can correctly refer disclosed or identified child protection cases.

25.1.12. Develop and implement child-friendly, multisectoral referral mechanisms and standard operating procedures so that nutrition and child protection workers can safely and efficiently refer both child protection and malnutrition cases. Determine if malnutrition should be a case management criterion.

25.1.13. Establish joint data protection protocols and confidential referral mechanisms for children and families who have experienced or are at risk of abuse, neglect, exploitation or violence.

25.1.14. Collaborate with children and other stakeholders to design, establish, implement and monitor joint, child-friendly, accessible and confidential feedback and reporting mechanisms for child protection concerns.

25.1.15. Ensure that all staff are trained on and sign safeguarding policies and procedures.

KEY ACTIONS FOR CHILD PROTECTION ACTORS

25.1.16. Include information and referrals for nutrition services (including therapeutic feeding services and infant feeding sensitisation programmes) in child protection activities that maintain the confidentiality of children and families.

25.1.17. Identify existing child protection services and mitigate any gaps, bottlenecks or barriers to children's access.

25.1.18. Identify and refer to the nearest health centre or nutrition team:

- Households and children who are at risk of undernutrition;
- Breastfeeding women and adolescent girls, especially those facing difficulties producing milk; and/or
- Children with disabilities or children who have difficulty suckling or swallowing.

25.1.19. Identify breastfeeding women and/or wet nurses (or, as a last resort, appropriate replacement feeding) for babies with no mother.

25.1.20. Identify patterns in intra-household food consumption and decision-making.

25.1.21. Distribute food and supplies.

25.1.22. Perform basic nutrition screenings.

25.1.23. Conduct basic nutrition response monitoring activities.

25.1.24. Provide appropriate spaces for breastfeeding girls and women at all community gathering places run by humanitarian actors such as registration centres, distribution sites, etc.

25.1.25. Support programmes that reduce child malnutrition and protection risks. (See 25.1.5.)

25.1.26. Provide infant and young child feeding (IYCF) support or supplementary feeding when possible during child protection activities.

25.1.27. Protect, promote and support exclusive breastfeeding for the first six months and then continued breastfeeding (along with nutritious, age-appropriate, complementary foods) through the second year of life and beyond.

25.1.28. Organise breastfeeding classes and peer support groups for adolescents who are pregnant and/or breastfeeding to raise awareness of the nutritional and health benefits of breastmilk.

25.1.29. Follow up on temporary care arrangements for children whose caregivers are placed in nutritional centres.

25.1.30. Advocate for the identification of connections between nutrition and child protection in evaluation and resource allocation processes, such as the *Post-Conflict/Disaster Needs Assessment*.

25.1.31. Conduct child protection screenings in nutrition facilities and programmes to determine the safety and care status of all children in the household.

25.1.32. Work with nutrition actors to facilitate discussions on early childhood development and child protection in mother-to-mother nutrition activities.

KEY ACTIONS FOR NUTRITION ACTORS

25.1.33. Establish mechanisms for child participation that enable all nutrition interventions throughout the programme cycle to:

- Be safe, accessible, inclusive and protective for all children, even the most vulnerable; and
- Address children's different genders, gender identities, ages, disabilities, developmental stages, nutritional needs and family settings.

25.1.34. Train nutrition staff to work with child protection actors to (a) identify parents who are in distress or at risk of negative coping mechanisms and (b) provide basic psychosocial and positive parenting support.

25.1.35. Train at least one staff member in each nutrition team to be a child protection focal point, if not the whole team.

25.1.36. Train child protection teams on basic nutrition screening techniques (such as measurement of mid-upper arm circumference) where feasible.

25.1.37. Reach all members of the affected population with assistance by:

- Using assessments to identify children who may have difficulty accessing food;
- Identifying barriers to access for different groups;
- Identifying and implementing strategies to overcome barriers; and
- Registering all adult women as the main recipients of assistance in contexts where polygamy is practiced to avoid excluding subsequent wives and their children.

25.1.38. Conduct a risk analysis during programme design that assesses the:
- Safety risks involved in accessing distribution sites and markets;
- Requirements for recipients, such as literacy or identification;
- Best timing for any interventions; and
- Needs of specific groups, such as those caring for young children.

25.1.39. Involve all subgroups of the affected population in designing, implementing and monitoring nutrition interventions, particularly those for children and caregivers who require additional support.

25.1.40. Provide beneficiary cards to child heads of households and children who are unaccompanied or separated so they can access assistance in their own names.

25.1.41. Work with child protection actors to (a) discourage families from intentionally separating to access additional benefits and (b) avoid making children targets of theft or exploitation.

25.1.42. Monitor children at risk (children who are unaccompanied and separated, etc.) who are admitted into nutrition programmes.

25.1.43. Assess and address any possible impact nutrition programmes and associated activities may have on childcare practices.

25.2. MEASUREMENT

All indicators about children should be disaggregated by sex, age, disability and other relevant diversity factors. The indicators below measure progress against the overall standard. Indicators and targets can be contextualised with the goal of meeting the indicative targets below. Additional related indicators are available *online*.

Indicators	Target	Notes
25.2.1. % of identified health facilities and nutritional feeding centres that accept referrals of children in need of services.	80%	Identify the facilities through a service mapping exercise and monitor them. These are facilities that meet quality standards as identified by child protection staff. Specify 'children in need of services' in-country (such as infants in need of lactation services or services for malnourished children).
25.2.2. % of supplementary or therapeutic feeding centres with at least one focal point trained in child protection.	100%	A timeframe by which to measure this indicator should be determined in-country since staff turnover can be high (such as monitored quarterly).

25.3. GUIDANCE NOTES

25.3.1. CAPACITY BUILDING

Child protection actors should understand how to:

- Present basic information about infant and young child feeding and the aims and activities of available nutrition programmes;
- Measure women's and children's nutritional status;
- Identify children who do not have equal access to nutrition services; and
- Identify and refer malnourished children and pregnant and breastfeeding women.

This is especially important for actors who work at community level, in integrated nutrition and child protection programmes or where no nutrition staff are available.

Nutrition actors, especially those who work without access to child protection staff, should understand how to:

- Identify and refer suspected child protection cases;
- Provide nutrition services to children at risk;
- Promote child protection in community nutrition outreach by, for example, (a) including information on safeguarding in nutrition radio messages and (b) hiring adequate numbers of female nutritional promoters;
- Promote psychosocial stimulation for infants and young children;
- Identify caregivers who might need support and implement psychological first aid for adults and children; and
- Use child-friendly communication skills.

25.3.2. CASEWORKERS

The role of child protection actors or caseworkers at nutrition sites may include:

- Helping families whose child has died;
- Supporting positive parenting, psychosocial support and child resilience programmes;
- Identifying and assessing possible child protection cases, including child separation;
- Supporting families to overcome barriers to accessing nutrition services;
- Raising awareness of child protection issues among nutrition staff, caregivers and community members; and
- Referring children and families to appropriate, multisectoral services.

25.3.3. FAMILY-LEVEL RISKS

Family separation may become more likely where malnutrition exists. Children or caregivers may leave to find paid work, including hazardous labour. Families may place their children in residential care so that their children can access food. Children may drop out of school and lose peer support. All actors must (a) understand these dynamics and the choices that families are making and (b) design nutrition interventions that do not encourage school dropout, family separation or child labour.

25.3.4. INFANT FEEDING

Breastfeeding is important for a number of health and development outcomes (such as strong mother-baby attachment). Mothers experiencing difficulties breastfeeding should receive counselling and support if so desired. Provide existing guidance to mothers living with HIV to enable them to make informed decisions about their options. Ensure programmes are informed by an understanding of traditional and cultural infant-feeding practices. Encourage mother or caregiver support groups to promote and support breastfeeding.

25.3.5. INTEGRATED MALNUTRITION/CHILD PROTECTION PROGRAMMES

There are many opportunities to integrate approaches, including:

- Joint case management;
- Holistic support for accessible services;
- Encouragement for appropriate care and nurturing;
- Joint programmes with therapeutic, supplementary or blanket feeding and positive parenting; and
- Multi-use spaces that meet both sectors' needs.

All those targeted by feeding programmes should meet the admission criteria established by national and international nutrition protocols. Services should never (a) encourage stigmatisation, (b) indicate 'favouritism', or (c) interfere with healthy family or community feeding habits.

25.3.6. CHILD PROTECTION MAINSTREAMING

If an integrated approach is not possible, mainstream child protection into nutrition interventions. For example, peer support networks and mothers' groups can help address challenges felt by adolescent mothers, adolescent mothers who were pregnant following sexual violence, etc. Include fathers and other family decision-makers, such as grandmothers, in similar activities since they often have significant influence on household food choices.

REFERENCES

Links to these and additional resources are available *online*.

- *'Food Security and Nutrition'*, *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*, Sphere Association, 2018.
- *'Food Security and Nutrition'*, *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, IASC, 2005, pp. 49–52.
- *Women, Girls, Boys and Men: Different needs – Equal Opportunities (IASC Gender Handbook in Humanitarian Action)*, IASC, 2006, pp. 105–110.
- *Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers Version 2.1*, IFE Core Group, 2007.
- *UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations*, UNHCR, 2011.
- *Guidelines for Selective Feeding: The Management of Malnutrition in Emergencies*, UNHCR and WFP, 2011.
- *'Nutrition'*, *Including Children with Disabilities in Humanitarian Action*, UNICEF.
- *Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and Their Very Young Children in Emergency*, ACF International.
- *Integrating Early Childhood Development (ECD) Activities into Nutrition Programmes in Emergencies: Why, What and How*, UNICEF and WHO.