

# Women Adolescent and Young Child Spaces: Responding to women and children's needs in emergencies

Global HEA, Health, Nutrition and WASH



## Acronyms

CBO	Community Based Organization
CDK	Clean Delivery Kit
CWBA	Child Wellbeing Aspirations
CWBO	Child Wellbeing Outcomes
CWBT	Child Wellbeing Targets
CFS	Child-Friendly Space
CFW	Cash for work
CHW	Community Health Worker
CiE	Children in Emergencies
CMAM	Community-based Management of Acute Malnutrition
EC	Emergency Contraception
ECD	Early Childhood Development
FP	Family Planning
GBV	Gender-Based Violence
HPV	Genital Human Papilloma Virus
IYCF	Infant and Young Child Feeding
LLIN	Long Lasting Insecticidal Nets
MHPSS	Mental Health and Psycho-Social Support
MNCH	Maternal Newborn and Child Health
MUAC	Mid-Upper Arm Circumference.
NFI	Non-Food Items
NGO	Non-Government Organization
PFA	Psychological First Aid
PLHIV	People Living with HIV
PLW	Pregnant or Lactating Women
cPMTCT	Community based Prevention of Mother-to-Child Transmission of HIV
SBA	Skilled Birth Attendant
STI	Sexually Transmitted Infection
TB	Tuberculosis
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene:
WAYCS	Women, Adolescent and Young Child Spaces
WV	World Vision

## Executive Summary

Some of the most vulnerable groups after an emergency are women and children, many of whom are not be able to access services, are voiceless in community consultations and risk malnutrition disease and death.<sup>1</sup> During conflict women and children are at an increased risk of violence, including rape. Over 80% of the 42 million people displaced by conflict and disasters are women, children and youth.<sup>2</sup> Humanitarian contexts can increase detrimental family coping mechanisms including reducing quantities of meals, skipping school, early marriage, increasing hours involved in paid labour and reducing food intake and access to health care which increase mother's and children's vulnerability towards malnutrition and disease.

World Vision's focus on ensuring that the wellbeing of children and their family is protected after emergencies, has led to the development of the **Women, Adolescent and Young Child Space** (WAYCS) model to ensure that the Child Wellbeing outcomes (CWBO) and targets are considered. The model fits within an Infant and Young Child Feeding in Emergencies (IYCF) intervention and not only caters for mothers and children under 24 months, but for women of reproductive age and children up to 59 months (if there is not Children in Emergencies (CiE) program to meet their needs) and their families. This model has a specific health and nutrition focus, but includes activities that will support other sectors including protection, food security and livelihoods, Water and Sanitation and Hygiene (WASH) etc.

Some additional interventions can include

1. Promotion of adequate nutrition for women, children and adolescents
2. Support for pregnant women
3. Promotion of good health and hygiene
4. Support for young mothers and families
5. Family planning, emergency contraception and support to survivors of gender based violence (GBV)
6. Provision of a safe recreational space that benefits women and infants
7. Encouraging men to support women's and infant's health and nutrition
8. Psychosocial Support to families
9. Information and support around protection issues
10. Support to adolescents (girls and boys with priority to girls)

There is no single way these spaces should be implemented to support women and their families. Each space needs to be contextualized to the community and disaster event. Community leaders, both male and female need to be engaged in the assessment of needs and the development of activities, to ensure community acceptance protection for women and their children.

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### CASE STUDY:

#### Women and Infant Friendly Spaces (WAIFS) – Pakistan 2010

After the 2010 Flood, WV Pakistan established 16 WAIFS in 8 Districts in Sindh, Punjab and KPK to address infant nutritional support, primary health care, reproductive health, nutrition and psychosocial support for over 20,000 women. The WAIFS were established near health facilities, and provided a forum for women to interact and re-establish their lives. Activities included breastfeeding support, nutrition, health and hygiene education, sewing, embroidery, cooking and literacy training and social interaction with other women, when normally they would be confined to their home or tent due to cultural norms.

The program ensured that 79 births were registered, over 2,000 families were referred for birth spacing, and over 2,500 women and children were referred to health and nutrition facilities and 500 women accessed breastfeeding support or the breastfeeding corners. Over 3,500 support sessions were conducted and approximately 1,000 women were trained in psychological first aid and 400 women were provided with specific psychosocial support or referral.

Focus group discussions with men after the response found that 70-80% felt that the women in their families had benefited from increased knowledge of health and nutrition and were better able to care for their families and seemed happier in the home.

<sup>1</sup> [http://www.who.int/gender/other\\_health/disasters/en/index.html](http://www.who.int/gender/other_health/disasters/en/index.html)

<sup>2</sup> Women's refugee commission, (2009) *Refugee Girls: The invisible faces of war*.

## I Introduction:

### Why do we need Women Adolescent and Young Child Spaces?

World Vision has adopted the Child Wellbeing Aspirations (CWBA), outcomes (CWBO) and targets (CWBT)<sup>3</sup> to improve the lives of children in their programs. This project model has a particular focus on women who are pregnant or with children up to 36 or 59 months. Children over 59 months are usually catered for by child friendly spaces (CFS).<sup>4</sup> This model builds upon an Infant and Young Child Feeding in Emergencies (IYCF) response within a breastfeeding space or tent (see WV NCoE document)<sup>5</sup>, but supports pregnant women and mothers with older children as well. The needs of the community and disaster context will guide which specific groups need to be supported and activities to include. This model has been developed out of responses in Haiti, and Pakistan which linked health, protection, child protection and mental health and psychosocial support (MHPSS). This document was developed after requests from the field, as a guide to help program managers develop activities for women and young children and *should* be read in conjunction with tools and models developed by other communities of practice

This model targets women and children who are often the most vulnerable after an emergency. They may not be able to access services, can be voiceless in community consultations and experience increased risk of malnutrition, disease and death.<sup>6</sup> For example over 80% of the 42 million people displaced by conflict and disasters are women, children and youth,<sup>7</sup> and humanitarian contexts can result in detrimental family coping mechanisms such as reduced meal and food intake, extending hours of work and undertaking risky activities for income or accessing basic needs and reduced access to health care which increases mother's and children's vulnerability towards malnutrition and disease.

This model will have greater impact if it is closely linked to other sectors. As well as IYCF activities, the model can offer emotional and psychosocial support for women and their children, improved child care and early childhood development, and health education to reduce the risk of malnutrition, communicable diseases and death, protection awareness and access to basic female and infant needs. Though the model focuses on women of child bearing age and young children other sections of the community should not be forgotten, such as men, adolescent boys, and older women. It aligns with the guidance from other international agencies including UNICEF and the nutrition cluster who are advocating for baby friendly areas or breastfeeding corners in communities or health centers,<sup>8</sup> and UN Women's safe spaces for women's protection and economic support.<sup>9</sup>

#### 1.1. What are the main components of the model?

This is not a definitive model that requires all the following elements to be included to ensure its success. Activities need to be contextualized to the community and disaster event. Community leaders, both male and female should be engaged at all levels of the project design and implementation, to ensure community acceptance for the activities and that women and infants are not placed at risk. For example in Haiti support for women and children was done shelter by shelter with a short daily meeting providing health and nutrition education and support in a meeting place in the camp. In Pakistan, a tent or permanent shelter was established in a village, camp or health centre where women were able to bring their infants and spend large parts of the day in a private female only space, learning new skills, receiving health education and nutritional screening. The decision on what activities are included will also depend on what other interventions are being done by WV and other agencies in the same area.

##### a. Core activity

Promotion of Infant and Young Child Feeding in Emergencies including breastfeeding and re-lactation support <sup>10</sup>

<sup>3</sup> The Child Wellbeing aspirations, outcomes and targets can be found at the following link. <https://www.wvcentral.org/cwb/Pages/Aspirations.aspx>

<sup>4</sup> The target group of this intervention will depend on the context of the emergency and the needs of the community. The suggested target group is based on the need to support women and infants who may not be covered in other programs. This may mean that adolescent girls need to be included as they are not able to attend child protection activities due to age or cultural reasons (such as in Pakistan) and infants over 3 years may be included if they are not catered for in the child friendly spaces or emergency education programs.

<sup>5</sup> WVI (2011) *Supporting breastfeeding in Emergencies: The use of Baby Friendly Tents*

<sup>6</sup> [http://www.who.int/gender/other\\_health/disasters/en/index.html](http://www.who.int/gender/other_health/disasters/en/index.html)

<sup>7</sup> Women's refugee commission, (2009) *Refugee Girls: The invisible faces of war*.

<sup>8</sup> WVI (2011) *Supporting breastfeeding in Emergencies: The use of Baby Friendly Tents*

<sup>9</sup> UN Women (2012), *Field Guidelines for women's friendly spaces*

<sup>10</sup> IFE Core group (2007) *Infant and young child feeding in emergencies (Version 2.1): Operational guidance for emergency relief staff and programme managers* [http://www.who.int/nutrition/publications/emergencies/operational\\_guidance/en/index.html](http://www.who.int/nutrition/publications/emergencies/operational_guidance/en/index.html)



One simple way to reduce the risks of illness in young infants is the early initiation of breast-feeding (within one hour after birth) exclusive breastfeeding for the first 6 months of life and continuing breastfeeding at least to 24 months, along with introduction of safe, nutritionally adequate and appropriate food. This intervention alone can prevent 22 per cent of child deaths.<sup>11</sup> In emergency situations where clean water is scarce, kitchen supplies are lacking and the environment is dirty, breastfed infants have the superior benefit and protection from diarrhoea because they can get the nourishing, clean breast milk from the mother. Mothers also are stressed and lack privacy, which may lead to reduced breastfeeding or stopping breastfeeding altogether. After disasters women may find that increased stress may temporarily interfere with their milk flow, and a common misconception is that mothers who are stressed mothers or have inadequate hydration or nutrition can no longer breastfeed. This may result in an inappropriate request for, or donation of, infant formula, milk products and baby food. Preventing inappropriate infant feeding practices or improving breastfeeding can be an efficient way of protecting the infant's nutrition status and thus preventing malnutrition and disease. In addition with limited or even different food supplies mothers may need advice on how to feed their children nutritionally adequate diets using the limited food available.

## **b. Additional activities based on community needs can include**

### **11. Promotion of adequate nutrition for women, children and adolescents**

Disasters and displacement can affect the nutritional status of the whole family, initially food is in limited supply, there may be little variety, and what is available may be foreign to them. The WAYCS is an ideal place to provide information about good nutrition for pregnant and lactating mothers and their children and adolescent girls. For example, there could be cooking demonstrations for the new foods, sessions on fortification to improve nutritional value or just sharing of recipes that the families enjoy with the new foods. Referral and screening to therapeutic and supplementary feeding programs for malnourished women and children. Information sharing on new technologies, like fuel efficient stoves. And for long-stay programs (i.e. women staying all day) nutritious snacks can be prepared for women and children

### **12. Support for pregnant women**

There will always be pregnant women affected by a disaster and they may not be able to access suitable antenatal support. The WAYCS could provide referral to skilled birth attendants and provision of clean birth kits (CBK) to visibly pregnant women or even provide the services of a midwife on a periodic basis to provide counselling and support such as performing ante natal care or post natal in a private space.<sup>12</sup> Information sharing about nutrition and healthy living practices during their pregnancy (e.g. not smoking, getting adequate rest etc.). In some cultures women in the later stages of pregnancy may be required to stay indoors, which can be restrictive or difficult if they are confined to tents or temporary shelter, but provision of a women only safe environment may enable them to meet with others and access the services that they need. Special care needs to be taken for young teenage mothers, in support and ensuring access to skilled birth attendance.

### **13. Promotion of good health and hygiene**

The humanitarian context may mean access to good health care is limited and changes in the living environment expose families to more health risks and poor hygiene. These informal spaces can mobilize women around good health and hygiene including communicable disease prevention, recognition of the signs of personal and childhood illnesses and the importance of timely health seeking behaviour; the appropriate and consistent use of LLITN in malaria endemic areas and good menstrual hygiene (including the distribution of female hygiene needs). The importance of bathing and hand-washing at appropriate times, water treatment and storage, good sanitation and waste disposal practices. Issues around reproductive health e.g. birth spacing, access to contraceptives including emergency contraception, STI prevention and treatment; HIV prevention and care can also be discussed and information on function health and nutrition centres, vaccination campaigns referrals provided where needed.

### **14. Support for young mothers and families**

Disrupted environments mean young mothers (especially those with their first child) may not have the space or support from family and peers to deal with their own or children's social and health needs. Families may stop playing with infants due to unsafe surroundings, or limited space. Child focused activities may not cater for infants under-three or five years of age. Additional activities may be needed to support the specific needs of adolescent mothers and care givers

### **15. Family planning, emergency contraception and support to survivors of gender based violence (GBV)**

For women affected by disasters or conflict, access to Emergency Contraception (EC) and Family Planning (FP) services is not only a right, but also a critical need that can help to maintain and improve their reproductive health. Women may no longer be able to access their normal family planning needs, or decide that their circumstances change and they do not want

<sup>11</sup> Women's Refugee Commission (2009)

<sup>12</sup> <http://www.womendeliver.org/knowledge-center/facts-figures/maternal-health/>

to become pregnant at this time. Having access to FP products will enable them to make informed decisions and reduce the risks of unwanted pregnancy. Displaced women are frequently victims of gender-based abuse, where men wielding power demand sex in exchange for safety, food or other commodities. Access to emergency contraception (EC) provides women and adolescent girls with an opportunity to avoid an unplanned or forced pregnancy, and reduces the risks associated with childbirth, or abortion. Young female adolescents may be the group most in need of EC as they are often targeted for sexual exploitation and rape yet, because they are not yet mothers they are not included in maternal and child health programs.<sup>13</sup> It should be noted that EC pills should be provided in accordance to World Vision guidance (issued in July, 2012)<sup>14</sup>, host county protocols, and refugee cultural values.<sup>15</sup> Because EC is appropriate for emergency use only, clients should be offered information on other contraceptive methods that they can use on a regular basis to protect themselves from unplanned pregnancies. It is important to inform clients that although EC should not be used as a regular contraceptive method, its recurrent use will not pose a health risk. In the early days of a humanitarian emergency, it is helpful to identify midwives and traditional birth attendants to discuss sexual violence and EC. They can also be given a supply of EC pills once they are educated about EC and what it can and cannot do. For example, EC pills should be taken as soon as possible (within 120 hours) after exposure to pregnancy and for already pregnant women, EC will not interrupt the pregnancy.

#### **16. Provision of a safe recreational space that benefits women and infants**

Engaging people in recreational activities can refocus their attention from stress related events, activities such as games afternoons, social events and community celebrations can refocus participants and lead to joyful anticipation and forward thinking. Craft, such as sewing and embroidery mean that women could learn from each other and produce clothing to replace those that have been lost in the disaster providing a possible income source<sup>16</sup> (It should be noted that any skill building for livelihoods needs to be done after a market assessment to ensure that there is not an oversupply of items. This project is probably not the place to plan longer term income generation activities). Women can be assisted to make toys for their children with local products. Social activities can enable that special events and significant milestones can be celebrated in an appropriate manner.

#### **17. Encouraging men to support women's and infant's health and nutrition**

Men and older women in the family are often decision makers on matters affecting women's and children's health and nutrition. It is important to engage them in decision making, information sharing to enable them to protect the health and nutritional status of their women and children. Men should also be encouraged to be directly involved in caring for and feeding their children. Timing of these sessions need to be suitable for men to attend, and may need to be segregated.

#### **18. Psychosocial Support to families**

The effects of a disaster and disruption to family life, can lead to increased stress and isolation. A place where women with children can meet to discuss and reflect on their needs and develop strategies to cope with the change will help them in re-establishing their lives. This may be the place where women can be empowered to deal with issues in the home and community including dealing with conflict or expressing their needs to their family in a culturally appropriate way. Training in Psychosocial First Aid (PFA) for community members could be included. Information is so important to a person's wellbeing and especially in cultures where women do not get information, other than from their families the WAYCS can be a central place where women can get information about what is happening, what are their entitlements, where they can go for physical, emotional, spiritual or medical support, and who is offering these services.

#### **19. Information and support around protection issues**

As a central meeting place for women, the WAYCS can be where women can discuss protection issues, express their concerns and complaints and get information and referrals for services that they and their children need including birth registration, GBV support, tracing, support for unaccompanied and separated children and families.

#### **20. Support to adolescents (girls and boys with priority to girls)**

<sup>13</sup> The Minimum Initial Service Package outlines a series of priority actions that respond to the reproductive health needs of populations in the early phase of humanitarian crises. More information is available at [www.rhrc.org/MISP/english/index.html](http://www.rhrc.org/MISP/english/index.html)

<sup>14</sup>

<https://www.wvcentral.org/community/health/Documents/Emergency%20Contraception%20Technical%20Brief%20July%20202011%20FINAL%20long%20version.docx.pdf>

<sup>15</sup> Country specific EC protocols for more than 50 countries are found at [www.emergencycontraception.org](http://www.emergencycontraception.org).

<sup>16</sup> WVPakistan(2010) *Woman and Infant Friendly Space Program* (internal paper). Families had lost everything, and as it was the fasting month of Ramadan, many mothers were concerned that they did not have any resources to make new clothes for their family for Eid (the festival at the end of Ramadan). WVP provided sewing machines, cloth, cottons etc, and a local tailor spent time with the women teaching them how to make clothes for their children, and older women, taught younger women embroidery so that they decorate the clothes and also earn additional income.

Where adolescent girls<sup>17</sup> are unable to attend child friendly spaces, this may be a location to provide health, nutrition information and access to basic needs such as female hygiene products, reproductive health education, training opportunities and referrals. It is important to also include adolescent boys in any educational activity and depending on the culture may be at the same or different times.<sup>18</sup> (See Appendix 10.2 for more details on possible responses for adolescents.)

## **1.2. How does the project model contribute to WV's ministry goal and specific child well-being outcomes, and reflect WV strategies?**

The main focus of this model are around the Child Wellbeing outcomes relating to health and nutrition including children are well nourished, children are protected from infection, disease and injury and children and their caregivers access essential health services, and the targets around health nutrition and wellbeing. It aligns with the Health, Nutrition and HIV DADD for acute emergencies providing a focus for many of the community focused activities and referrals to services within the community whether provided by the national government, WV or other organizations.

## **2. Context considerations**

### **2.1. In which contexts is the project model likely to work best?**

This model is planned for emergency contexts where there are large numbers of women and infants who are experiencing stress from the disaster. In most cases the women will have been displaced and living in temporary shelter in camps (formal and informal) or near their damaged homes. It may also be useful where women are living with host communities in cramped living conditions and they need some space and time out from living in another person's home

### **2.2. In which contexts should this model not be considered?**

This is a *short term* program to meet the needs of a disaster affected community. It *should not* be planned as a *long term* program, and if the community wants to extend the program, transition plans need to be made to develop community led women and children's programs. Integration and collaboration with other groups responding to the needs of women and infants, needs to be made from the start, and where other agencies are working with the same group, identifying a specific gap that WV can fill is important.<sup>19</sup>

### **2.3. Information and assessments that staff should collect if they plan to adapt this model**

#### **a. Who else is working with women and children**

##### Formal groups and organizations

Before a disaster - contact details and locations of government departments/service providers, NGOs and other groups that are providing services for women and infants and share proposal concepts. For example

- *Local Disaster Management Department* - evacuation points, evacuation procedures, registration of agencies, and development of MoUs and designated lead agencies etc.
- *Ministry of health* - proposed referral centres and health facilities that cater specifically for MNCH and nutrition. Approved health, hygiene, HIV, nutrition and breastfeeding messages, local staff including midwives, nutritionists, paediatric nurses who may assist in programs or provide community education.
- *Community health workers (CHW)*- who usually run the health and nutrition promotion programs in the community
- *Departments of Women's Affairs. Social Welfare, Education* - services and staff who could provide assistance
- *NGOs CBOs and UN agencies operating in project area* – their plans and resources and staff that they can contribute.
- *Faith based communities and leaders* – local resource people

After the disaster - ensure that this contacts and links are maintained and check with

- *The government, NGOs CBOs and UN* on planned responses, locations of activities and supporting staff that meet the needs of the women and infants.

<sup>17</sup> The age that a girl is considered adolescent will depend on the culture and may be as young as 10 or 11 as conservative parts of Pakistan or after puberty in other areas. In some cultures it may not be appropriate for girls to attend CFS or education centres even when they are gender segregated. In this case the WAYCS may be the most appropriate place for them to meet together.

<sup>18</sup> In WV India's research study re: HIV and AIDS prevention program for adolescent girls in Mumbai in the early 90s, the first recommendation by the girls themselves is to include boys. Similarly in Kenya & Tanzania in mid-90s where both sexes requested for an adolescent-friendly health services – they opted to go on Saturdays when clinics are not being used by the general population.

<sup>19</sup> In Pakistan in 2012, WVPakistan set up WAYCS in Jeloasi Camp to cater for women and infants health and psychosocial needs. In the same camp there were other women's centres run by other agencies focusing on reproductive health and GBV, economic development, and female education. All centres were open to all women, and they self selected the ones they wanted to participate in. It is important to ensure that there is complementarity in services not competition

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- Regular engagement with relevant *clusters* – Health, Nutrition, WASH, Protection
- Sharing of assessments and other reports with relevant agencies including number of pregnant women, families with infants under 6 months, under 36 months, female and child headed households etc.

### Community and vulnerable groups

Consultation is needed with representatives from the community and marginalised groups such as: PLHIV, elderly, disabled, and sex workers, minority ethnic, religious or cultural groups, CHW to develop the programme. Family decision makers from before a disaster need to be engaged as well as the affected women in any programme and activities. For example older women and men may feel disenfranchised when they see younger women and children are getting all the assistance, and feel they are no longer able to make decisions about their extended families

- Engage with community leaders, religious leaders, CHW engaged in health and nutrition activities, women's and youth groups about the concept of a women's space, and ensure they are included in assessments, location and structure for activities, setting up of programme and monitoring of activities.
- Be aware of practical barriers (language, meeting locations) that can inadvertently exclude some groups
- Obtain commitment from male and female leaders and husbands/fathers for the support of the program and their willingness to allow women to attend with their children.
- Establish a committee (with male and female community members) to manage and select site, and suitable community members to facilitate activities.
- Provide regular meetings and information sessions with men and older women for activity updates.
- Ensure the centre is a place of information exchange regarding the response, including comment boxes for those too shy to speak out in public meetings about the quality of the program or staff.

### **b. Working with other sectors and organizations**

Whichever department that manages the programme needs to work with the other sectors to ensure that the needs of women and their families are met. For example: if space is limited in camps then project facilities may need to be shared. Some of the sectors to consider are:

- *WASH* - provide floor mats or clean flooring, latrine and washing facilities near where the women will meet, and appropriate WASH items such as female hygiene kits. Safe drinking water or water purification tablets and containers for storing drinking water, and safe waste disposal.
- *Children in Emergencies/Education in Emergencies/MHPSS* - regarding child development activities. Can activities be run at the same time and next to, or nearby to enable mothers waiting for children in the Child Friendly Spaces to benefit from the program?
- *Protection* - regarding safety and protection issues in the community, safe access to WAYCS and other services, safe and unsafe cultural practices, tracing and family reunification.
- *Health* – filling of gaps such as referrals to health and other related services, (e.g. could a midwife or nurse visit on a regular basis), health and hygiene promotion activities, psychological first aid, HIV&AIDS awareness, distribution of health related NFI including clean delivery kits, LLITN etc?
- *Accountability and Liaison* - to ensure that women can hear what is going on and understand their entitlements, voice concerns and get feedback. (This is especially important where women do not normally mix with people outside their immediate families)
- *Camp Management* – to ensure that there is no overlap of services and programs are accessible at appropriate times.
- *Livelihoods* – especially if the program includes skills training or income generation activities
- *Nutrition and food aid* - for appropriate nutrition support and targeting to ensure that women and infants within the program are also part of targeted food aid programs. It may also be necessary to have healthy snacks for mothers and older children if they are in the centre all day. Links to CMAM programs and other IYCF programs in the community
- *Security* - regarding location of activities and ensuring that women and children are safe while at the programme but also in travelling to and from activities.

### **c. Engage the community from the beginning**

Some points to consider as part of an assessment (many items can be part of a preparedness plan)

#### ***Safety and appropriateness***

- What are the main threats (physical and psychological) for the women, adolescents (especially girls) and infants?



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- Will the WAYCS program diminish or increase these threats?
- How many visibly pregnant women, women with children <6 months; 6-36/59 months, and infants without female carers and adolescents are in the affected area? How are they being identified and registered as part of regular programs?
- Are women with disabilities or carers of children with disabilities able to come to location and will they face any stigma?
- What cultural practices did women have with their infants before the disaster, and who made the decisions about health, breast feeding and infant feeding, women's behaviour etc, and has anything changed? Who else needs to be involved to ensure that safe practices will be continued?
- What are the women doing now, and what time is the most suitable for women to attend? Are there any at risk community members who cannot attend (example female headed households, pregnant women, minority groups, women or children with disabilities)?
- Is the site in a safe location, both for women to attend and movement from their homes to the centre?
- What hours should the centre run (1-2 hours day, 24/7) and do you have trained staff and volunteers available?
- Number of women and infants in the community and number of facilitators. (Probably no more than 15 women and infants to a facilitator at one time)
- What facilities are needed? Are women separated from men, and does the centre need to have a tent and boundary wall (e.g. Pakistan) or can women meet in a public meeting space (e.g. Haiti)?
- Is there space to have confidential conversations if women want to discuss health or psychological needs, gender based violence or other abuse?
- Are there other activities for women organized by other organizations that WV can partner with who can offer health promotion, MHPSS or HIV&AIDS education?

### *Community engagement*

- Are processes to assess needs and select beneficiaries transparent and well publicised? Will the community be involved in this selection?
- How will the community view the setting up of women and infant spaces? Will the community/religious/clan leaders support the activities or undermine anything that takes women out of their home space?
- Can the community support and provide facilitators? Who are the people that women already go to for advice and assistance?
- Is there a mechanism for the community to provide feedback about the program and other WV activities?
- Will the community set up a committee to help manage it or integrate it with other committees such as Protection, WASH or health?
- When is the best time to run the centres (example, in the morning, in the afternoon after women have completed their chores, all day for women to drop in for breastfeeding with targeted activities at set times)?
- Is there a need for staggered activities for different groups through the day, e.g. women and infants, adolescent mothers and single girls, older women?
- How can you involve men into the program?
- In a conflict context: What are community and other local actors' perception of the identity of project staff? Is WV perceived to have any role in the conflict?

### *Site Selection*

- Where do women with children meet, is the site suitable for the community as a whole, and does it provide adequate privacy and safe access routes?
- Is the site near to where women do their chores, work and have access to older children who will not be attending the centre? Is it near the health centre so women can use it as a waiting room (e.g. Pakistan)?
- Is the site chosen accessible to all groups, regardless of their background, ethnicity, etc or are there any barriers that can exclude certain groups?
- Is the site hazard free, cleared of rubble and rubbish,
- Is there adequate shade, protection from the weather and dust and can this be provided with tent, tarpaulin or building? (note in hot environments a tent may be too uncomfortable to women to meet in e.g. Ethiopia)
- Are there facilities such as lockable latrines, washing areas, and adequate drainage to prevent contamination of the area close by? How far are other facilities such as health centres, nutrition centres,

- and distribution sites?
- Who owns the land/ building and how long is it available for women to use?
- Are women and infants protected from further risks such as abuse, violence, further disasters such as flooding, fighting, aftershocks from earthquakes etc?

### 3. Who are the key target groups and beneficiaries of this model?

Women of child bearing age, young children (0-36/59 months)<sup>20</sup> and adolescent girls are the main target groups, men, older women including grandmothers, community and faith leaders and teachers (especially when catering for adolescents) should not be forgotten. They need to understand the WAYCS concept and why women, young children and adolescents are targeted. Any WAYCS program should have regular community, father, grandparent or adolescent meetings to provide ongoing information about what the program is doing and receive feedback. Depending on the context adolescent girls who are not mothers may be included if there are no other programs catering for their needs. Pregnant adolescents and adolescent mothers are considered to be part of any mothers targeted in the program. However it is important that there are also separate sessions for this group as there may be issues that they are facing that they do not feel free to share with older women.

A major concern with any program targeting women is to ensure that the most vulnerable and marginalized women are included. Some specific groups may be sex workers, ethnic or religious minorities, women or children with disabilities etc. The program staff need to consider how to get the messaging and information to these women and ensure that they are included in distributions and have access to relevant information and support. It may mean that separate sessions are needed for minority groups to benefit from these services Life cycle stages to which the model contributes

### 4. How does the project model work?

#### 4.1. Overview of approach/methodology

The approach will vary depending on what activities are implemented. Some key components include

- Assessment of the needs and other actors and possible partners
- Engagement of the community in understanding what the program will do. Where possible set up a committee or social group that can guide the selection of activities.
- Identification of local facilitators who can guide and supervise the program. They need to be trained in PFA.
- Linkage with other groups and sectors that can provide support and inputs.

For more details see section 2.3

#### 4.2. What potential partners could/should be involved?

This program is a temporary response to the needs of disaster affected women and infants. As it needs to reflect the needs of families, the potential partners will depend on who is present in the community at the time. It is desirable that all government and community groups that are functioning are engaged in supporting the program. Their roles will also depend on the activities carried out and the women's needs. They may include:

Potential partner	Priority for partnering (Essential, Desirable)	Partner role
Religious leaders	Desirable (in some contexts essential to get community engagement)	Spiritual support, leadership of prayer and religious festivals
Government health services and community health volunteers	Desirable	Health, nutrition, HIV and hygiene education, referrals
NGOs (National and International) and appropriate UN agencies	Essential	Provision of services that WV is not able to provide

<sup>20</sup> The specific age group of young children will depend on the family needs and the age groups covered in the CiE programs.

Potential partner	Priority for partnering (Essential, Desirable)	Partner role
Community-based groups (those are not necessarily legal or registered, but might play a large role in certain communities)	Essential	Provision of smaller-scale social services to peer community members
Government social services	Desirable	Information about compensation and ongoing support, birth registration etc.
Response coordinating bodies (clusters, government disaster management groups etc.)	Essential	Information sharing, accessing referral services etc.

## 5. Project DME

### 5.1. What goal and outcomes will be sustained as a result of this project model?

The program will work towards the reduction of mortality and morbidity of women and infants under 36/59 months, due to health, nutrition, HIV and hygiene related causes, and provide social and emotional support. The outputs would include the improvement of infant health and development, and women being able to cope with the stress of displacement or the aftermath of the disaster and able to adequately care for their family. This will be achieved through different activities based on the needs expressed by the women and what other services are available. The indicators should relate to health, nutrition, safety and possibly livelihoods and skill building. They may include IYCF, child development, Health, nutrition hygiene and HIV prevention, response to threats of GBV, newborn and infant care and development

### 5.2. Sample log frame for this project model

(Not all outcomes and outputs may be needed. It will depend on the needs of the community and what other services are provided in the area)

	Hierarchy of Objectives	Indicators	Means of Verification	Assumptions/comments
Project Goal	To protect the health, nutrition and psychosocial status of women and children under 36 months affected by the shock event.	The health, nutrition and psychological status of women and young children remained stable or improved.	Caregiver survey, health information systems at different levels (local, national)	The WAYCS may be part of a larger health intervention with mobile clinics etc. Or will provide linkages to existing health services
Outcome I	Carers and children are well nourished.	% of caregivers who access nutrition based services and practice behaviors enhancing the health and nutritional status of the families.	Caregiver survey	Links to food aid/cash programs may be needed or included
Output I.1	Exclusive breastfeeding and re-lactation are promoted among caregivers of infants aged 0-6 months of life	#of caregivers who exclusively breastfeed their <6 month children % reduction of bottle fed infants	Monitoring reports	The WAYCS includes breastfeeding corners etc.
Output I.2	Appropriate infant and young child feeding is promoted among caregivers of children aged 6 months and above	# of children who receive age-appropriate, adequate and safe food in addition to breast-milk	Monitoring reports	Link to SFP or GFD programs to ensure appropriate food included in the rations

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	Hierarchy of Objectives	Indicators	Means of Verification	Assumptions/comments
		#of caregivers who continue breastfeeding beyond 6 months and use locally available nutritious foods as complimentary food		
Output 1.3	Caregivers able to access services for malnourished children	# caregivers with malnourished children know where to go for screening, and access appropriate services		CMAM and SFP facilities are available Community mobilisers can be encouraged to screen and follow up at WAYCS
Output 1.4	Women including PLW and adolescent girls understand the importance of a balanced diet and have negotiation skills to access nutritious food for self and children	#of caregivers and HH decision makers who are ensuring mothers have a balanced diet during pregnancy and lactation		May include snacks or micronutrient supplementation for women esp. if they remain in the centre for long periods
Outcome 2	Household heads and women demonstrate practical skills to maintain their own and their families' health	% of women with children who demonstrate sound hygiene practices % of women who access health referrals and services % of women who access RH services and are delivered with a SBA	Caregiver survey Medical reports from health services and SBA around increased access	
Output 2.1	Infants under 36 months are protected from infection and diseases	#of mothers who are able to cite at least two methods to protect young children from infection #of mothers who are able to cite at least 3 symptoms of diseases that require immediate health care in children less than 36 months	Monitoring reports Clinic reports	LLITN may be distributed at the WAYCS for mothers and children.
Output 2.2	Pregnant women are supported with appropriate referral to skilled birth attendants	#of pregnant women who have received counseling on the need for a SBA and know where to go to access clean delivery kits	Monitoring reports Interviews with SBA	Clean delivery kits may be distributed from WAYCS if no health facility nearby.
Output 2.3	Women are sensitized around health and health seeking behaviour, hygiene and reproductive health (e.g. birth spacing,	#of women who report washing their hands with soap at critical moments # of women who are able to cite at least three	Monitoring reports Clinic or SBA reports	Hygiene kits may be distributed for women and children

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	Hierarchy of Objectives	Indicators	Means of Verification	Assumptions/comments
	access to contraceptives) related issues.	examples of disease prevention (including STI/ HIV) # Women receiving EC pills distributed, and the number and type of contraceptives distributed.		
Output 2.4	Men and older women are sensitized on good health and nutrition needs of women and children to support the health status of the family.	# of HH heads and grandmothers partaking awareness sessions on mother and child health and nutrition	Monitoring reports observation	Separate sessions may be set up for men with health (inc RH) nutrition hygiene and HIV messaging
Output 2.5	Women / adolescent girls are provided with access to basic needs such as female hygiene products, reproductive health education, training opportunities and referrals.	# of women / adolescent girls who have attended awareness sessions on reproductive health or referred to reproductive health service providers # of hygiene kits distributed to women /adolescent girls	Monitoring reports Distribution reports	This intervention is for all women (married or single) and adolescent girls (married or single) Female hygiene kits may be given if not part of the general hygiene kit
Outcome 3	Young children flourish emotionally and develop within a healthy family environment	% of infants from 0-36 months old who demonstrate healthy early childhood development <sup>21</sup>	Caregiver survey	ECD activities for all caregivers and children
Output 3.1	Caregivers provide positive emotional & physical stimulation to their children	# of caregivers who display positive interaction techniques with their children	Observation reports	
Output 3.2	Men and older women actively engaged in positive interaction with their children	# of men and grandparents who display positive interaction with their children	Observation reports	Separate sessions may be set up for men
Outcome 4	Women learn new skills, receive psychosocial support, and rebuild/strengthen their resiliency after an emergency in a safe space	% of women who demonstrate improved resiliency after an emergency	Caregiver survey with women	
Output 4.1	Recreational and vocational skills activities are provided to women of different ages at the WAYCS	# of women who demonstrate learning new skills (craft, income generation activities , embroidery, cooking)	Monitoring reports	This may be a referral and active participation than activity in the WAYCS
Output	Women of all ages are	# of women and their	Monitoring reports	

<sup>21</sup> ECD includes physical, cognitive, and emotional growth and change, further indicators can be found in references in Appendix 10.3



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	Hierarchy of Objectives	Indicators	Means of Verification	Assumptions/comments
4.2	provided with information around protection issues including GBV response and mental health service providers	family members who know where to go for physical, emotional, spiritual or medical support		

### 5.3. Recommended monitoring methods

The monitoring needs to ensure that the WAYCS are meeting the needs of the women and their infants, and identifying when activities need to change, or where there are gaps in information and activities. As the emergency situation changes the needs of the women and infants will also change. When services are re-established women need to be encouraged to use these and the WAYCS **should not** take on the roles and responsibilities of the government where it is able to provide services for its people.

- A committee or community group (of women and men) should engage in the monitoring and evaluation of the program and be checking with community members on their satisfaction with the program. Both participants and non participants need to be consulted.
- Some specifics that can be monitored include number and type of activities, attendance by specific groups, staff and facilitator skills, community satisfaction, health status of the women and children.

### 5.4. Accountability component

As this program deals specifically with women and infants some issues may arise out of the needs of the community that require advocacy a various levels. As the program should not be long term, it will not necessarily have the time to train people in advocacy skills, but volunteers and staff need to be sensitized to take issues to the appropriate groups. The program needs to link with the accountability activities so community members are informed of their rights and have the opportunity to make complaints and comments about this program and other services. From the feedback mechanisms that should be in place, advocacy issues may be raised and they should be taken forward by advocacy teams, or other appropriate mechanisms.

### 5.5. Does and Don'ts

Do	Don't
Coordinate with the government and other agencies and sectors that that implement women and children's programs, especially health, protection, psychosocial, education, and other relevant coordination groups	Set up women's spaces without consultation with other agencies, government and the community (especially men and elders)
Ensure that the community understand the purpose of the women and infants centres and what activities are planned and who is eligible	Exclude women without children (who have skills and abilities to share with the participants) vulnerable groups like minorities, or women or children with disabilities.
Keep the number of women with infants to a manageable number and ensure that enough local trained staff are available to meet the needs of the women and infants (1:15 women with infant would be a maximum) (Types of staff will depend on the needs e.g. midwife, CHW, MHPSS officer)	Overcrowd the centre, it is better to have more centres or stagger the session times for different groups than have women and infants be too cramped and hot (they will not come back)
Ensure the safety of the women and infants not only while in the centre, but also coming and going from the centre.	Don't locate in areas that may have hazardous waste or debris, or could be subject to security or environmental hazards (e.g. flooding)
Ensure that the location is comfortable (e.g. tents without	Plan location without consultation with the community and

shade may be too hot for women to come to)	camp committee if in a camp setting
Ensure that the community is involved in management such as a community elected committee to manage the centre.	Dictate activities without consultation with the community.
Ensure timing and nature of activities take into consideration daily activities (e.g. activities may be run concurrently with CFS so women participate while waiting for children, or 24/7 access if women needed space to breastfeed in privacy etc.)	Plan activities and timing without consultation with the community
Ensure that staff understand the code of conduct and any data and information collected from the participants and the community is kept confidential and not shared without informed consent	Share confidential information without consent of the person concerned or store reports, case notes and other participant information in accessible locations (always ensure that it is in a locked container)
Ensure that the WAYCS is inviting and comfortable, and that women feel free to come and go. Private spaces may need to be established for private conversations, breastfeeding etc.	Locate WAYCS in a place that excludes specific groups such as disabled, minority groups etc.
Consider setting up a WAYCS early in the response, and allow it to be dynamic to the needs of the women and their children	Expect the WAYCS to remain the same it needs to be dynamic to meet the needs of the women and their children.
Ensure that the WAYCS is a place for information sharing and through accountability measures ensures that the community has a voice	Assume that because women are living in the community that they know what is going happening in the response or feel free to provide feedback
Find ways to engage men, and older women (especially grandmothers etc) in a culturally appropriate way	Endorse harmful cultural practices
Monitor and evaluate the program and use the information to improve program quality	Evaluate for outsiders only, but ensure that the results are shared with the community and participants
Develop and exit or transition strategy with the community.	Continue the WAYCS indefinitely

## 5.6. Phase out

WAYCS are designed as temporary support activities to meet the needs of women and children and help them deal with the aftermath of a disaster. The survivors will want to return to a normal routine as soon as possible, so in conjunction with the women and community a phase out or hand over strategy needs to be planned as soon as possible and communicated in a timely manner. If the community and members of the WAYCS want to transition into a longer term community health, livelihood or support group the program should assist the whole community to develop a transition plan, and consider funding and staffing of the new phase.

## 6. Protection and equity considerations

### 6.1. How can child protection be promoted in the implementation of this project model?

The main focus of the project model is to ensure that children are protected from disease. The project will ensure that the most vulnerable children are targeted and are included in activities. Staff will be oriented in child protection and protection issues, and accountability systems will be put into place to ensure that any violations by staff or the community are dealt with swiftly and in accordance with the law and WV Policy.

### 6.2. How can the model promote equitable access to and control of resources, opportunities, and benefits from a gender perspective as well as other perspectives, such as disability, ethnicity, faith, etc.?

The programme will address women's exclusion from decision-making processes by ensuring that women are consulted and involved in deciding on the design of the centre and its day to day running. It will also be a conduit for response information to be shared with women and allow them to engage with accountability staff through feedback and complaints mechanisms.

The project will endeavour to create venues to enhance women's capacity and opportunities to decide and manage community activities. Project staff will also be required to more practically and demonstrably factor gender in programming and information gathering. Proactive action will be taken to ensure individuals, groups and disaster-affected populations have equitable access to the services. The unique situation and needs of some individuals and groups will require undertaking special measures such as translating information, making it available in a format that is easily understood, structuring the centre for privacy, etc. The needs of women with disabilities and carers of children with disabilities will be taken into consideration in siting of the program and ensuring that services are offered in a way to ensure their access and limit stigma and further alienation.

## 7. Project Management

### 7.1. Guidelines for staffing

Staffing for the WAYCS program will depend on the extent of the program and number of sites. It needs a coordinator who has health, nutrition, social work or psychology background, who has managed projects in the past. At each site consider 1 (one) community mobiliser (who has received PFA training) to approximately 15 women. Where there are a number of sites or session times a facilitator can work with the mobilisers to coordinate with the committees, and ensure follow-up with other sectors etc. Additional support can come with visits from female health workers (e.g. CHW, Midwife, and nurse), hygiene promoters, nursery teachers, trainers for specific activities such as sewing, cooking etc. if this is carried out as part of the program. Additional technical staff could be ad hoc advisors or employed as part of the program and provide roving rostered activities.

### 7.2. Resources for project implementation

#### Suggested supplies

- ✓ Shelter and screening (may be a tent, local structure, or building)
- ✓ Lockable steel box to hold materials and confidential paperwork
- ✓ Office stationary (paper, pens, stapler, markers, ink pads etc)
- ✓ Furnishing to make the centre comfortable, e.g. rugs, cushions, chairs etc. *Consider people with disabilities and elderly*
- ✓ Curtains /Screens and furniture such as cushions and mattresses for a breastfeeding corner
- ✓ Table for registration and recording distributions etc
- ✓ Sewing machines or other craft equipment and materials (fabric, wool, knitting needles, embroidery thread and rings etc.)
- ✓ Drawing materials and paper
- ✓ Games (ludo, snakes and ladders, cards) for adults
- ✓ Educational toys, balls etc for infants (if available in country the UNICEF ECD kit)
- ✓ Musical instruments (cymbals, drum, and tambourine)
- ✓ Weighing scales, MUAC tapes and height boards for screening children
- ✓ Posters and pictures (decoration and relating to activities, e.g. safe motherhood, hand-washing, use of LLITN, breast-feeding etc)
- ✓ Notice board for information and for presentations
- ✓ Community feedback/complaints box
- ✓ Water cooler and glasses and water purification tablets/sachets
- ✓ Cleaning materials for WAYCS and associated WASH facilities

*Where women are staying for long periods during the day, or there is need for nutritional support*

- ✓ Cooking equipment (if there is wet feeding, tea or coffee, cooking lessons or child feeding)
- ✓ Plates or bowls, spoons, and cups
- ✓ Washing bowls and soap for dishes
- ✓ Soap and hygiene materials for women (if not included in hygiene kits)
- ✓ Nutritious snacks for women and children (especially if food ration not adequate)

*NFI specifically for women and children*

- ✓ Clean delivery kits for visibly pregnant women
- ✓ LLITN (if not part of family package)
- ✓ Clean clothing for women and infants.

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- ✓ Additional support for women who have just delivered (*in Haiti additional tents and supplies were allocated to newborn infants though the WAYCS program*)
- ✓ Torches for movement at night

### 8. Supporting tools

IYCF operational guidelines: [http://www.who.int/nutrition/publications/emergencies/operational\\_guidance/en/index.html](http://www.who.int/nutrition/publications/emergencies/operational_guidance/en/index.html)

Supporting breastfeeding in emergencies – Use of breastfeeding tents

<http://www.wvnutrition.net/home/resources/guidelines/breastfeeding-in-emergencies.html>

UNICEF Early Childhood Development materials (based on the UNICEF ECD Kit)

[http://sphereprototype.conted.ox.ac.uk/cases/learningistheirfuture/pdf/ECD\\_Kit\\_Handbook\\_for\\_Caregivers.pdf](http://sphereprototype.conted.ox.ac.uk/cases/learningistheirfuture/pdf/ECD_Kit_Handbook_for_Caregivers.pdf)

[http://www.unicef.org/videoaudio/PDFs/Activity\\_Guide\\_EnglishFINAL.pdf](http://www.unicef.org/videoaudio/PDFs/Activity_Guide_EnglishFINAL.pdf)

Psychological first aid [http://whqlibdoc.who.int/publications/2011/9789241548205\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf)

Health promotion: Facts for life <http://www.factsforlifeglobal.org/>

Guide to MNCH and nutrition in emergencies

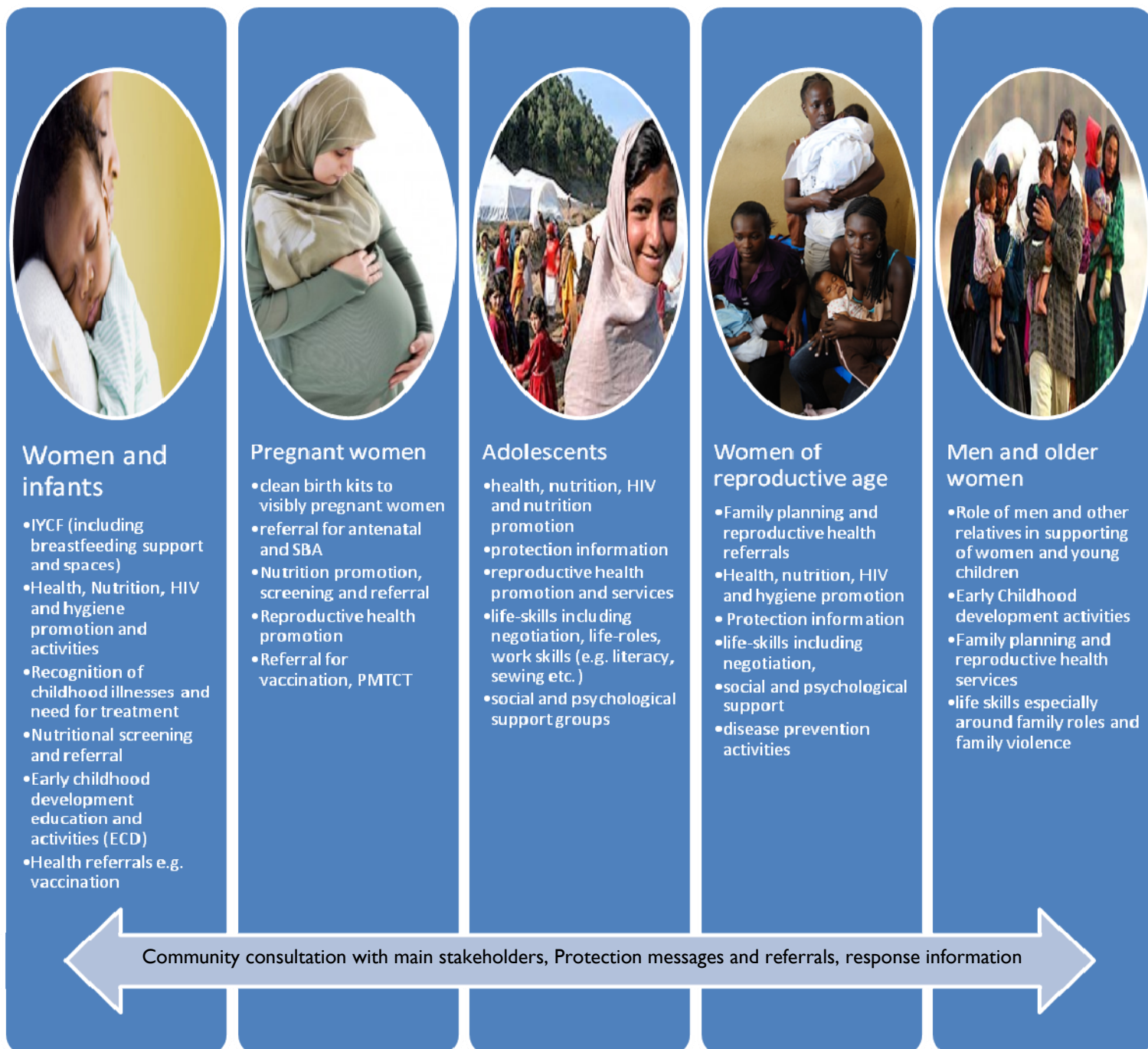
<https://www.wvcentral.org/community/health/Documents/MNCH%20in%20Emergencies%20Guide%20FINAL.pdf>

### 9. Linkages and integration

This program needs to liaise with the following teams, WASH, Food Aid, Protection, Children in Emergencies, Education, Nutrition and Health, Livelihoods to ensure referrals and facilities are available for the participants. In a camp setting the camp liaison/accountability team can assist in assessment of needs and security needs to ensure location is safe for staff and participants.

## Decision guide for WAYCS

When you know the demographics and needs of the affected community, activities can be organised to meet their specific needs. Below is a summary to start thinking of the kinds of activities you can offer for the different groups. Timing of these will depend on when the target group want to meet and on cultural and space issues.





## Appendices

### 10.1 Suggested Budget

(The actual costs will depend on the context and activities undertaken)

	%	cost	months	total	comments
<b>Staff</b>					
* Protection/health manager	20%				Will also manage other health or protection projects.
*WAYCS coordinator	100%				Oversee all WAYCS
*WAYCS facilitator/officer	100%				Where a number of sites, to provide training and support for volunteers of 3-4 WAYCS
Project counselor (PFA trainer)	100%				Depending on need (1:30 clients)
Translator	50%				If project staff do not speak local language
Health support staff	Pro rata to time				Midwife, CHW, nutritionist, ECD officer etc. If there is a number of WAYCS in area, could have 100% health staff with roving support.
*Community mobilizers (need to be from the community)	100%				Allowance for (1:15 women) <i>consider CFW rate depending on qualification,</i>
*Cleaning staff	100%				Allowance for community members cleaning WAYCS and WASH areas <i>consider CFW rate</i>
Distribution staff	20%				Where women and infants items are distributed to the whole community through the WAYCS.
Driver	50%				Support referrals, and ensure specialist staff able to visit for training and activities
Admin support functions	10%				As per response policy for indicative staff
*Security	100%				Protection of facilities, and control of access. (this may be done voluntarily by community, <i>consider CFW rate</i>
<b>Sub total: Salaries/benefits</b>					
<b>Project costs</b>					
Laptop and printer					Report writing, training material etc.
Communications equipment					Cell phones, radios etc (1 per site and 1 for coordinator)
Tent/shelter					Per site local materials are the best, preferably with inner walls and floor (1 sq mt per woman)
Fencing or protection wall					Could be tarpaulins, brush fencing etc for privacy and controlled access to area
Furniture					Tables, chairs, benches, mats, cushions etc. (consider older women and those with disabilities)
Office supplies					Stationary for reporting, registration et
IEC and accountability materials					Materials for education and information sharing

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Health or hygiene materials					For distribution
Equipment					Depending on activities
Toys for infants					Washable toys and items for mothers to make toys
Drinking containers etc.					Access to drinking water at site
Program supplies					Food (if providing snacks, tea etc)
WASH					Latrines, washing areas for personal and infant hygiene, waste disposal
Cleaning materials					For the WAYCS, latrines etc.
Signage and notice boards					To indicate site, guidelines, provide information to women
Utilities/fuel					If in building with utilities, consider fans in hot and heating in cold climates,
Transport and fuel					Vehicle, maintenance etc
Accountability					Help desks etc.
Monitoring and evaluation					% as per response guidelines
<b>Sub total: Project costs</b>					
<b>Sub Total: Admin costs</b>					% of budget as per response rules
<b>Total project costs</b>					

\*= Core staff

## 10.2 Guidelines to support adolescent girls

### Background

Adolescents, especially adolescent girls are often an ignored group, post crisis despite the fact they can assume disproportionate levels of responsibility in the family, take on leadership roles and inadvertently become a means of survival for families in crisis. They may forego meals, engage in unsafe livelihoods, assume high levels of domestic responsibilities or marry early and as a result can also become isolated from friends, school and community. They often fall through the response gap as families and communities do not recognize them as leaders and providers often think they are part of existing programs such as the children in emergencies or education in emergencies or with women's programs for older adolescents.

The link with the child wellbeing targets of health and nutrition, includes improving the health and nutritional status of adolescents, development of life skills and reproductive health knowledge before they become pregnant, e.g. healthy timing of pregnancy, healthiest age of childbearing will help address overall goal to reduce maternal and infant mortality and morbidity. They are vulnerable to physical and sexual exploitation, and when taking on caring and family support roles in the home can lose their peer support, further undermining their physical health and emotional well being.

According to the Coalition for Adolescent Girls<sup>22</sup>, studies have shown that adolescent girls in a crisis are often invisible in the community and face obstacles and challenges different to the experiences of their male peers or females in other age groups. Most of these challenges and obstacles can be met by a WAYCS program.

1. **ADOLESCENT GIRLS FACE THE GREATEST RISK OF PERSONAL AND BODILY SAFETY** The breakdown in community cohesion and temporary housing conditions make them more vulnerable to perpetrators both known and unknown. They can be exposed to violence including GBV, injury, and risk taking behaviors such as substance abuse and suicide. The WAYCS can be a place where they can meet with their peers, develop life and negotiation skills to protect themselves and give and receive information about the risks and support structures.
2. **ADOLESCENT GIRLS ARE AT A PARTICULAR RISK FOR HUMAN RIGHTS ABUSES** and this includes exploitation by aid workers and community members, and they are often intimidated to voice their concerns publicly. A safe place where they can meet with peers may enable them to express their needs and seek justice.
3. **ADOLESCENT GIRLS TAKE ON DISPROPORTIONATE LEVELS OF THE HOUSEHOLD BURDEN** including; caring for younger siblings, being unable to maintain social networks, or continue their education, which can result in isolation. Being able to meet with other women and youth caring for children they can develop new networks and access to social, financial, health, and educational services that they may miss out on if tied to the home.
4. **ADOLESCENT GIRLS FACE GREATER MALNOURISHMENT** as their bodies change during puberty and when they are malnourished are more at risk of disease. During a crisis families do not typically prioritize the nurture of girls and may prioritize feeding male members of the family, or even livestock. The WAYCS focuses on education of the family on the importance of a balanced diet, and ensuring that all women as well as men and children have adequate nutrition. Specific nutritional needs include micronutrient deficiency, malnutrition, nutrition related chronic disease risks and poor eating patterns and lifestyles
5. **ADOLESCENT GIRLS LACK ACCESS TO QUALITY, YOUTH-FRIENDLY REPRODUCTIVE HEALTH SERVICES, INFORMATION, AND COMMODITIES.** The emergency context or the constraint in income that it creates often exacerbates this situation. Emergency settings foster an increase of early and unintended pregnancies, HIV and other sexually transmitted infections, and unsafe abortions. Youth friendly reproductive education and services can meet this need, ensuring access to contraception, education, and youth friendly delivery and medical services.
6. **ADOLESCENT GIRLS MAY ENGAGE IN UNSAFE LIVELIHOODS** on their own initiative or due to family pressures. In some settings, transactional sex is a common strategy to augment family income. Linkages to livelihoods programs, life skills training and literacy education either within the program or in supporting activities should reduce this risk.
7. **ADOLESCENT GIRLS DO NOT HAVE ACCESS TO SCHOOLING** of the caliber available to male counterparts in the same circumstances. This is particularly true for secondary education. Families may pull adolescent girls out of school for a variety of reasons, such as cost, security risks or the need to care for the household. A centre supporting the women

<sup>22</sup> Anooradha Siddiqi (2012) *Missing the Emergency: Shifting the Paradigm for Relief to Adolescent Girls*, The Coalition for Adolescent Girls. [www.coalitionforadolescentgirls.org](http://www.coalitionforadolescentgirls.org) (accessed 13/11/2012)

and children, can provide linkages back to the education in emergencies program, or a space for the children to be cared for while the adolescent girls can catch up on their studies.

8. **FAMILIES MAY SEE THE BRIDE PRICE OF ADOLESCENT GIRLS AS A MEANS OF SURVIVAL.** The rate of early marriage tends to increase in the wake of natural disasters. Female genital mutilation may occur at an earlier age, if social norms promote genital cutting to ensure girls' marriage ability. Community education around women's health can tackle some of these issues.

Considering this list, a WAYCS programs need to run specific services for adolescents (girls and boys), and this may also need to be broken down into younger and older adolescents (10-15 and 15-19) and segregated according to gender in some countries, ensuring that the activities support their needs. This will include opportunities to develop networks and skills to protect them from violence. The timing for these activities and access needs to be when adolescents are free from family responsibilities and not at a time that will put them in physical danger.

#### Activities can include

1. Targeted HIV&AIDS and STI awareness and testing (by referral) activities with skills to help the girls make informed decisions and be able to negotiate for their safety. UNFPA and UNAIDS have adolescent friendly materials <http://www.unfpa.org/public/home/adolescents/pid/6486>
2. Targeted reproductive health services including fertility awareness and body literacy, contraception and birth spacing advice, antenatal and post natal support, TT, HPV immunization, PMTCT for teen pregnancies, encouragement and support for access to youth friendly SBA, and advice on where to go for treatment and support for STI and HIV. UNFPA and Save the Children US have produced a toolkit which contains programming advice: *Adolescent Sexual and Reproductive health toolkit for Humanitarian Settings* <http://www.unfpa.org/public/home/publications/pid/4169>
3. Provide structured and unstructured opportunities for adolescents to share their concerns with their peers in a safe environment maybe through play, drama, music and dance. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings has some suggestions for adolescents. [http://www.who.int/mental\\_health/emergencies/guidelines\\_iasc\\_mental\\_health\\_psychosocial\\_june\\_2007.pdf](http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf)
4. Targeted health and nutrition education and support including supplementary feeding, micronutrient supplementation, and the importance of prompt access to life-saving health services (injury, violence, road traffic accidents and communicable disease outbreaks). Understanding the importance of treatment for HIV&AIDS, diabetes, TB and other chronic diseases and provision of referral to ongoing services. WHO has produced a fact sheet on the main health risks for adolescents <http://www.who.int/mediacentre/factsheets/fs345/en/index.html>
5. Life skills and education around healthy lifestyles, good nutrition for development and growth and harm reduction and care seeking for substance abuse (tobacco, alcohol, illicit substances), eating disorders etc.
6. Life skills training, literacy training and income generation activities that can link them to other services, such as the education in emergencies programs
7. Distribution of adolescent specific aid such as female hygiene supplies, nutrition support etc.
8. Note: Even though there is a need for specific adolescent activities they should also be welcome at the regular sessions, such as mother and baby sessions where they can learn with other mothers how to care for their children or younger siblings.

### 10.3 Supporting Infant & Maternal Mental Health in Emergencies

#### Background

The World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) recommend that mental health & psychosocial support for both infants and caregivers must be included within a child focused response to ensure a child develops to their full potential both intellectually and physically, and does not develop lifelong disability as a result of nutritional deficiencies and a lack of stimulation<sup>23</sup>. The WHO guide provides a good reference table of suggested activities for emotional and physical stimulation.

For some time it has been recognized that for children to reach their full potential they need more than adequate nutrition, they also need psychosocial (physical & emotional) stimulation from caregivers. It is during the first three years of life that the brain is developing most rapidly. For adequate growth it is essential that it receives physical stimulation in the form of different sounds, introduction to objects through touch & movement, positive emotional attachment to a caregiver and adequate nutrition. If these things are not provided a child's brain can develop abnormally, leading to mental disability and vulnerability to mental illness later in life.

During an emergency it is even more vital that such concerns are considered. A child experiencing nutritional deficiencies or increased stress as a result of the crisis may show reduced activity and become apathetic. Therefore, the caregiver may reduce the amount of stimulation provided to the child as the child stops responding to a caregiver, leading to permanent developmental delays and vulnerability to mental health issues<sup>24</sup>

#### Intervention Examples for Infant Psychosocial Stimulation

1. **One to one message dissemination:** All associated staff or volunteers who have direct contact with mothers can be trained to provide simple health messages to give to the mother. For example messages on how to breastfeeding provides the opportunity to show warmth and love and communicate through singing, touch, and facial expression.<sup>25</sup> Staff and volunteers can become familiar with such techniques using the UNICEF Care for Development Counseling Cards and checklists which can be found at [http://www.who.int/mental\\_health/emergencies/ecd\\_note.pdf](http://www.who.int/mental_health/emergencies/ecd_note.pdf)
2. **Mother/caregiver and baby groups at the WAYCS:** Mothers/caregivers and babies can be invited to attend mother and baby groups within the WAYCS. This can be done by demarcating dedicated time in existing WAYCS, and using existing modules such as
  - a. 'Learning through play' <http://www.hincksdellcrest.org/Home/Resources-And-Publications/Learning-through-Play/Learning-through-Play.aspx>
  - b. 'WVI Early Childhood Care & Development tool' [http://www.wvshellbooks.org/index.php?title=02\\_Education/Early\\_Childhood\\_Care\\_%26\\_Development](http://www.wvshellbooks.org/index.php?title=02_Education/Early_Childhood_Care_%26_Development)
  - c. Equipment and tools can be found in the UNICEF *Early Childhood Development Kit* (ECD), which contains puzzles and games; counting and sorting activities; books and puppets for storytelling; art supplies; soaps and water containers for promoting hygiene. And an Activity Guide with suggestions on how to use each item based on children's age and interest. Additional web based supportive materials include a Trainer's Guide and a Coordinator's Guide is also available at [http://www.unicef.org/earlychildhood/index\\_52596.html](http://www.unicef.org/earlychildhood/index_52596.html)

A caregiver's mental health will also have an impact on their ability to feed and adequately care for their child. Research into mothers experiencing depression showed a strong link between depression and a mother ceasing to breastfeed her infant. In addition, a caregiver experiencing depression is less likely to be able to emotionally & physically stimulate their child. Approximately 40% of women in developing countries are likely to experience post-natal depression.<sup>26</sup> Therefore, support should be provided to mothers within a holistic program to reduce depressive symptoms and thus enable them to provide adequate care to their child.

<sup>23</sup> World Health Organisation. (2007). Mental Health & Psychosocial Well-being among Children in Severe Food Shortage, WHO: Geneva

<sup>24</sup> WHO (2007)

<sup>25</sup> UNICEF. (2012). Integrating Early Childhood Development (ECD) activities into Nutrition Programmes in Emergencies. Why, What and How. UNICEF: Geneva

<sup>26</sup> Cooper P.J., Tomlinson M., Swartz L. (1999). Post-partum depression and the mother-infant relationship in a South African peri-urban settlement *Br. J. Psychiatry*; 175:554–558



## Intervention Examples for supporting Caregiver Mental Health

1. **Psychological First Aid:** Support can be provided to caregivers showing signs of distress or depression through an approach known as 'Psychological First Aid' (PFA). PFA is a supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes; practical care and support that does not intrude; assessing needs and concerns; helping people to access basic needs (e.g. food and water, information); comforting people and helping them to feel calm; helping people connect to information, services and social supports & protecting people from further harm.<sup>27</sup> Ideally all staff or volunteers working within the WAYCS should receive training in PFA. At a minimum they should become familiar with the approach through reading the PFA Guide for Fieldworkers.  
[http://whqlibdoc.who.int/publications/2011/9789241548205\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf)
2. **Positive Lifestyle & Relaxation:** There is significant evidence that relaxation, healthy sleep patterns, physical activity and good nutrition promote good mental health. Following a birth a woman's life may be disrupted and lifestyle should be adapted as such- for example a mother should be encouraged to rest or nap during the day when the baby is asleep. Therefore, WAYCS staff or volunteers should promote relaxation and stress reduction techniques, good sleeping patterns, exercise and good nutrition. A helpful tool with suggestions on relaxation can be found <http://www.cci.health.wa.gov.au/docs/ACF10F9.pdf> other tools around anxiety can also be found on this website.  
[http://www.cci.health.wa.gov.au/resources/infopax.cfm?Info\\_ID=46](http://www.cci.health.wa.gov.au/resources/infopax.cfm?Info_ID=46)

Research suggests that combining programs that support a child's nutrition and health inputs with support for positive parenting & stimulation have a long term effect on children's mental health. In a study on the impact of providing food supplements and stimulation to stunted and non stunted 9-24 month old children in Jamaica, the stunted children who received both interventions weekly over a two year period had higher developmental scores than those who received neither intervention, or only the nutrition intervention.<sup>28</sup>

<sup>27</sup> Inter-Agency Standing Committee (IASC) (2007) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

<sup>28</sup> Walker, S., Chang, S., Powell, C., & Grantham-McGregor, S., (2005). Effects of early childhood psychosocial stimulation and nutritional supplementation on cognition and education in growth-stunted Jamaican children: prospective cohort study. *Lancet*, 366: 1804-1807

## GLOSSARY OF KEY TERMS AND CONCEPTS

### CDK

A Clean Delivery Kit contains essential items meant to improve hygienic birth practices and to promote a safe, clean delivery following the WHO six principles of cleanliness at birth. A basic CDK includes the following elements: 1) a piece of soap, to ensure birth attendants clean hands and mother's clean perineum, 2) a plastic sheet, to ensure clean delivery surface, 3) a razor blade in its original packing, to ensure clean cord cut, 4) two pieces of clean string to ensure clean cord tie, 5) a flannelette blanket, to swaddle the baby and ensure the cord stump is clean and dry. One pair of gloves might be added to reduce risk of infection transmission. The items are packaged in a plastic bag and are joined with pictorial instructions that explain how to use each item in the kit.

### CHW

They are members of the community chosen to provide basic health and medical care to their community, often in communities that have limited access to health professionals. Community health workers are given a limited amount of training, supplies and support to provide essential primary health care services to the population.

### CWBA

Child Wellbeing Aspirations: The ministry aspirations for World Vision's (WV) work: Children enjoy good health; Children are educated for life; Children love God and their neighbours; Children are cared for, protected and participating. Guided by these four inter-related aspirations, we work with partners to contribute to the child well-being outcomes.

### CWBO

Child Wellbeing Outcomes: Refer to operational outcomes that describe our intentional contribution to the well-being of children, in support of the four child well-being aspirations. WV doesn't impose our definition of a good life for children on others, but use it as a catalyst for discussion with families, communities and agencies. The outcomes are intended to guide our strategy and programming choices, and contribution to the outcomes will vary according to context.

### CWBT

Child Wellbeing Targets: Are a crucial part of creating focus across World Vision toward child well-being aspirations and outcomes. They are objectives that reflect priorities from our national and regional strategies. Over the next three to six years, we will measure the impact of our programs toward these targets. Specifically, the targets are: 1) Children report an increased level of well-being (ages 12-18); 2) Increase in children who are well-nourished (ages 0-5); 3) Increase in children protected from infection and disease (ages 0-5); and 4) Increase in children who can read (by age 11)

### CFS

Child-Friendly Space: Are widely used as a first response to children's needs and rights to protection in contexts where children's lives have been, or are at risk of being, disrupted by natural disaster, conflict, or exploitation. They usually consist of a space converted to allow children play, draw, sing, share their feelings, engage in non formal education and begin a return to a normal routine. Broadly, the purpose of CFS is to support the resilience and well-being of children and young people through community organized, structured activities conducted in a safe, child friendly, and stimulating environment.

### CiE

Children in Emergencies: Protecting **children** is an obligation across all humanitarian action and is central to all WV's emergency programming. Children's vulnerability to illness, malnutrition and abuse, their dependent social status, their critical physical and mental development, and the important contribution they have to make in their own families and communities require special attention in design and implementation of any humanitarian response.

### CMAM

Community-based Management of Acute Malnutrition: CMAM is the internationally used term to describe a programming approach that involves 1) timely detection of acute malnutrition in children in the community, 2) treatment at home of children with severe acute malnutrition without complications, using ready-to-use therapeutic food, 3) inpatient care of severely malnourished children with medical complications and 4) provision of nutrient-dense supplementary food to moderately malnourished children. The central principle of CMAM is to treat malnourished children in their homes and not as traditionally done through therapeutic feeding centers called Community-Based therapeutic Care (CTC).

### ECD

Early Childhood Development: ECD refers to a comprehensive approach to policies and programs for children from birth to eight years of age, their parents and caregivers. Its purpose is to develop the child full cognitive, emotional, social and physical potential during the first eight years of life through good nutrition and adequate psychosocial stimulation.

### GBV

Gender-Based Violence is an umbrella term for any act based on socially ascribed differences between males and females that is perpetrated against a person's will. GBV is essentially any act that results, or is likely to result in, physical, sexual, or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty. GBV encompasses sexual violence (such as forced prostitution, sexual harassment and sexual exploitation), domestic violence, trafficking, forced or early marriage and harmful practices (such as female genital mutilation, honour killings).

### Healthy living practices during pregnancy

Healthy living practices during pregnancy means that pregnant women should attend antenatal care; eat a well-balanced and nutritious diet; get adequate rest; avoid drinking alcohol, smoking cigarettes or using other dangerous drugs to safeguard both hers and the baby's health.

### HPV

Genital Human Papilloma Virus which is a common sexually-transmitted infection showing up in the form of genital warts or remaining without external sign. A form of HPV is also associated to cervical cancer.

### IYCF

Infant and Young Child Feeding is a feeding program targeting infants and young children. The WHO and UNICEF recommendations for optimal IYCF are as following: 1) early initiation of breastfeeding within one hour of birth, 2) exclusive breastfeeding for the first six months of life and, 3) the introduction of nutritionally adequate and safe complementary foods at six months, together with continued breastfeeding up to two years and beyond.

### LLIN

Long Lasting Insecticidal Nets are treated with an insecticide that is incorporated into the net fibers that lasts at least 20 washes in standard laboratory testing and three to five years of recommended use under field conditions. With LLINs, the time-consuming method of retreating old nets – known as insecticide treated nets (ITNs) or bed-nets - is no longer necessary. LLINs are promoted by key malaria partners as a cost-effective and sustainable method for protection against malaria.

### MUAC

Mid-Upper Arm Circumference: This is the circumference of the left upper arm, measured at the mid-point between the tip of the shoulder and the tip of the elbow. MUAC is a quick and simple way for assess the nutritional status of children and to determine whether or not a child is malnourished. To measure MUAC, a simple flexible colored measuring tape is used. At present during emergencies, MUAC is only recommended for use with children between one and five years of age.

\*MUAC less than 110mm, RED COLOUR, indicates Severe Acute Malnutrition (SAM). The child should be immediately referred for treatment.

\*MUAC of between 110mm and 125mm, RED COLOUR (3-colour Tape) or ORANGE COLOUR (4-colour Tape), indicates Moderate Acute Malnutrition (MAM). The child should be immediately referred for supplementary feeding.

**NFI**

Non-Food Items are supplies typically provided in an emergency or after situations of displacement where there is loss of personal property. NFIs often include shelter and hygiene materials, such as: blankets, sleeping mats, plastic sheeting, kitchen sets, soap, jerry cans, clothes, shoes, baby food, sanitary supplies, etc. NFIs vary according to culture and context and should correspond to the needs of the population and the climate.

**PLHIV**

People Living with HIV, it is the new internationally preferred term to use as per UNAIDS recommendation in its 2011 Terminology Guidelines. The term PLHIV is thought to reflect the fact that a person infected by HIV may continue to live well and productively for many years. (The old term People living with HIV and AIDS should no longer be used)

**PMTCT**

Prevention of Mother-to-Child Transmission of HIV: is a program model developed by the UN in 2001 to end mother-to-child HIV transmission by 2015. PMTCT provides drugs, counselling and psychological support to help mothers safeguard their infants against the virus. Across the developing world, it is recommended that PMTCT programs are delivered consistently and scaled up to include all mothers and babies who need them.

**SBA**

Skilled Birth Attendant: According to WHO, SBA refers to an accredited health professional with midwifery skills such as doctor, midwife and nurse. Only health professionals who have been trained to proficiency in the skills necessary to manage normal pregnancies, deliveries and the immediate postnatal period, and to identify, manage and refer complications in women and newborns can be called SBA. In addition to the skills, SBA should be supported by an enabling health system capable of delivering appropriate emergency obstetric care for women who develop complications during childbirth.

**STI**

Sexually Transmitted Infection, is a broad term that includes all infection passed on from person to another through unprotected sex or through genital contact. STIs that are most common are gonorrhoea, Chlamydia, herpes, syphilis, genital warts, HIV, trichomoniasis, pubic lice and scabies.

**TB**

Tuberculosis is an infectious bacterial disease caused by *Mycobacterium tuberculosis*. TB most commonly affects the lungs but the TB bacteria can attack any part of the body. The TB bacteria are put into the air when a TB-infected person coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected. In healthy people, infection with *Mycobacterium tuberculosis* often causes no symptoms. The symptoms of active TB of the lung are chronic cough with blood in the sputum, weakness, weight loss, fever and night sweats. Tuberculosis is preventable through vaccination. Tuberculosis is treatable with a six-month course of antibiotics. If not treated, tuberculosis can be fatal. It should be noted that TB in children is more difficult to diagnose and is not as infectious but is still deadly if not treated.

**TT**

Tetanus Toxoid is a vaccine recommended to be given to all infants 6 to 8 weeks of age, and to mothers before or during pregnancy to prevent tetanus. Tetanus is an infectious disease caused by contamination of wounds from the bacteria *Clostridium tetani*. Tetanus results in uncontrollable muscle spasms, initially in the jaw muscles (hence the nick name of the disease as "lockjaw"). As the disease progresses, mild stimuli may trigger generalized seizure-like activity; rapidly, the muscles used to breathe will spasm, causing a lack of oxygen to the brain and other organs that may possibly lead to death.

## Contacts for further information and assistance

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