# LEARNING REVIEW

# 2019

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# INTRODUCTION

Learning is the transformative process that turns information into knowledge. Continuous learning, reflection and adaptation is critical to building knowledge and evidence. Through collectively capturing and sharing knowledge we are enabled to build on what we have learned, and increase the quality of our work.

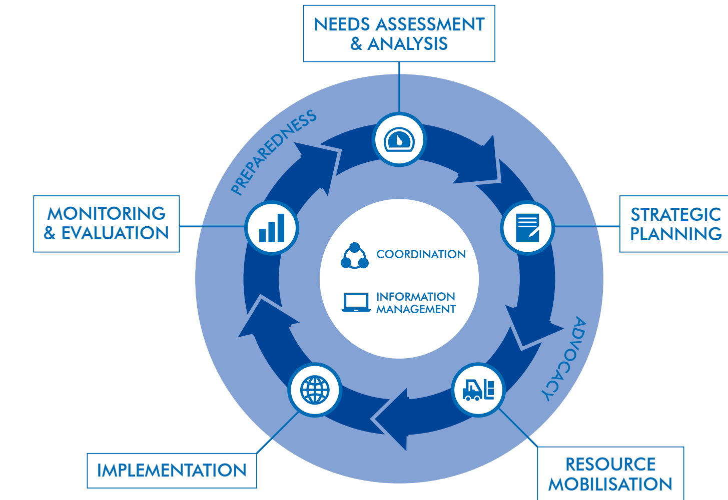
At Action Against Hunger we are committed to making learning a core part of our culture. We strive to develop ways to make learning and evidence from practice easily accessible, enabling us and others to improve and design higher quality and more accountable programmes.

The Learning Review is an annual publication providing staff across Action Against Hunger with a platform to share their learning and reflections from a diverse range of projects, research and experiences.

In addition to outlining best practices, the learning review highlights challenges encountered and how our teams have learned from these experiences. We believe that it is equally as important to learn from the mistakes we have made as it is to learn from our successes.

Following positive feedback last year, we have structured this year's learning review around the five stages of the programme cycle. In order for us to continuously improve the delivery of our programmes, it is essential for learnings to be gathered at every stage of this cycle.

This publication would not be possible without the valuable contribution of our staff from across Action Against Hunger, whose commitment to sharing experiences is a clear demonstration of the importance they place on learning and knowledge exchange. We hope to inspire dialogue through sharing this portfolio, and above all, to facilitate knowledge exchange and uptake.




*Left: the programme cycle*

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# ACRONYMS

| | |
|---|---|
| **BMZ** | Federal Ministry for Economic Cooperation and Development (Germany) |
| **BDM** | Becker-DeGroot-Marschak lottery |
| **BFS** | Baby Friendly Space |
| **CEPEDRENAC** | Coordination Centre for Natural Disaster Prevention in Central America |
| **CMAM** | Community Based Management of Acute Malnutrition |
| **DHS** | Demographic and Health Survey |
| **DRM** | Disaster Risk management |
| **DRR** | Disaster Risk Reduction |
| **FGD** | Focus group discussion |
| **GBV** | Gender-based violence |
| **GNC** | Global Nutrition Cluster |
| **HS** | Household survey |
| **IHC** | Integrated Health Centre |
| **INP+** | Multi-sectoral nutrition programme |
| **IYCF** | Infant and Young Child Feeding |
| **KII** | Key informant interview |
| **LGA** | Local Government Area |
| **LBW** | Low birth weight |
| **MEAL** | Monitoring, Evaluation, Accountability and Learning |
| **MHPSS** | Mental health and psychosocial support |
| **NFHS** | National Family and Health Survey |
| **NGO** | Non-profit organisation |
| **PDSEC** | Social, economic and cultural development programmes |
| **PDP** | Psychological Distress Programme |
| **PLW** | Pregnant and lactating women |
| **R4ACT** | Research 4 Action |
| **R4NUT** | Research 4 Nutrition |
| **RRT Tech** | Rapid Response Team |
| **SAT** | Safety Audit Tool |
| **SITCA** | Secretaría de Integración Turística Centroamericana |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **UNICEF** | United Nations Children's Fund |
| **URENI** | Unit of Recovery and Severe Ambulatory Nutritional Education |
| **VHP** | Volunteer hygiene promoter |
| **WASH** | Water, Sanitation and Hygiene |
| **WFP** | United Nations World Food Programme |
| **WHO** | World Health Organization |

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# NEEDS ASSESSMENT AND ANALYSIS

## KEY LESSONS FROM BASELINE SURVEY AND WAY FORWARD FOR THE FIRST-1000-DAYS PROGRAMME IN INDIA

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### BACKGROUND AND CONTEXT

A Lancet study by Black et al. (2013) estimates that 40 to 50 million Disability Adjusted Life Years (DALYs) are lost to wasting in India; costing an economic loss of almost US$48 billion in lifetime loss of productivity. As per India's National Family and Health Survey (NFHS 2015-16), 21% of the population were affected by wasting, 38.4% had stunted growth and 35.8% of children under the age of five were underweight.

Action Against Hunger India first began its work with rural and urban slum populations in India through Community Based Management of Acute Malnutrition (CMAM). CMAM focusses on identification, treatment and prevention of malnutrition after the age of six months. In addition to child malnutrition, 50% (NFHS 2015-16) of pregnant women suffer from maternal anaemia. This, coupled with poor nutrition, affects the foetus during pregnancy, resulting in malnutrition such as low birth weight or small for gestational age. Poor Infant and Young Child Feeding (IYCF) practices further contribute to the high levels of child wasting and stunting. To prevent malnutrition from manifesting in children from birth, it is important to begin interventions with pregnant and lactating women. Therefore, in addition to working with children from 6-59 months through CMAM, it became imperative to incorporate the first 1000 days approach to achieve sustainable impact on maternal and child health and nutrition outcomes.

In order to develop Action Against Hunger India's first 1000 days plus CMAM intervention strategy, it was necessary to understand the factors contributing to the high prevalence of maternal and child malnutrition. A baseline survey was therefore conducted in Rajasthan, Madhya Pradesh and Maharashtra to ascertain the prevailing knowledge, attitude and practices associated with malnutrition.

### METHODOLOGY

The baseline was designed for pregnant women, lactating mothers with children aged six months, and lactating mothers with children aged from one to two years. The sample size for the baseline was calculated using the prevalence rates of three key nutrition and health indicators from the NFHS 2015-2016:

1. Children aged 12-23 months fully immunised (BCG, measles, and three doses each of polio and DPT) (%)
2. Children under age six months exclusively breastfed (%)
3. Mothers who had at least four antenatal care visits (%)

The survey questions investigated demographic and socio-economic status, access to hygiene and sanitation, knowledge and practices on maternal, new-born and child nutrition and healthcare, and access to government schemes. The tool was pilot tested to ensure its relevance and validity. To ensure arising challenges are resolved in a timely and appropriate manner, communication and documentation was conducted on WhatsApp.

## KEY FINDINGS AND LESSONS LEARNT

In all three states, despite diverse geographies, many indicators were similar. Indicators such as prevalence of institutional delivery, early registration of pregnancies at health facilities and early initiation of breastfeeding were found to be performing better than others. While Action Against Hunger India's collaborative work with the government during the CMAM project has facilitated gradual improvements in some of these indicators, considerable work is still required to decrease malnutrition in women and children in India. The survey highlighted high levels of maternal anaemia (80% or higher), low birth weight in new-borns (40% or higher), lack of exclusive breastfeeding and low uptake of ante-natal care. Dietary diversity in women and children was reported to be almost inexistent with a prevalence in the range of 1% - 9%. Poor hygiene and sanitation behaviours were reported, with an average of 91% mothers reporting unsafe methods of stool disposal for their children, and less than half of the mothers practicing handwashing before feeding, or after cleaning their child. The wasting prevalence ranged from 10% - 40% for the three states, showing a diverse range in the magnitude of child malnutrition.

It was interesting to find that low birth weight, anaemia prevalence, uptake of ante-natal care, exclusive breastfeeding, diet diversity and WASH practices were reportedly poorer in the baseline in comparison to those projected by government health surveys.

Migration of the beneficiaries from the sampled villages posed an operational challenge. In order to account for loss of sample size due to migration, the current estimated prevalence of migration was considered as the non-respondent rate. In addition, while conducting the baselines, women were often unavailable to participate in the survey, as they would leave to work in the fields. In order to overcome this, the community mobilisers would conduct the baseline survey with the women in their farm fields.

## WAY FORWARD FOR THE FIRST 1,000 DAYS PROGRAMME WITH CMAM

The findings from the baseline survey are now paving the way for Action Against Hunger India's revised strategy for the first 1,000 days with CMAM. It has brought to light the practices to be improved for better maternal and child nutrition and health outcomes. It became clear that the programme should incorporate Kangaroo Mother Care, a WHO recommended practice which involves holding the new-born to the caregiver's chest for a prolonged period of time. The baseline has also raised the need to find the reason behind the high anaemia rates and the low prevalence of diet diversity. An in-depth understanding on the knowledge levels and behaviour patterns surrounding diet and nutrition existing in the community is required to attain sustained impact in the long-run.

Maternal nutrition has a direct impact on the new-born and continues to influence the child's diet and nutrition as the child grows older. Though nutrition lays the foundation for a child's health, physical and cognitive development and in preventing malnutrition, other factors such as hygiene and sanitation also influence the child's vulnerability to malnutrition. The baseline findings revealed that certain practices such as safe disposal of stool, use of constructed toilets (home-based or community), access to safe water, and handwashing practices during critical activities continue to be poor. Therefore, innovative strategies in the area of WASH, in collaboration with the government, will facilitate improved adoption of good hygiene and sanitation practices that can prevent the spread of infections, and assist in breaking the disease cycle of malnutrition.

*Community mobilier conducting the baseline with sample beneficiaries*

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Traditionally, nutrition and health programmes have women as their main target for awareness and behaviour change. However, husbands and fathers along with mothers-in-law play an important role in household level health and nutrition decision-making. Where possible, baseline interviews were also conducted with husbands or fathers. The preliminary findings from the baseline suggested that men have similar levels of awareness as women. Considering these findings, it would be important to understand the knowledge, attitude and practices of husbands and fathers in relation to health and nutrition. Simultaneously, it becomes essential to progressively include them as part of the programme implementation.

Despite the availability of government health and nutrition schemes and services, access, uptake and service delivery remains limited. Collaboration with the government at each step, at the facility and the community level, will be required to increase availability and access to health and nutrition services.

The process and findings of the baseline have raised critical lessons on programme implementation, systems that require improvement and areas of opportunity to maximise impact.

# THE RESEARCH 4 ACTION (R4ACT) METHODOLOGY: HOW CAN RESEARCH INFORM OUR PRACTICES?

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## BACKGROUND

After decades of interventions, the need for improved integration of the latest available evidence into humanitarian programming is now recognised by all, including the international community. However, the quality and quantity of the current evidence on health interventions in humanitarian contexts is still limited. Many questions are still pending to bridge the gap between research and programming.

## METHODOLOGY

Action Against Hunger France developed the R4ACT (Research4Action) methodology in 2017. It provides methodological support to embed scientific evidence into programming and advocacy. This method actively engages programme, research, and uptake teams in all stages of the research, from framing the research question to incorporating scientific evidence into programmes, so that the three perspectives are equally and consistently considered throughout the process. The R4ACT topic is decided collegially based on relevance, priority and possibility to have actionable results. It involves a cross-sectorial needs assessment of the programmatic areas of interest and explores the impacts of one sector on another.

The first pilot, launched in 2017, focused on the impacts of cash on Severe Acute Malnutrition while the 2019 pilot explored the impacts of Water, Sanitation and Hygiene interventions on Acute Malnutrition. This article will detail the results of the 2019 pilot and explore the various stages of the methodology.

### STAGE 1. WHAT DOES THE EVIDENCE SAY ABOUT THE IMPACT OF WATER, SANITATION AND HYGIENE ON ACUTE MALNUTRITION? COLLATING PROGRAMME-FOCUSED EVIDENCE.

During stage 1, Water, Sanitation and Hygiene, and Nutrition and Health technical advisors jointly defined a list of specific Water, Sanitation and Hygiene interventions, referred as indicators, on which they needed evidence in order to assess their impact on Acute Malnutrition. Engaging both sectors in this exercise is essential to ensure indicators respond to key questions of both sectors and to improve integration between Water, Sanitation and Hygiene and Nutrition.

A review of the available scientific literature was then performed by a researcher in collaboration with the uptake advisor to make sure the report was a practical document providing a ready to use summary of the existing evidence.

## KEY FINDINGS

- The review highlighted the lack of robust evidence on the majority of indicators and the crucial need for more research on the relation between Water, Sanitation and Hygiene interventions and Acute Malnutrition.
- Moderate evidence showed the positive impact of water quality at household level during the treatment phase of Acute Malnutrition.
- Consistent evidence showed no association between the presence of improved household latrines and the prevention of Acute Malnutrition.

### STAGE 2. MOVING BEYOND RESEARCH: PAVING THE PATH TO PRACTICAL CHANGE

The R4ACT methodology uses a qualitative approach for stakeholder engagement. Rather than reaching a large number of actors, a limited but diversified and qualified panel of actors was invited to a one-day workshop in Paris. The panel was composed of technical advisors from a variety of NGOs and global clusters, with equal representation from Nutrition and Water, Sanitation and Hygiene sectors. The purpose of the limited but diversified audience is to keep the process flexible and dynamic while still taking into account various points of view, which fosters constructive discussion and facilitates transversal collaboration.

Based on the findings of the review, participants were requested to translate the evidence into concrete, practical actions that teams could implement to reinforce comprehensive programming on water quality. The group endorsed six key activities:

#### ACTIVITIES AT THE HEALTH FACILITY LEVEL

- Improve water systems in health facilities
- Systematically coordinate delivery of household water treatment adapted to context with Severe Acute Malnutrition management
- Water, Sanitation and Hygiene experts train health centre staff to: a) run health centre water systems and b) build caregiver capacity on correct use of household water treatment products

#### ACTIVITIES AT THE HOUSEHOLD LEVEL

- Develop behavioural change on water treatment in areas covered by Severe Acute Malnutrition treatment services
- Use of participatory methodology to select the most appropriate household water treatment method
- Improve information, knowledge and data sharing

At the end of the workshop, participants selected the activities that their organisation would commit to implementing in their programmes. Participants requested official sign-off of the report from senior management. Quarterly calls to follow up on the roll out of the roadmap will be organised over the year.

## HOW WILL THESE FINDINGS ENHANCE OUR PROGRAMMING?

The summary of the scientific evidence complemented by the outcomes of the workshop, will allow all the relevant stakeholders to make decisions, design and implement programmes based on the best scientific evidence available, which is fundamental to increase the efficiency and effectiveness of interventions. R4ACT also reviews current gaps in knowledge and will advocate for research in programmatic sectors in which evidence is still scarce.

## WHAT DID WE LEARN ABOUT THE R4ACT PROCESS?

The R4ACT pilots proved to be a very promising methodology to bridge the gap between research and action. Its main strengths are threefold:

1. **TIME** The process takes approx. 2 months for the literature review and report editing, followed by a one-day workshop, and regular follow-ups of the action plan roll out), inclusiveness and the fact that it is action focused.

2. **INCLUSIVE** The researcher's input is crucial in the first stage of the process to guarantee the robustness of the approach while the technical expert ensures the programmatic relevance of the questions explored. Inclusiveness is also achieved by systematically choosing a cross-sectorial topic to improve integration.
3. **ACTION-FOCUSED** The R4ACT process can only achieve behaviour change if efforts are made to ensure recommendations are disseminated within the teams and if they are integrated in new proposals, strategies, interventions and advocacy.

### WHAT HAS ALREADY CHANGED?

- The findings of the review were presented in two international scientific conferences: University of North Carolina, and Research 4 Nutrition (R4NUT)
- The Global Nutrition Cluster and the Water, Sanitation and Hygiene cluster are kick-starting discussions on a common work plan.
- Action Against Hunger launched the TISA research project, aligned with key R4ACT findings regarding the quality of water.
- Advocacy teams in West Africa drafted their advocacy strategy based on R4ACT recommendations.
- Other R4ACT participants besides Action Against Hunger have integrated R4ACT recommendations into Health and Nutrition strategy revisions, COVID-19 response plans, new proposals, joint assessment questionnaires, etc.

### WHAT STILL NEEDS TO BE DONE?

- It is important to have a person responsible for moderating the discussion at the internal level as well as with other organisations that take part in the R4ACT workshop to ensure that both sectors continue collaborating on the implementation of activities.
- Cascading the information to the field and ensuring that the people in charge of implementing the activities commit to implementing the action plan remains a challenge. Technical teams from the field should play a more active role in the process.
- The definition of indicators is important to monitor progress. Holding participants accountable to these indicators remains a challenge.

The next pilot will therefore explore ways to better engage field operations from the outset. We are planning to scale up the methodology thanks to its very simple pattern: what do we know? What should we do? How can we change? The adoption of R4ACT reinforces the overall learning culture of our organisation, which has a strong positive impact on the quality of services delivered.

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# WILLINGNESS TO PAY: IMPROVING ACCESS TO SAFE DRINKING WATER IN HAITI

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### ACCESS TO SAFE DRINKING WATER IN HAITI

Over the past 10 years, Action Against Hunger has been working to facilitate access to safe drinking water in vulnerable communities in Haiti, particularly in cholera-prone areas. Our work includes water point construction, water point rehabilitation, supply of drinking water and promotion of home water treatment. These initiatives stem from the fact that the country's poor access to drinking water is conducive to water-borne diseases and thus increases the risk of malnutrition. According to the results of the Mortality, Morbidity and Service Use Survey (EMMUS VI, 2016-2017), only 60% of the Haitian rural population has access to improved water sources and the prevalence of diarrhea is 20.6% for girls and 21.8% for boys under the age of five. Due to the impossibility of supplying all areas with hydraulic infrastructures quickly, Action Against Hunger is relying on home water treatment to improve the situation of vulnerable Haitians in the short and medium term.

### EXPERIMENT IN PROMOTING HOUSEHOLD WATER TREATMENT

From June 2018 to February 2019, Action Against Hunger implemented a project funded by UNICEF to promote home water treatment. The strategy revolves around two main axes: distributing fully subsidised coupons to users of unsafe water points for the acquisition of a home water treatment solution/Aquajif, and supporting the vendors of water treatment products. The intervention reached 8,048 beneficiaries with the involvement of 10 vendors. As a first step, Action Against Hunger gave a bottle of Aquajif to households in order to familiarise them with this product and its use. Then, each beneficiary received two coupons covering the entire price of a bottle of Aquajif in order to connect households to their nearby retailers. The coupon distributions were coupled with awareness sessions to

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encourage purchase and use of Aquajif after the intervention. The results of the final survey showed that the majority of the targeted population had adopted the use the water treatment product. During this survey, 77% of the households visited underwent a test for residual chlorine in drinking water (a sign that the water has been treated). Results show that the beneficiaries didn't use the correct dose of the product. Only 45% of the tests showed an appropriate residual chlorine level between 0.5-1g/L. However, traces of chlorine in drinking water were found in approximately 70% of beneficiary households, up from 43% of households at the baseline. The vast majority of households report treating 2 to 3 buckets of 25 liters of water per day. 32% of beneficiaries said they wanted to integrate this product into their household's current expenses and are prepared to spend 57 gourdes on average to get a bottle (the price is 50 gourdes).

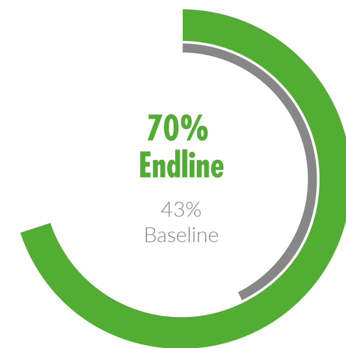


*Figure 1: Presence of chlorine in drinking water (Source: Endline)*

However, a study conducted in February 2019 showed that availability and access are the main factors in the use of these products and that the willingness to pay for a bottle of Aquajif is actually less than 57 gourdes. This study used the Becker-DeGroot-Marschak (BDM) lottery, an experimental method, to avoid reporting bias. BDM's exercise consists of a free lottery game, in which respondents have the opportunity to buy the product at the maximum price they wish to pay for it. This method puts the consumer in a real situation of purchase. The results suggest that users are willing to pay between 32 and 35 gourdes for the bottle (its selling price is 50 gourdes).

*Community sensibilisation on water treatment*

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These key lessons prompted us to conduct a post-intervention follow-up survey three months after the project. From March 2019 to May 2019, Aquajif vendors sold a total of 45 bottles combined. The people who frequent the outlets are mostly former beneficiaries. Assuming that each of these 45 bottles was bought by a different beneficiary, only 0.56% of the beneficiaries continued to buy the product. They understand the health benefits of treated water and they use domestic water treatment products when they are given free of charge. However, they do not buy them, even when they are available nearby.

## HOW TO ACHIEVE BETTER RESULTS?

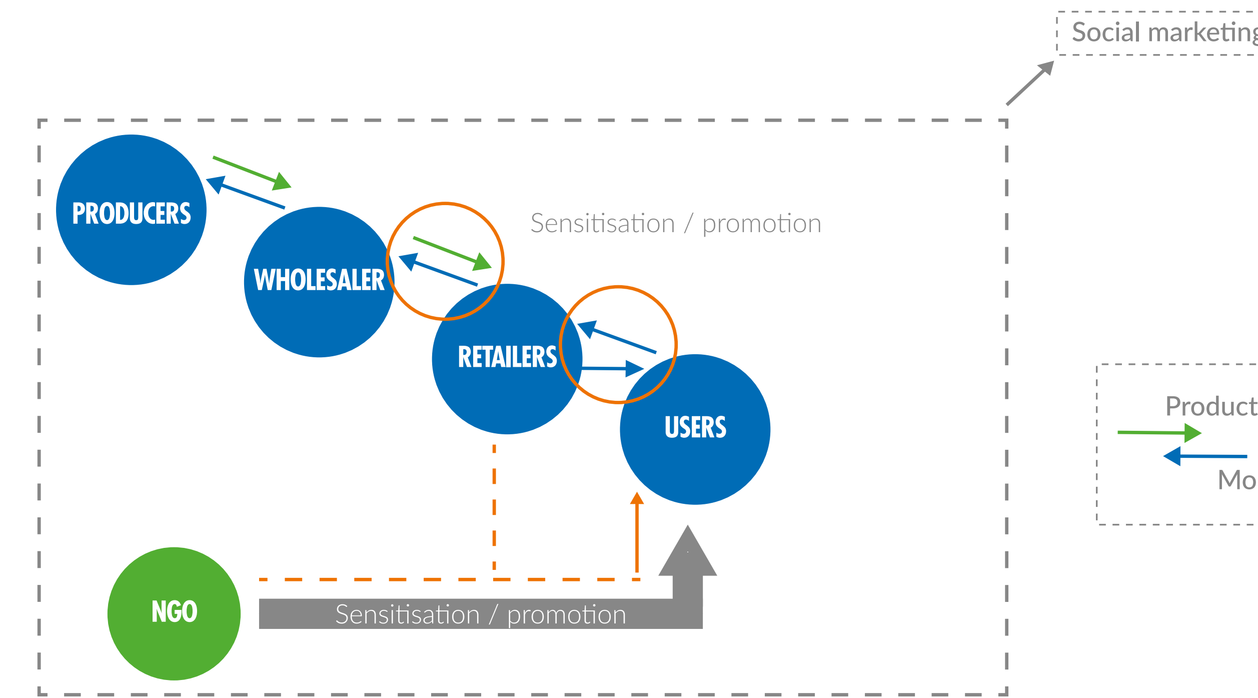


*Figure 2: Distribution chain of home water treatment products.*

UNICEF, the project's donor, organised a lessons learned workshop with different partners they are funding in the WASH sector. This study has showed that in any intervention aiming to increase the use of home-water treatment products, special attention should be given to the restocking of the points of sale and the retention of users. These learning exercises fuelled the design of a new project. Building on lessons learned, the new project will feature:

- A social marketing strategy that makes use of declining vouchers in order to progressively acclimatise users to buying home water treatment products.
- Continuous awareness and promotion activities outside the project period.
- The establishment of a framework agreement between the producer of Aquajif and Action Against Hunger in order to guarantee price stability.
- Stronger connections between wholesalers and retailers of water treatment products.

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# STRATEGIC PLANNING AND RESOURCE MOBILISATION

## BUILDING RESILIENT TOURISM IN CENTRAL AMERICA

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### MULTI-THREATS AND VULNERABILITIES

Central America is the world's second most vulnerable region to adverse climate and geological hazards and is therefore constantly exposed to multiple threats. Tourism is a major driver of the economy and is highly sensitive and vulnerable to the expectations and confidence of visitors in the event of a disaster. Indeed, beyond the most direct humanitarian impact of disasters, their occurrence could damage the reputation of the tourist destinations, with negative effects on livelihoods and the local economy. In recent years, the region has faced Hurricane Otto, Hurricane Nate and the eruption of the Fuego Volcano, which all caused human losses and significant material damage. These disasters particularly affected tourist destinations with fragile knowledge of Disaster Risk Reduction (DRR) practices. The main tourism destinations are in areas with a low culture of disaster preparedness. Additionally, the tourism sector in the region has no history of inter-institutional coordination on DRR issues.

### PUBLIC-PRIVATE PARTNERSHIP AND DRR APPLIED TO THE TOURISM SECTOR

Action Against Hunger in Central America and its' partners developed a response plan to address this problem. Climate and geological disasters affect communities that completely depend on the tourism sector for their livelihoods. Loss of this source of revenue will undoubtedly drive swathes of the population into poverty. Action Against Hunger has been working under a Public Private Partnership model in Central America since 2015. We expanded this approach to the tourism sector by connecting the national Chambers of Tourism with civil protection bodies to generate coordination for the development of resilient tourism in four pilot areas.

The eruption of the Volcano Fuego in Guatemala led to a number of joint initiatives between the public and private sectors in recovery and reconstruction processes, which highlighted the importance of coordination in implementing resilient practices.

Since 2000, Action Against Hunger has worked to promote DRR by including innovative approaches from the private sector. The organisation's accumulated experience has been key to the development of DRR in Guatemala and Nicaragua to strengthen the resilience of the most vulnerable tourism destinations. In the last two years, interventions have been implemented around four axes:

- Assessment of the existing risks
- Improvement of the public-private capacity for disaster prevention and mitigation
- Improvement of Disaster Response Preparedness
- Promotion of resilient and sustainable tourism

This project has been developed in alliance with the National Chambers of Tourism of Guatemala (CAMTUR) and Nicaragua (CANATUR), Universities (UNAN-UNI), Governing Bodies in charge of DRR, tourism entrepreneurs, Municipal Governments and regional governmental bodies (SITCA and CEPREDENAC). It represents an example of collaborative, holistic and multidimensional work that has managed to improve resilience in Central American destinations.

### WORKING TOGETHER TOWARDS RESILIENCE

The initial alliance between the tourism and civil protection sectors revealed a lack of mutual knowledge between both areas of work in the countries, particularly when faced with a hypothetical emergency or disaster in tourism destinations. On one hand, there was no coordination mechanism for emergency and disaster response in these communities, and on the other hand, there were no contingency plans from private companies to withstand the impact of disasters, which would put business continuity, jobs and development at risk.

One of the challenges we faced was the preconceived notion that entrepreneurs and the general population were already resilient, and that building additional resilience would be too costly. The greatest challenges have been to achieve a change in the behaviour of business people concerning responsibility and commitment to civil society, and for state entities to strengthen their work in collaboration with the private sector.

The project created spaces for coordination between the tourism and civil protection sectors and trained members of civil society on DRR and disaster risk management (DRM) issues. Local and national authorities also joined the trainings in the aim of contributing to safe and resilient tourist destinations in inter-institutional coordination.

We learned that the recognition and inclusion of all stakeholders is key to establishing strategic public - private alliances to save lives, prevent and reduce losses, ensure rapid recovery of the affected area, its population and livelihoods.

### PUTTING REGIONAL INTEGRATION INTO PRACTICE

Following these initial trainings, the governing body of civil protection in Guatemala replicated some of the project's activities, such as the minimum standards for the certification of "resilient hotels" and the creation of a "pilot" award to companies that are committed to Integrated Risk Management and Disaster Risk Reduction in Guatemala.

Public and private partnership and DRR interventions from the tourism sector are an example of regional integration that has favoured i) the protection of life; ii) the improvement of the quality and competitiveness of tourism enterprises; iii) the collective multi-stakeholder support; iv) the promotion of investment with resilient parameters and; v) the promotion of disaster risk reduction from public and private investment as a contribution to sustainable economic development.

Sharing good practices and experiences in dialogue spaces before regional bodies such as the Central American Tourism Integration Secretariat (SITCA) and Coordination Centre for Natural Disaster Prevention in Central America (CEPEDRENAC) has contributed to strengthening processes of adoption of DRR initiatives for the tourism sector with a view to future replication, consolidation and sustainability.

### THE FUTURE OF TOURISM RESILIENCE

The coordination between these sectors has opened the door to a new stage of tourism in the region. For instance, the regional entity for

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Risk and Disaster Management in Central America and the Dominican Republic has included the issue of risks in its minimum quality standards of the sector, and scaled it up to the Central American Tourism Integration System. DRR standards presented by Action Against Hunger, the National Chambers of Tourism and Civil Protection, were adopted and recommended for implementation in tourism zones.

The Guatemalan Chamber of Tourism prioritised creating spaces for discussion around resilience. Even after the closing of the project, it continued to open new spaces for DRR discussion with government entities. It presented the topic at world forums alongside the Ministry of Tourism, such as the International Tourism Fair held in Madrid in January 2020. At the local level, tourism destinations have adopted tools for territorial and business planning that allow them to improve their disaster preparedness. The sector's heightened vulnerability to disasters has contributed and increasingly coordinated a proactive approach to planning, training and preparing tourism destinations. We will continue exploring public-private partnerships in future projects to build on these lessons learned around maximising stakeholder engagement and project impact.

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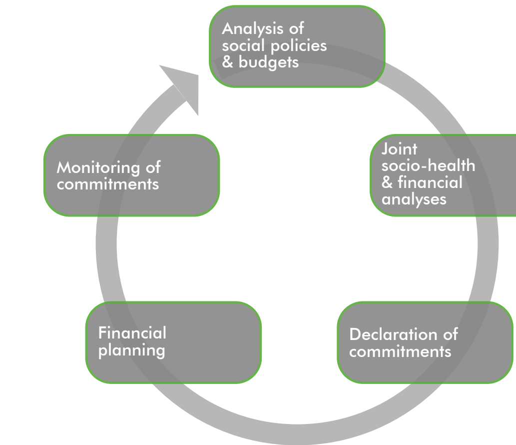
## CONTEXT

Action Against Hunger has been present in the sub-region (Mali, Mauritania, Niger) for fifteen years[1], implementing multi-sectorial projects that aim to reinforce resilience within communities for the prevention and treatment of malnutrition.

The main challenge Action Against Hunger faces in the region is that of ensuring the continued delivery of services related to food safety and nutrition. To overcome it, our efforts are twofold. First, we ensure that nutrition is systematically integrated into communal development plans and budgets, and we support the implementation of a multi-sectorial response at the decentralised level. Second, we support the formulation and implementation of multi-stakeholder dialogue at the regional level, and advocate for the inclusion of nutrition in budgets with parliamentarians.




## ADVOCACY CENTRED ON COMMUNITIES

Action Against Hunger uses a 5-step methodology to conduct an in-depth analysis of the socio-economic and health situation of local communities. Together with town councils and other partners in the area, plans, policies and budgets are analysed in order to identify underlying deficits, as well as opportunities for sustainable investment in the delivery of services related to food safety and nutrition. This approach often involves strengthening the technical, managerial and financial capacities of key decision-makers at the local level during workshops held in Mali, Mauritania and Niger.

## IN MALI

Since 2017, Action Against Hunger has undertaken advocacy actions in partnership with the National Federation of Community Health Associations at the national and local level in order to advocate in favour of sustainable investment towards the continued delivery of services related to food safety and nutrition by local authorities. In 2019, thanks to our advocacy work, 53 communes in the Kayes region integrated nutritional security into their social, economic and cultural development programmes (PDSEC). For example, the commune of Gadougou built two maternity wards, and recruited

1 In Mali, in the Kayes region, these interventions started with Kita Cercle (2007) before reaching Kayes Cercle (2016) and Bafoulabé Cercle (2018). In Mauritania, Action Against Hunger is present in Guidimakha, Nouakchott, Hodh El Charghi and Gorgol. In Niger, interventions have been deployed in Tahoua, Maradi and Diffa since 2005.

two obstetric nurses, while the commune of Sefeto-Nord built a structure for the care of children admitted to the Unit of Recovery and Severe Ambulatory Nutritional Education (URENI) within the community health centre.

This unprecedented success was made possible thanks to the strong mobilisation of all stakeholders in the process, such as municipalities, local media, community and district health centres, and administrative and technical authorities, including mayors.

## LOCAL ADVOCACY COMPLEMENTS NATIONAL EFFORTS

In Niger, at the national level, Action Against Hunger worked with the Ministry of Public Health to elaborate a roadmap for the resumption of National Protocol for Integrated Management of Malnutrition (PCIMA) activities by the state. This document provides for the implementation of coordinated recovery plans between the authorities and humanitarian actors. Within this context, advocacy actions carried out at the communal level led to an increase in the number of activities related to nutrition and health included in the Annual Investment Plans (PIA). Advocacy actions also led to an increase in the share of domestic financing dedicated to these activities.

For example, the municipality of Mayahi contributed to connecting its Integrated Health Centre (IHC) to the water reservoir, while the municipality of Tchaké covered the costs of water supply for its IHC. The health evacuation system particularly benefited from this increase in financing, reaching up to CFA 1,900,000 per municipality (€2,900).

The main challenge was that the majority of local elected officials did not master the methodology for developing and reviewing PIAs. Action Against Hunger therefore organised trainings in planning and budgeting that were provided by the decentralised directorates of the Ministry of Planning. This peer-to-peer capacity building has proven to be sustainable as local actors who have concrete experience of cooperation between different levels of governance will then replicate it on other occasions.

## INNOVATIVE SOURCES OF FINANCING TO MOBILISE RESOURCES

To compensate for the limited resources of communes in Niger, a campaign of mobilisation of good will was launched with town councils. Representatives of diasporas, the private sector, as well as influential personalities were identified to participate in mobilisation workshops. During these workshops, the mayors presented the health situation in their respective communes, as well as current nutrition and health activities in need of funding. The various representatives made commitments to help and collection committees were set up. Since then, several infrastructure works have been carried out, including the renovation of the IHC in the commune of Tabotaki and the construction of treatment rooms in the commune of Tamaské.

Faced with the reluctance of some local elected officials to seek alternative sources of funding, an inter-municipal meeting was organised, during which the communes presented the challenges they faced in terms of recovering funds, monitoring, and carrying out activities, as well as the solutions they had put in place to remedy them. Some communes were thus able to serve as models to others.

## THE DIFFICULTIES OF DECENTRALISATION AND THE CHANGING POLITICAL LANDSCAPE

In Mauritania, despite several notable advances, strong partnerships with the network of women parliamentarians and mayors' associations; commitments made by mayors following inter-communal workshops, significant challenges remain.

Decentralisation in Mauritania was instituted in 1986 through the creation of municipalities that were given certain competences, which had been the abilities of the state until then. However, the impact of these reforms on communal structures is still limited. Indeed, the municipalities have not made any progress in terms of recovering revenue and mobilising external funding. Very few municipalities submit requests for funding, rather, it is the partner that takes the place of the municipality and offers funding. The plans for communal development have often been allowed to relapse, partly because of difficulties being able to edit and revise the plan, with the exception of those that have benefited from the support of a partner.

In addition to financial constraints, several municipalities changed mayors during the last elections in 2018. Indeed, out of 18 communes where Action Against Hunger intervenes, 12 new mayors were elected. With each new elected official, we have been forced to restart the five step cycle and organise new trainings, thereby slowing the rate of progress in the area.

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# STRENGTHENING RESILIENCE THROUGH CROWDFUNDING IN SOMALIA

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## BACKGROUND AND CONTEXT

The standard humanitarian funding approach is primarily donor driven: a top down approach with little engagement with beneficiaries and local Government actors. The beneficiary contributions to programming in particular need examining as they are not well integrated into the standard project design approach. A different approach to funding and project design is crowdfunding. This aims to integrate local resources such as beneficiary communities, local authorities, private investors and diaspora populations through an online fundraising platform. Not only can this generate extra resources for humanitarian and development funding, it can also enhance accountability, transparency and effective programming. Through a collaborative process, government and local actors can also be involved in the procurement/ finance process.

The concept of crowdfunding has been introduced in Somalia in recent years with many Somalis showing interest in contributing to community owned activities. For too long, decisions on what gets to be funded have been taken by everyone except the communities most affected by those decisions. In Hudur, in the south west of Somalia, Action Against Hunger in collaboration with Shaqadoon, a local NGO, started an online campaign to raise funds for communities living in Hudur through their online platform called Bulshokaab. This platform is for development initiatives across the Somali region. Bulshokaab is an initiative of the Somali Resilience Program (SomReP), a consortium of seven international agencies (Oxfam, ADRA, Action Against Hunger, Danish Refugee Council, CARE International, COOPI and World Vision International) aimed at building resilience across Somalia.

## USING THE APPROACH IN SOMALIA

Action Against Hunger in collaboration with Shaqadoon established a crowdfunding platform for projects with a social impact. Seeking to secure funding from the administration, individual citizens, non-profit organisations and private companies. Shaqadoon were responsible for sensitising communities to get a better understanding of how crowdfunding works to promote community ownership over social initiatives. They have transformed the community mindset to contribute towards a common goal through crowdfunding by mobilising and training community representatives who have then presented successful crowd funding projects in Gedo region.

The community was mobilised to form a 13 member committee (consisting of intellectuals, religious groups, elders, youth groups and the local authority) to be in charge of every project who then opened accounts in both Dahabshil and Salaam bank. The project was posted on their online platform and people from across Somalia and the diaspora started contributing money towards the three shallows wells and one borehole for the community in Hudur district.

Currently, Sheikh Aweis borehole crowdfunding is at $10,330 and $3117 for the three shallow wells in Shidle, Kheyr Cabdille and Waney village in Hudur. With the amount raised for each shallow well, Action Against Hunger will top up with $28,427.50. The rehabilitated water catchments and shallow wells by the SWS-DRP project are currently supporting the communities amid the looming drought and water crisis in Hudur, while complimenting WASH projects targeting IDPs with water trucking.

Based on the experience of the Action Against Hunger team in Somalia, there are four steps to ensuring that a crowdfunding initiative is successful:

1. Setting up the platform and sensitising, mobilising and training community members on how to propose projects.
2. Communities (endorsed by their local authorities) and initiatives (endorsed by an organisation) submitting projects to an online crowdfunding platform like Bulshokaab.
3. An expert panel reviewing and deciding whether the project proposal that has been submitted meets the criteria to qualify for funding through the online platform.
4. Selected projects receiving a start-up workshop.Communities should have access to one on one support on how they can create awareness about their project with the support from their endorsed organisation.

*One of the shallows that the community and Action Against Hunger have crowdfunded for in Waney village Hudur district South West Somalia.*

© Action Against Hunger Somalia

## KEY FINDINGS AND LESSONS LEARNT

Through the formation of committees for the crowdfunding project, a sense of community ownership was developed as members of the community organised and made decisions at each stage of the project. This also allowed for transparency and accountability as committee members regularly updated the community on the amount of funds raised on the platform.

Various stakeholders were brought together through the crowdfunding initiative. The community, local authority and ministries at state and national level were involved in the process of raising awareness and mobilising people to contribute through the crowdfunding platform. Shaqodoon have in the past succeeded in raising $300,000 from local diaspora communities for one of their crowdfunding initiatives in Jubaland.

Community members have also had an opportunity to give their feedback through a Beneficiary Feedback System that allows for the organisation to give first-hand response on any matters arising from the crowdfunding project as well as other projects. Feedback such as complaints, suggestions, enquiries and appreciations are shared through either SMS or through the Interactive Voice Response (IVR) system. The IVR has been a unique initiative, since it allowed beneficiaries to share their feedback directly by sending a recorded message through an easy to remember short-code (310), which is then captured into a platform where Shaqodoon maps the nature of the feedback into categories. This type of technology friendly feedback mechanism has really boosted the confidence level in communities.

On the other-hand, some of the challenges we have encountered is the limited financial systems that hinder the diaspora community from contributing to the platform. We are currently using Shaqodoon's Crowdfund platform, who are a local organisation that is not internationally registered therefore limiting contributions from Somali diaspora who have credit card facilities. However, they do have Taaj service, a money transfer company. Taaj is limited to the diaspora community who have credit card facilities and are not familiar with remittance companies such as Dahabshiil. The current platform is connected to all local financial institutions who provided the FINTECH mobile money services in Somalia making it simple for those with access to mobile banking to contribute through the platform.

Lastly, community projects are not a familiar concept in most rural areas in Somalia. Some of the challenges that arise from crowdfunding for this project include reluctance from the communities to contribute to projects, with many citing that there should be projects other than construction and rehabilitation of water points in the community.

Action Against Hunger will assess the impact of this approach during Action Against Hunger SomRep EU southwest drought recovery end line evaluation. The findings of the endline evaluation will be disseminated through social media (Twitter, Facebook), high level events organised by the government/private investors and sector work groups meeting (food security clusters, resilience working group forums) to create awareness on the approach's viability and promote confidence in the contributors to support future funding for such initiatives.

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# IMPLEMENTATION AND MONITORING

## INTEGRATING A PSYCHOLOGICAL DISTRESS PROGRAMME ALONGSIDE NUTRITION SERVICES – GAMBELLA, ETHIOPIA

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### BACKGROUND AND NEED

Experience of working in mental health shows us that often those most in need are least likely to access services. Reaching out into the community and talking about psychosocial issues, promoting anti-stigma messages, building knowledge among family, community leaders and teachers allows greater chances to identify and engage with those in need of psychological assistance – especially among the most hidden and vulnerable in the community.

Reports on the mental health of South Sudanese refugees in camps in the region (UNHCR, 2016) showed high levels of moderate to severe poor mental health including Post-Traumatic Stress Disorder, major depression, acute anxiety, psychosomatic symptoms[2], adjustment disorder, negative behaviour, suicidal ideation and neglect of both family and self. Most affected are vulnerable groups including mothers and young children, which impacts basic infant and child care practices.

Following the formation of South Sudan and the subsequent civil war, hundreds of thousands of South Sudanese fled the region into neighbouring countries, including Ethiopia. In response to a renewed round of fighting and violence which led to a new influx of refugees, a new camp was established to host 82,000 individuals. As part of Action Against Hunger's response, five nutrition centres were constructed, each containing a Baby Friendly Space (BFS). A BFS is a holistic, safe space providing Infant and Young Child Feeding, Care Practices and Psychosocial Support to pregnant and lactating women and infants as part of an integrated Community Management of Acute Malnutrition (CMAM) programme.

The BFS teams reported **HIGH LEVELS OF POOR MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS AMONG THEIR PREGNANT AND LACTATING BENEFICIARIES**, and noted that many were not engaging with services regularly. Stigmatisation of poor mental health also seemed to be contributing to isolation and a lack of engagement. As there was no mental health provision in the camp, a special psychosocial support sub-activity named the 'Psychological Distress Programme' (PDP) was developed as a pilot under the BFS range of activities in the next round

2 Psychosomatic Symptoms – such as pain or shortness of breath, or more general symptoms, such as fatigue or weakness

of funding, that involved establishing a small team of psychologists to link into the community. The service was designed as a mobile (peripatetic) activity, with the team being able to move around the camp. The team were able to provide activities in different locations such as 'under the tree' in the camp community, in schools, health sites, other NGO buildings as well as in Action Against Hunger sites including the Baby Friendly Space.

## WHAT WAS OFFERED

The primary objective of the service was to reach out and engage with those in need of psychological support that were being missed or were hidden – particularly mothers and caregivers who were part of the nutrition programme. This also included family members. The service also wanted to contribute to improving the acceptance of mental health and understand more about how mental health is seen within the Nuer refugee population.

The programme was implemented by three teams, comprising of three qualified psychologists and three local speaking psychosocial workers, working in pairs. The teams were clinically supported by one Senior Psychologist and a Mental health and psychosocial support (MHPSS) Technical Advisor in the programme. These teams would provide group and individual therapeutic sessions, organise awareness campaigns in the community, train teachers and community leaders on psychological first aid and mental health awareness, make and support referrals with protection and health agencies, and advocate with NGOs and UN agencies at cluster and coordination level.

## KEY FINDINGS & LEARNINGS

The **PILOT WAS ABLE TO EVIDENCE A HIGH PREVALENCE OF POOR MENTAL HEALTH AMONG BENEFICIARIES**. Psychologists reported from one-to-one sessions of high levels of multiple issues including: depression (67%), acute anxiety & fear (44%), psychosomatic symptoms (41%), self-harming & suicide ideation (19%), drugs/alcohol (self or partner) (15%), and psychotic symptoms (14%). Other key findings showed that 45% of children referred (between 5-10 years old) were for symptoms related to epilepsy. 86% of the referrals for children (16 years old and under) were for developmental, intellectual and/or physical impairment issues. The results showed a number of hidden issues. One worth noting is that 8% of adolescent and adult females coming to counselling sessions sought help for problems relating to gender based violence including rape. This led to the establishment of a close collaboration with GBV and Child Protection providers for referrals and case management.

These findings clearly indicate the huge need for mental health support within the refugee population, and have provided evidence for the humanitarian community, supporting further initiatives in this sector. For example, a specialist mental health NGO used these findings to secure long-term funding for their mental health programme in the same camp targeting adults through the health sector.

This pilot helped us understand how we can reach and better assist those who are most vulnerable. We found that mothers and caregivers were quick to engage with the range of services offered, illustrating that with sensitive programming (that included building a lexicon of words that describe mental health issues in their language) and with strong linkages via nutrition services, trust could quickly be established. In beneficiary feedback interviews, 98% said they found services helpful and 85% said they would recommend this to others mothers and caregivers they knew.

A particularly important learning concerning complementarity of nutrition and mental health services, is the effectiveness of the BFS as a linkage between nutrition, IYCF, child care practices and psychosocial support. As most mothers used the BFS, they had already experienced a more psychologically orientated service that incorporated their emotional well-being and this contributed to establishing of trust and improved acceptance of working with psychologists. This also worked effectively for GBV and protection beneficiaries who preferred to discuss issues initially with the psychologists who then linked them to protection agencies. It is therefore vital for future programming to create links between the various services, taking a more holistic approach that considers all aspects of health and well-being.



## CHALLENGES

The main challenge lies in longer-term financing. For most donors, Mental Health and Psychological Support activities usually sit outside of nutrition interventions and are more typically considered part of a health or protection interventions. Securing funding for these type of programmes can therefore be more difficult, although positioning this as an integrated programme with nutrition was successful.

Another challenge is to ensure that there is a suitable referral pathway for more severe cases. Support from a regional hospital with a psychiatric unit is helpful, and collaboration with universities in the region with mental health departments can be beneficial for mental health advocacy. Both regional hospitals and local universities can play a vital role in providing clinical resources such as staff and students.

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# BABY WASH AND PROTRACTED DISPLACEMENT: LESSONS LEARNED FROM NANGERE LOCAL GOVERNMENT AREA, NIGERIA

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## BACKGROUND

Despite economic growth in recent decades, Nigeria continues to carry one of the most severe malnutrition burdens in the world. According to the Nigeria Demographic and Health Survey 2018, 37% of Nigerian children aged 6 to 59 months are stunted, 7% are wasted and 22% are underweight. UNICEF estimates that just 18% of Nigerian children aged 6 to 23 months receive the minimum acceptable diet, and 80% of malnourished children under 5 lack access to treatment.

Regionally, stunting is most prevalent in the country's northern states, where non-state violence under the Boko Haram Insurgency has uprooted more than 2.5 million from their homes. Of all states, Kebbi, northwestern Nigeria, bears the highest proportion of stunted children (57%), while Anambra in the Southeast bears the lowest (18%). In Yobe, northeastern Nigeria, military interventions have depleted security barriers and exposed pockets of famine, allowing humanitarian organisations to access the displaced.

## THE BABY WASH APPROACH

A growing body of evidence indicates that access to safe water, sanitation and hygiene (WASH) is a key determinant of growth in a child's nutritional development, with a number of studies signalling the need for stronger integration of the WASH and nutrition sectors of programming.

In line with this evidence, a Link Nutrition Causal Analysis (LinkNCA) conducted by Action Against Hunger in 2017 found inadequate access to safe WASH to be a major risk factor for malnutrition in Nangere Local Government Area (LGA), Yobe State. The study revealed that 99.1% of households in the survey area relied on untreated groundwater for drinking and washing, 85.6% lacked access to safe latrines, and 14.1% used soap and water for handwashing. Among the participants surveyed, ash was not known as an alternative to soap, and knowledge of water treatment practices was minimal. The findings called for a multi-sectoral response, underlining the potential that a more integrated approach to programming could have in remedying the high rates of stunting and global acute malnutrition (GAM) in the region, which, in 2017, stood at 68.8% and 14.7%, respectively.

In response, Action Against Hunger applied the Baby WASH approach – an integrated package targeting children in their first 1000 days of life (the critical window of opportunity for preventing malnutrition). The pilot aimed to address the LinkNCA's findings by providing pregnant and lactating women (PLWs) with basic handwashing resources (soap and materials for constructing a 'tippy tap'); complementary feeding items (lidded cups and bowls, child cutlery and play mats); and training on child WASH and nutrition. 5,562 PLWs were targeted across a period of 18 months, and interventions were administered as part of a wider multi-sectoral nutrition programme (INP+), which was implemented in partnership with UNICEF, the WFP and the local government.

## ASSESSMENT OVERVIEW

A mixed methods study comprising 800 household surveys (HSs), 11 key informant interviews (KIIs) and 9 focus group discussions (FGDs) was undertaken to determine the relevance, effectiveness and sustainability of the response. For comparative purposes, data from the target group was mapped against that of a non-intervention community in Tarmua, who did not receive the package.

HSs were constructed using an Open Data Kit platform, and answers were recorded using mobile devices. 9 of the 11 KIIs were conducted individually, and 2 were conducted in 2 groups of 2 and 4 members. FGDs were undertaken in 5 intervention communities and 4 non-intervention communities, 8 of which were identified as comprising the highest number of participants in the INP+ programme. The fifth intervention community, a smaller rural community in Nangere, was selected to broaden analysis.

## KEY FINDINGS

When compared with the non-intervention community, rates of handwashing were significantly higher (17.2%) in the intervention community, with 90.4% of PLWs in Nangere demonstrating consistent and adequate use of soap upon endline observation. While 90.9% of Baby WASH participants reported daily use of the complimentary feeding items and child play mats, acceptance of the 'tippy tap' remained low, with 96.05% of PLWs expressing a preference for traditional kettles.

Risk perception of child diarrhoea incidence remained low among PLWs in both communities, and, although Baby WASH participants demonstrated significantly better knowledge of 6 faecal to oral transmission routes, fewer than half were able to identify routes besides drinking dirty water or eating food contaminated by flies. Additionally, there was no significant difference ($p<0.05$) in the number of PLWs who identified child mouthing as a cause of diarrhoea between the communities, and FGDs in both revealed that many PLWs still believed that diarrhoea was a symptom of teething.

Despite these findings, the recalled prevalence of diarrhoea among children under 2 was significantly lower ($p<0.05$) in the intervention community (16.7%) than in the non-intervention community (23.0%), and a binary logistic model showed that children in households with improved sanitation were three times less at risk of diarrhoea than those in households with unimproved sanitation.

## EVALUATION

The Baby WASH package was implemented in Nangere LGA with the aim of improving household sanitation and reducing the prevalence of stunting and malnutrition among children within their first 1000 days of life. While an overall improvement in household sanitation and diarrhoea prevalence was observed, the sustainability of the approach was, upon evaluation, questionable.

Many PLWs in the intervention community expressed that, although they wanted to implement their learnings from WASH training sessions, they often lacked the resources to do so fully and effectively. Only 46% of households in the survey area had access to a safe water source such as a borehole or protected well, and those who fell outside of this percentage felt that, on a practical, day-to-day level, using sterilised, boiled water at all times during baby care was not easily achievable.

In KIIs, community stakeholders also expressed concerns over the sustainability

of the Baby WASH package in Nangere LGA, emphasising that, in exclusively targeting PLWs, interventions were unlikely to promote community uptake of safe WASH practices, and, in turn, the development of safe WASH environments for children who had reached roaming age. They also emphasised that, because the Baby WASH package was primarily implemented by Action Against Hunger staff, interventions replicated those rolled out in emergency response contexts, rather than those that would facilitate sustainable development.

### RECOMMENDATIONS

The issues outlined above emphasise that, if the Baby WASH approach is to facilitate community resilience and long term uptake of safe WASH practices in protracted displacement contexts, household level interventions need to be integrated with those that improve WASH at the community level. Findings from the HSs, FGDs and KIIs suggest that more direct stakeholder engagement in interventions, coupled with a greater focus on capacity building initiatives that allow community workers to take ownership of WASH and nutrition training sessions, would greatly enhance the Baby WASH approach's sustainability and long term effectiveness. It is also evident from KIIs that interventions need to target all caregivers (including fathers and the elderly) to ensure that the full impact of Baby WASH training is realised.

Such changes could be reinforced by (a) engaging local institutions (such as mosques, schools and community groups) to disseminate and reiterate child WASH and nutrition messages; (b) mobilising volunteer hygiene promoters (VHPs) to monitor household WASH practices; and (c) grouping PLWs according to the age of their children.

*Tippy tap usage demonstration.*



# PEER-REVIEW AND EVALUATION

## MITIGATING AND PREVENTING GENDER-BASED VIOLENCE IN OUR FIGHT AGAINST HUNGER

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### BACKGROUND

At Action Against Hunger we know that gender inequality and gender-based violence (GBV) are both a cause and consequence of hunger. Knowing this, the organisation has taken steps to promote gender equality with initiatives such as the organisation's Gender Minimum Standards and to look at ways to prevent and mitigate GBV in our work. In 2019, Action Against Hunger wrapped up a two-year pilot project on '**ENHANCING THE ACCOUNTABILITY FOR GENDER-BASED VIOLENCE WITH HUMANITARIAN NUTRITION ORGANISATIONS**', funded by the Bureau of Populations, Refugees and Migration (PRM), within the United States State Department.

The project was piloted in three countries – Bangladesh, Mauritania, and South Sudan – and looked at how Action Against Hunger and its nutrition partners could improve their accountability to mitigate and prevent GBV in the fight against hunger. The project focused on four main activities:

1. **TRAINING AND SENSITISING** humanitarian teams on core gender equality and GBV concepts;
2. **STANDARDISING CORE REQUIREMENTS FOR MAINSTREAMING GENDER** in Action Against Hunger's offices with the rollout of Gender Minimum Standards;
3. **ADAPTING KEY TOOLS** used by country offices to consider gender equality and GBV, these tools were consisting of surveys, assessments, questionnaires, and checklists, and
4. **MONITORING AND EVALUATING** the project to collect information about the progress of project activities as they were happening.

An end line project evaluation was conducted to better understand the intended and unintended outcomes, best practices, challenges and recommendations for the future that can be used to inform decision-making for the **ROLLOUT OF A METHODOLOGY TO INTEGRATE GBV RISK MITIGATION AND GENDER EQUALITY IN NUTRITION ORGANISATIONS.**

An important outcome of the project was around collaboration and coordination, which has brought together the Action Against Hunger headquarters to work collectively on mitigating the risks of GBV in its day to day activities, programmes, and projects. This has created shifts in thinking and practices on the ground mainly around staff as well as the managements in Action Against Hunger country offices. The project approach had helped to create a very

important space within the organisations to tackle and embrace challenges linked to GBV in nutrition programmes. However, there should have been emphasis on the ground on the ingenuity of the people and communities experiencing those challenges first-hand. The future projects show focus more on the power of contextualised evidence on the potential innovation that exists in the programmes.

Another important dimension is the relevance of the project to nutrition activities. The evaluation found that the project work and its uptake demonstrated that mitigating GBV issues is clearly relevant and has a transformational capacity for the whole sector. Therefore, the activities were appreciated by the Global Nutrition Cluster (GNC) members, nutritional clusters and all other relevant actors who were engaged in the project in different capacities.

Among many useful outcomes of the project, a thinking framework – **SOMETHING ELSE, SOMETHING MORE, AND SOMETHING DIFFERENT** – emerged from the project evaluation. The framework shows how Action Against Hunger team members in three pilot countries struggled to situate gender equality and GBV risk mitigation in the nutrition programmes until they were able to merge it.

## WHAT WE LEARNED FROM THE EVALUATIONS

In the beginning of the project, gender was **SOMETHING ELSE** for team members. They believed integrating gender required specialised expertise and that it was not integral to nutrition activities. As the project continued, they felt gender was something more, meaning it might require additional structure, resources, and extra time to work. Team members felt that these additional activities would deviate from the organisation's mandate and expertise. By the end of the project, team members recognised that integrating gender equality and GBV means transforming existing approaches. Fitting gender into nutrition work means identifying issues that are harmful and excludes at-risk or vulnerable groups. Transforming our approaches does not necessarily require more resources, but instead thinking **SOMETHING DIFFERENT** by reassessing and transforming our current ways of working. This includes piloting, sharing best practices, involving teams at all levels, and ensuring programme participants are at the centre of our work.

This change is well-illustrated by an anecdote from a team member in South Sudan: "The culture and habits of the country are patriarchal and difficult to tackle. When I arrived, the project was only beginning. Through its actions across the country programme, I have observed changes in staff behaviour, we are gradually recruiting more women; colleagues are respectful to one another and our working mothers can come to work knowing there is the breastfeeding room to accommodate them. With such inclusive workplace, our creativity, effectiveness and efficiency are improving, and everyone feels more invested in the success of the country programme."

## LEARNING AND SHARING

For learning and sharing purposes, learning workshops were organised to share the results of the end line evaluation with Action Against Hunger country teams, partner organisations, nutrition cluster members, and relevant government entities in Bangladesh, Mauritania, and South Sudan.

Also, a blog page was created to present the evaluation process that was an opportunity to document the learnings, visualise the data real-time, and communicate the emerging highlights of the evaluation. The blog also provided an opportunity for the respondents to communicate and share their views and insights on the project activities.

In a larger scope, the learnings from the end line evaluation were also shared

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during a learning workshop in Geneva, Switzerland. Participants for this event were members from the GNC, UNICEF, Mercy Corps, Tech Rapid Response Team (RRT), and Action Against Hunger Spain participated in this event.

Overall, external staff appreciated the efforts made by Action Against Hunger in mitigating the risks of GBV in nutrition through practical approaches. However, there is still a lot that needs to be done in integrating gender lenses and mitigating GBV by all actors including gender-aware programme designs, systematic monitoring, evaluation, and learning, evidence sharing, continuous awareness raising at all levels on why gender matters.

## WHAT IS NEXT FOR ACTION AGAINST HUNGER?

Action Against Hunger is committed to integrating the learning from this pilot project and other initiatives across the Action Against Hunger network to mainstream gender equality and integrating measures to mitigate and prevent GBV. At Action Against Hunger, we will:

- **CREATE AWARENESS AND CONTINUOUS ORGANISATIONAL** support on mainstreaming gender in our activities and programmes.
- **SUPPORT PRACTICES AND INITIATIVES** on gender equality and GBV risk mitigation.
- **EMBRACE A LEARNING CULTURE** by exploring and sharing the tacit knowledge that helps create dialogue, discussion, and learning.
- **INVEST IN COMMUNICATION FOR LEARNING** by documenting sharing data including tools, documents, ideas, dialogues with Action Against Hunger and other humanitarian and development networks.
- **CREATE COMMUNITIES OF PRACTICE** by bringing together other actors, organisations, networks, and individuals for experience and knowledge sharing.

Entrepreneurship Shuttle participants exhibiting their products at the forum.

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# IMPROVING SOCIAL INCLUSION PROGRAMMES THROUGH QUALITATIVE RESEARCH

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## SOCIAL INCLUSION PROGRAMMING IN SOUTH CAUCASUS

Despite recent economic growth, the South Caucasus region, and Georgia in particular, has consistently faced a wide range of socio-economic challenges. These challenges, which are underscored by prevalent poverty, include inadequate access to employment, entrepreneurial and educational opportunities and gaps in soft skills. To address this, diverse social inclusion programmes have been introduced across the region.

Action Against Hunger in the South Caucasus has been an important player in tackling economic inequalities and disengagement of vulnerable groups. Central to Action Against Hunger's programming is the adaptation and implementation of the Employment and Entrepreneurship Shuttle methodology, developed by Action Against Hunger Spain. Through this methodology, social inclusion programming in the South Caucasus has yielded positive results, including increased participation and economic and social inclusion of vulnerable communities. However, given the complexity and multi-faceted nature of social inclusion programming, monitoring and evaluation of such programming has proven to be difficult.

## MONITORING AND EVALUATION IN DEVELOPMENT PROGRAMMING

Various kinds of toolkits can be used to monitor and evaluate a programme, with Monitoring, Evaluation, Accountability and Learning (MEAL) teams often relying on quantitative data to inform, substantiate, and conceive programme findings. Most commonly, these toolkits are used to collect data on key socio-economic indicators at regular intervals before, during, and after programme implementation, to determine its success.

Generally, however, monitoring and evaluation is considered as being separate from programme activities, and programme implementers rarely go beyond quantitative data to collect other forms of data that may further inform programming. This implies, however, that several other components that relate to the success of a programme remain unobserved.

Increasingly, the complexity of development programming require the consideration of deeper and further reaching areas of impact that cannot be understood through quantitative research alone. Qualitative research, in response to this concern, helps to elicit deeper insights and explore participants' behaviour, perceptions and understandings. However, the mainstreaming of qualitative approaches to monitoring and evaluation is often overlooked and remains a key challenge.

## IMPLEMENTING A QUALITATIVE RESEARCH APPROACH

In 2019, Action Against Hunger in the South Caucasus decided to take on the challenge of going beyond quantitative data to implementing a qualitative research approach in its social inclusion programming.

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The qualitative research approach, incorporating carefully-designed methodologies and tools, aims to ensure that the information obtained carries with it the validity and reliability that is necessary to inform effective programming. This involved following a number of key steps, ranging from clearly defining research objectives and the sampling methodology, to the adoption of appropriate data collection and analysis tools.

In implementing this approach, the South Caucasus MEAL team identified several key learnings that stand to inform efforts to collect and use qualitative research in future programming. At the heart of these lessons is the value of qualitative research in development programming.

## WHAT HAVE WE LEARNT?

The South Caucasus experience elicited a number of useful lessons. These are described below and include ways to improve implementation of qualitative research approaches and steps that can be taken to ensure that qualitative data is used in an effective manner.

- **ADAPT:** A key takeaway is the importance of being open to adapting the approach throughout the research process. For instance, when the MEAL team recognised that programme participants had different linguistic backgrounds and competencies, adaptive steps were taken to ensure that all questionnaires, interviews, and discussions were translated to encourage meaningful participation.
- **INNOVATE:** As with any approach to monitoring and evaluation, the experience of the South Caucasus reiterated the transformative potential of being innovative in the implementation of a robust qualitative research approach. For instance, the MEAL team learnt that pre-existing quantitative information on research participants could be uniquely leveraged to supplement qualitative research efforts; whether it is to stimulate discussions, formulate questions, or even determine a primary sampling pool.
- **BE INDEPENDENT:** Another critical lesson was the importance of guaranteeing the independence of the monitoring and evaluation process and ensuring that it remains distinct from programme implementation. A failure to distinguish between personnel and/or protocol in these parallel processes risked skewed findings—the programme team was less inclined to fully report on qualitative information from participants, and participants were less inclined to share their honest opinions with the programme team. In response, a distinct MEAL team was set up that was not directly involved in the implementation of programme activities. This helped to increase objectivity, eliminate bias and, in turn, improve the validity and reliability of research findings.
- **SUPPORT IMPLEMENTATION:** In addition to improving the qualitative research process through flexibility, innovation, and independence, the MEAL team also learnt that qualitative data can be used to support effective programme implementation. In many cases, participants, or programme beneficiaries, associate with a development programme over several months and thus the programme becomes an integral part of their lives. Naturally, participants develop their own ideas and perceptions of how programmes could best function and what could be improved. The team learnt that such insight can be instructive and carry pertinent guidance on how a programme can be tailored and adapted to better meet the needs of beneficiaries.

  In the South Caucasus, the qualitative information collected through key informant interviews (KIIs) and focus group discussions (FGDs), among other tools, confirmed that programme participants were eager to share their views and experiences. Qualitative information collected from a social inclusion programme, for instance, revealed that programme participants were dissatisfied with over-exposure to corporate volunteers as part of the shuttle sessions. The MEAL team communicated this feedback to programme implementers, encouraging them to make necessary adjustments.
- **ENRICH COMMUNICATION:** The MEAL team also learnt that the adoption of a qualitative research approach stood to yield a wide range of unique findings that can enrich both internal and external communication efforts. For instance, qualitative information obtained from a social inclusion programme that aimed to improve employment skills tracked behavioural change to find that the programme resulted in participants reporting increased confidence in the use and application of skills to secure employment. Reliance on quantitative data alone would have only confirmed whether or not a participant was able to secure employment. Qualitative research can generate unique findings and deeper insight into the success of a programme which, in turn, can enrich learning and communication, be it internally among the programme team or externally in donor reporting.

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*Entrepreneurship Shuttle participants working during a breakout session of a forum.*

## LOOKING AHEAD

This article reflects the experiences of Action Against Hunger's South Caucasus MEAL team in implementing a qualitative research approach in monitoring and evaluating social inclusion programmes. Read alongside a how-to guide on implementing qualitative research, the lessons shared in this review aim to provide a basis for the development of a comprehensive framework around mainstreaming qualitative research approaches in future programming.

In advocating the collection and use of qualitative data, the team is confident that this is a widely replicable approach that elicits valuable insights from programme participants and provides a unique participant-led perspective on what already works in a programme and what can yet be improved. Accountability to participants also obliges programme implementers to use qualitative findings to continuously refine programme design and implementation.

When qualitative research is valid and reliable, it can significantly improve programmes by providing a deeper understanding of participants' perceptions and feelings. The South Caucasus' experience has demonstrated that MEAL approaches to qualitative research can be strengthened through an openness to adapt, a willingness to innovate, and a commitment to independence. In doing so, the experience also confirms that qualitative research can be used to support effective programme implementation and enrich both internal and external communication. Action Against Hunger in the South Caucasus aims to continue to implement, refine and share new lessons from this approach as it consistently strives to better monitor and evaluate development programmes.

# HOW A SAFETY AUDIT TOOL IS USED AS A PLATFORM TO MITIGATE GENDER-BASED VIOLENCE RISKS AT NUTRITION SITES IN SOUTH SUDAN

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## BACKGROUND

In South Sudan, the cumulative effect of years of conflict, violence and destroyed livelihoods has led to a humanitarian emergency of high proportions. The recently revitalised peace process promises to offer new opportunities in the coming years for South Sudan's women, men and children.

Violence, abuse and exploitation remain the greatest protection risks to women and girls, reflecting continued gender inequalities exacerbated by the prolonged crisis. Naturally, these risks extend to nutrition sites, and nutrition programme beneficiaries are among the most affected. To assess and address these risks, Action Against Hunger, in collaboration with UNICEF and Care, have developed a gender-based violence (GBV) Safety Audit Tool (SAT) for the nutrition facilities.

## THE TOOL

The SAT was designed to identify potential GBV-related safety risks at and around nutrition sites. To do this, a combination of structured and semi-structured questions were formulated to assess risks and challenges experienced by women and girls. These questions formed the basis of the following three key activities included in the tool:

1. An observation checklist
2. Focus group discussions (FGDs) with beneficiaries
3. Key informant interviews (KIIs) with staff at nutrition sites

## THE PILOT

In early 2019, the tool was piloted in eight of Action Against Hunger's 35 nutrition sites. This identified the following key risks faced by women and girls and recommendations to address these:

### 1. LACK OF BENEFICIARY AWARENESS ON AVAILABLE FEEDBACK AND COMPLAINT MECHANISMS

**CHALLENGES:** Generally, women considered local authorities (police, traditional leaders, public radio stations) as their primary reporting channels for GBV-related safety risks. While some women indicated that they might report an issue to site staff, a reluctance to report issues on site was noted among many beneficiaries.

**RECOMMENDATIONS:** Strengthen communication on programme feedback and complaint mechanisms by implementing one or more of the following: (1) monthly staff meetings between first-line implementers and field office staff; (2) FGDs with direct beneficiaries at the site level; (3) individual interview forms; (4) comment boxes at field office gates; and (5) hotline numbers (where applicable) to enable anonymity.

### 2. LACK OF FEMALE STAFF ON SITE

**CHALLENGES:** 60-70% of nutrition sites lack female staff to facilitate referral of gender sensitive cases and collect feedback from women who are not comfortable reporting issues to male staff.

**RECOMMENDATIONS:** Gender-diverse staffing is critical to quality service delivery, and should be made a standard on all nutrition sites.

### 3. THEFT AND ASSAULT AROUND THE NUTRITION SITE

**CHALLENGES:** Theft and assault were especially common on sites located in urban areas or adjacent to markets, and, findings indicated that risk of GBV increased with distance travelled to nutrition sites.

**RECOMMENDATIONS:** Strengthen advocacy with local authorities and community leaders to increase overall coverage of nutrition services and decrease distance travelled.

*Beneficiaries interviewed during safety audit .*

### 4. TOOL APPLICABILITY IN STABILISATION CENTRES

**CHALLENGES:** A pilot of the SAT in Action Against Hunger's stabilisation centre in Malualkon, Aweli East County found that a significant proportion of survey questions were not applicable.

**RECOMMENDATIONS:** Develop an adapted tool to capture risks specific to stabilisation centres, including those related to child and caregiver overnight stay.

### 5. LACK OF DATABASE FOR PARTNERS TO DIRECTLY UPLOAD THEIR ASSESSMENTS

**CHALLENGE:** Currently, Action Against Hunger supports the nutrition cluster with the compilation of after action safety audit data received from partners. A cluster-level repository for SATs and reporting templates would maximise efficiency and strengthen data analysis.

**RECOMMENDATIONS:** Develop a harmonised reporting mechanism (including a master database, reporting templates, guidance notes and supportive supervision) for after action safety audits at the cluster-level.

## IMPLEMENTATION OF THE SAT IN SOUTH SUDAN

The SAT was implemented in South Sudan by the national nutrition cluster in three phases:

### PHASE 1: INDUCTION OF NUTRITION CLUSTER PARTNERS

Partners were familiarised with the SAT during the national nutrition cluster meeting in August 2019. This was followed by a sub national nutrition cluster induction via skype.

### PHASE 2: DATA COLLECTION, ANALYSIS AND REPORTING

To avoid overwhelming partners in the nutrition cluster and maximise uptake of the safety audit methodology, the rollout of the SAT followed a two-tiered approach. While the observation checklist was rolled out across all sites, FGDs with community members and programme staff were targeted at sites where implementing partners had capacity to facilitate and analyse sessions.

## PRELIMINARY ANALYSIS AND REVIEW

**KEY FINDINGS:** The observation checklist was rolled out across a total of 583 nutrition sites and 47 stabilisation centres. Key findings were similar to those elicited during the pilot: a significant proportion of sites lacked female staff, and protection concerns regarding travel to and from sites were widespread among beneficiaries. Assault, theft and intercommunal youth fights were identified as key barriers to service use, and, in Paguir, caregivers reported making longer journeys through bush and swampland to mitigate GBV-related risks. A lack of water points on journeys to and from sites was also noted as a barrier in Paguir, and a number of beneficiaries raised concern over the lack of reporting channels for GBV issues beyond the facilities.

These issues were, however, raised among more positive comments, and, in FGDs, beneficiaries commented on the friendliness and helpfulness of staff at nutrition sites. In stabilisation centres, caregivers felt safe among male staff, and agreed that the presence of guards brought them ‘peace of mind’ when accessing the facilities. Finally all beneficiaries were satisfied with the services, and felt that staff provided ample information regarding treatment, products, how often to use the facilities and when to return.

**RECOMMENDATIONS:** Upon evaluation, findings from the SAT’s pilot and rollout signal the need for greater gender diversity on nutrition sites and further staff training on gender, GBV and referrals. It is also evident that stronger community advocacy on gender and GBV is required to improve reporting channels beyond the facilities, and increase awareness on current feedback and complaint mechanisms. Additionally, greater engagement of nutrition staff to develop site-specific strategies for mitigating barriers to service use is required to improve access. Finally, a thorough review of fencing and security barriers is required at stabilisation centres in high risk areas to determine if reinforcement is needed.

**ACTIONS:** In response, Action Against Hunger have already undertaken a number of actions, including: improving gender diversity on nutrition sites; enhancing fencing at sites in high risk areas; sensitising staff to GBV and gender discrimination; repairing locks in latrines; deploying mobile teams for long distance journeys to and from sites; integrating GBV safety training into 2020 proposals; and strengthening feedback mechanisms through onsite suggestion boxes.

## WAY FORWARD

### PHASE 3: GBV LEARNING WORKSHOP

Moving forward, a follow-up GBV learning workshop will be organised with nutrition partners to share key lessons learned, review observation data and overall findings, analyse key trends identified through consultations, and plan how to highlight findings. Attendees will include UNICEF (Regional and Country), WFP, and national and local partners in the nutrition cluster.

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# COORDINATION, INFORMATION MANAGEMENT AND PREPAREDNESS

## CAN CARE GROUPS IMPROVE HEALTH SEEKING BEHAVIOURS? RESULTS OF AN IMPACT EVALUATION IN NORTH-EASTERN NIGERIA

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To address food security and nutrition challenges in Yobe and Borno states in Nigeria, Action Against Hunger is using the Care Groups aim to elicit positive changes in behaviours related to nutrition and health. The approach combines cascaded training and peer support groups and aims to reach at least 80% of pregnant women, mothers and caregivers of children under two years in the area of intervention. In 2018, an impact study was carried out in the two states to assess the strength of the programme.

### THE CARE GROUP APPROACH IN NORTH-EAST NIGERIA

In the Care Group approach, a structured curriculum of lessons is delivered, focusing on key aspects of maternal and child health, including optimal infant and young child feeding and maternal nutrition practices, hygiene practices, common diseases and utilisation of healthcare services. Every month, Action Against Hunger nutrition staff trained field-based female health promoters selected from target communities. In turn, the promoters cascade the learning to 10-16 volunteers who then replicate it with a further 10-15 households through meetings and home visits. This strategy enabled one nutrition staff to reach between 5,400–8,100 households every month (Figure 1), and in total, approximately 146,500 households are reached each month through face-to-face activities.

### EVALUATION OF THE CARE GROUP APPROACH

Demographic and Health Survey (DHS) data from the Nigerian Federal Ministry of Health were reviewed for evidence of outcome-level improvements in health seeking behaviours. Indicators examined were antenatal carevisits, postnatal care visits, healthy facility utilisation rates, infant mortality rates, and low birth weight rates.

Changes in indicators were modeled over time and compared between baseline (2015) and post-implementation of the Care Group approach (2018).

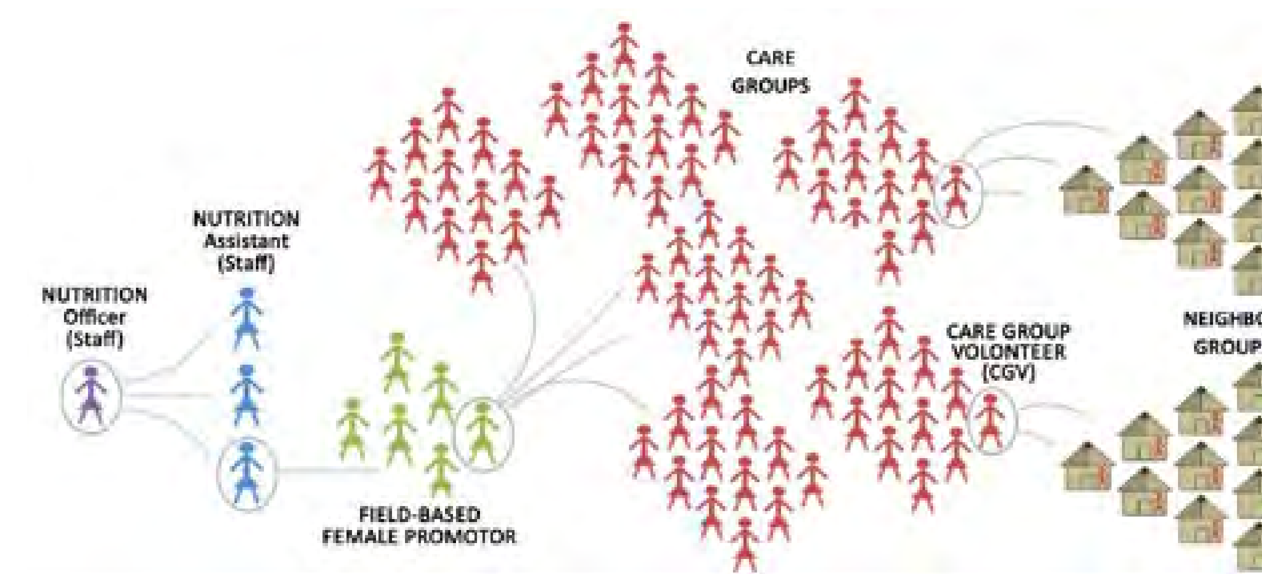


*Figure 3: The Care group cascade used in Nigeria (illustration adapted from Care Groups: A Reference Guide for Practitioners 2016)*

### WHAT DID THE CARE GROUP APPROACH CHANGE?

The results detailed in table two are summarised here:

- The greatest improvements were observed in antenatal care attendance and facility utilisation rates. This included an increase in the number of women attending all four antenatal visits.
- Postnatal visits also increased following the start of Care Group activities.
- Data quality issues meant that the effect on infant mortality and low birth weight could not be assessed. No significant impact on changes to mean infant mortality was detected due to lack of data or its quality.

### LESSONS LEARNED ON THE EVALUATION PROCESS

The evaluation methodology was cost efficient as it used existing routine data from the monitoring health system that are robust enough to ensure representation of the population. However, as with all existing data sets used for secondary analysis, there is a risk of data quality issues. Ensuring best practices in data collection and management would improve greatly the quality of future evaluations.

### LESSONS LEARNED ON PROJECT IMPLEMENTATION

Based on this experience, we can see that there is a great potential of behaviour change using the Care Group approach, as this model allows implementation at scale and with positive effect on entire populations. Several good practices were identified by the project team during a review workshop, such as introducing an additional layer to the original model, importance of constructive supervision, adjusting promoter's workload, replacing pregnant volunteers close to delivery period, and the importance of participatory methods such as games and storytelling that make the sessions more attractive.

Based on the evaluation results, we believe that the approach can still be improved to support behaviour maintenance for antenatal care. The antenatal care lesson should be introduced at the start of the curriculum and more opportunities to reinforce the behaviour could be created. Attending all antenatal visits is a complex behaviour, that requires planning, time, and reorganising household task. Promotors should be trained on techniques to help women manage these difficulties, like using reminders and goal setting. In addition, behaviour change intervention at individual and peer level might not be enough. The project should assess, and address barriers linked to the physical environment and the social and gender norms,which may hinder women's access to health services.

## HOW ARE WE MOVING ON?

The evaluation was presented at the 3rd R4NUT Research for Nutrition Conference in November 2019 and at UNICEF Workshop on wasting, in Senegal, in November 2019 where implementation, cost and curriculum design were discussed.

MSF Belgium also reached out to Action Against Hunger staff to build on its experience. The care group curriculum implemented by Action Against Hunger in Uganda was adapted based on the recommendations provided by our study.

Care groups can be implemented at large scale, and influence positively health-seeking behaviors of a large population. Future implementers should embed these lessons learned in similar interventions, assess their impact and share their findings to ensure continuous learning and programme improvements.

| | CONTROL | | INP+ | | | | ECHO | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MEAN | MEDIAN | MEAN | MEDIAN | | | MEAN | MEDIAN | | |
| **Coverage of one antenatal visit** | 58% | 52% | 91% | 73% | Increase | 🟢 | 149% | - | Increase | 🟢 |
| **Coverage of four antenatal visits** | 2.10% | 1.40% | 3.64% | 2.90% | Increase | 🟢 | 4.42% | 3.70% | Increase | 🟡 |
| **Percentage of postnatal visits (within 3 days)** | 21% | 14% | 30% | 27% | Increase | 🔴 | 23% | 15.5% | Increase | 🔴 |
| **Facility utilisation rate** | 0.27% | - | 0.44% | - | Increase | 🟢 | 0.88% | - | Increase | 🟢 |
| **Infant mortality rate** | 17.01% | 0 | 6.70% | 0 | No change | 🔴 | 14.80% | 8.20% | Decrease* | 🔴 |
| **Low birth weight rate** | 15.83% | 11.60% | 10.97% | 9.25%* | Decrease* | 🟡 | 15.01% | 12.30%* | No change | 🔴 |

*Figure 4: Summary of indicator changes*

** These changes cannot be attributed to Care Group programming*

A 'Result Reliability Index' was calculated according to data quality and applicability of the difference-in-difference model. The relative strength of these results is color-coded as low, medium, and high. Care Group programming was most strongly associated with a rapid improvement in health facility utilisation.

Low Reliability Index 🔴 Medium Reliability Index 🟡 High Reliability Index 🟢

*Each session starts with a game to break the ice and create a safe space for sharing experiences.*

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# THE EMPLOYABILITY INTEGRATION APPROACH: INTEGRATING MENTAL HEALTH AND PSYCHO-SOCIAL SUPPORT WITH EMPLOYABILITY

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## BACKGROUND

From 2017 onwards, Action Against Hunger's food security and livelihoods sector in Iraq, has been transitioning from the delivery of large-scale food assistance programming to refugees and internally displaced persons in camps and out of camps, towards the provision of sustainable livelihoods solutions to remainees and returnees. More particularly, the sector has been addressing unemployment of youth and women in urban areas.

In the past three years, Action Against Hunger has implemented a range of projects focused on the **EMPLOYABILITY APPROACH**. Beneficiaries can benefit from employability assistance ranging from technical capacity building, financial assistance for micro and small businesses, to apprenticeship schemes co-funded by local enterprises, and direct employment. The intervention often includes a cash for work component, which supports the rehabilitation of communal facilities and infrastructure while ensuring short-term employment schemes.

In the post-conflict context of a massive population displacement and economic crisis, the targeted audience for this approach needs to strengthen their resilience to socio-economic shocks. Motivation is central for the placements' success, as well addressing psychosocial barriers to employability.

In response to these needs and in order to ensure sustainability of the project, a psychosocial follow-up was integrated into livelihoods' intervention. It consisted in providing beneficiaries with indispensable life, social and emotional skills in addition to material support. The integration of livelihoods and mental health was formally recognised as essential in this intervention's final evaluation. As a result, Action Against Hunger Iraq staff have been working together to better frame the **INTEGRATION APPROACH**.

Good practices have been put in place for impactful action. At programme design stage, protection aspects have also been integrated into business grants and apprenticeship activities, through internal and external referrals. Business grants and apprenticeship beneficiaries are now selected on the basis of online registration, which allows better inclusion of persons with disabilities and specific risks of vulnerabilities. Assessments are then carried-out by staff who are livelihoods and psychosocial workers. They visit families to discuss and address their issues, as well as detect sensitive cases. Apprentices' working conditions are monitored weekly.

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## LEARNING: INTEGRATING LIVELIHOODS AND PSYCHOSOCIAL ASSISTANCE IMPROVES SOCIO-ECONOMIC INCLUSION

The integration approach increased the livelihoods and psychosocial resilience of its beneficiaries, as evidenced by recent learning exercises in employability projects such as a final evaluation and learning workshops.

Beneficiaries acquired life and communication skills through mental health and psychosocial support sessions, improving their well-being, self-esteem, communication, confidence and decision-making skills in addition to increasing the sustainability and profitability of their economic activity. They were able to make informed and adapted livelihoods choices and to integrate the market, thus increasing their socio-economic inclusion in the community. Performance evaluations conducted five months after activities recorded a satisfactory 66% of apprentices still at work and 70% of grants beneficiaries still running their businesses.

Persons with disabilities in particular reported how the livelihood and psychosocial support sessions enabled them to overcome their psychological difficulties due to their personal financial and disability situation, and feel empowered in the market and local economy. One said "I attended all the mental health and psychosocial support sessions as they provided me with a lot of positive energy."

Life, Social and Emotional trainings coupled with psychosocial follow-up have proved to be beneficial for both livelihoods and protection components, especially for women who had not entered the labour market before. Involving women in the employability schemes proved to be a challenge. It required adaptation of trainings' time, support for transportation solutions and, not the least, support by psychosocial workers aimed at overcoming cultural gender barriers and coping with harassment in the workplace.

The short duration of interventions is also a challenge. The employability approach requires more time than emergency interventions to meet long term sustainability achievements linked with job inclusion and retention.

Overall, the integration approach enhanced the project's relevance, effectiveness, efficiency, sustainability, and impact, emerging as one of the best practices across the apprenticeship and business components of the livelihoods intervention.

## NEXT STEPS: INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT NEEDS TO BE TAKEN FURTHER

Through systematic learning workshops, Action Against Hunger Iraq identified ways to further foster inter-sectorial integration in their employability programmes.

Action Against Hunger will allocate more **RESOURCES** to the integration approach. More human resources are needed on the protection side to ensure greater coverage and increased inclusion in the provision of the mental health and psychosocial support services.

**OUTCOME INDICATORS** which consider both livelihood and psychosocial support will be designed, and will consider the inclusion of mental health, wellbeing and resilience aspects.

The provision of **CROSS TRAINING** at the inception of a new program will also support the collaborative approach between the two sectors.

Livelihoods and protection staff will better jointly engage on carrying-out joint **INITIAL ASSESSMENTS** of beneficiaries' enabling and limitation factors to enter the job market. A good understanding of the barriers individuals might be facing would facilitate targeting.

With regard to **SELECTION PROCESSES**, the current scoring system will be revised accordingly and the selection committee will be integrated to ease discussions between livelihoods and protection staff. Employability programmes are at the crossroads of several types of vulnerabilities. They need to provide specific psychosocial services for individuals that could eventually not qualify for a job but are in a situation of psychological distress. The employability programs are a good entry point for detection of psychosocial needs and internal referral.

Joint **MONITORING** visits need to be encouraged as well so that the situation of each beneficiary can be understood holistically.

**INNOVATIVE SOLUTIONS** will be considered in order to involve and maintain women in the job market, such as services oriented to women with children and different working times.

The overall future interventions will need to be more linked to **LOCAL PARTNERS**, to ensure a complementarity of action and long term sustainability. In this end, availability of locally managed microfinance solutions will also be assessed in order to replace the direct provision of grants, with a consequent improvement of cost-efficiency.

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**FOR CHILDREN
THAT GROW
UP STRONG.**
AGAINST LIVES
CUT SHORT.

**FOR CROPS
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DROUGHT
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