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.
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ACRONYMS

BMZ Federal Ministry for Economic Cooperation and Development (Germany)

BDM Becker-DeGroot-Marschak lottery

BFS Baby Friendly Space

CEPEDRENAIC Coordination Centre for Natural Disaster Prevention in Central America

CMAM Community-Based Management of Acute Malnutrition

DHS Demographic and Health Survey

DRR Disaster Risk Management

DRR Disaster Risk Reduction

DOD Focus group discussion

GBV Gender-based violence

GNC Global Nutrition Cluster

HS Household survey

IHC Integrated Health Centre

INP+ Multi-sectoral nutrition programme

ITCF Infant and Young Child Feeding

KII Key informant Interview

LGA Local Government Area

LBW Low birth weight

MEAL Monitoring, Evaluation, Accountability and Learning

MHPPS Mental health and psychosocial support

NFHS National Family and Health Survey

NGO Non-profit organisation

PDSEC Social, economic and cultural development programmes

Psychological Distress Programme

PLW Pregnant and lactating women

R4Aequity Research 4 Action

R4Nut Research 4 Nutrition

SAT Rapid Response Team

SICIT Safety Audit Tool

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

WHO United Nations World Food Programme

World Health Organization
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 focuses 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) (%) 3.
2. Children under age six months exclusively breastfed (%) 3. Mothers who had at least four antenatal care visits (%) 2.

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 piloted 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 LEARNED

In all three states, despite diverse geographies, many indicators were similar. Indicators such as 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 baseline survey, women were often unavailable to participate in the survey, as they would have 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.

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.

The baseline findings revealed that certain practices such as safe disposal of stools, use of constructed toilets (public-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. The baseline findings revealed that certain practices such as safe disposal of stools, use of constructed toilets (public-based or community), access to safe water, and handwashing practices during critical periods 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. 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.

Way forward for the first 1,000 days programme with CMAM

Maternal nutrition has a direct impact on the newborn’s health 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 stools, use of constructed toilets (public-based or community), access to safe water, and handwashing practices during critical periods 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. 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.

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. Collaborative 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?

BACKGROUND
After decades of interventions, the need for improved evidence on 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, the LAB Advisor (Hygiene, and Nutrition and Health Analysis Advisor), and the Research and Advocacy Advisor France, France

The R4ACT methodology uses a qualitative approach for stakeholder engagement. Rather than reaching a large number of actors, a limited but diversified 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, from Nutrition and Health, 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:

- Develop behavioral change on water treatment in areas covered by Severe Acute Malnutrition treatment services
- Facilitate regular follow-ups of the action plan roll out, inclusiveness and the fact that it is action focused.

In the end, the workshop, participants selected the activities that their organisation would commit to implementing in their programmes. Stakeholders articulated 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.
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 pragmatic relevance of the questions explored. Inclusiveness is also achieved by systematically choosing a cross-sectoral 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 framework of the review was 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 kickstarting 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 the technical expert to 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.

### 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 diarrhoea 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 has been working since the age of five. Due to the impossibility of supplying all areas with hydraulic infrastructures quickly, Action Against Hunger has been working since the past 10 years, Action Against Hunger is relying on home water treatment to improve the situation of vulnerable Haitians in the short and medium term.

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

**Karoline Weshe**
Head of MEAL

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 vendors of water treatment products.**
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 of 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).

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).

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.

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

For more information contact: rddmeal@actioncontrelafaim.org

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.
STRATEGIC PLANNING AND RESOURCE MOBILISATION
BUILDING RESILIENT TOURISM IN CENTRAL AMERICA

MULTITHREATS AND VULNERABILITIES
Central America is the world’s second most vulnerable region to 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. Despite being one of the most affected regions in the world during recent years, it is also vulnerable to multiple threats. Tourism is a major source of revenue and employment, and is therefore exposed to the impact of disasters, which would put business continuity, jobs and development at risk. Public and private cooperation and DRR interventions from the tourism sector are therefore crucial to change the narrative at the local level. The recognition and inclusion of all stakeholders is key to establishing strategic public-private alliances to save lives, prevent and reduce losses, ensure good recovery, enhance the resilience of tourism destinations, and promote a strong and sustainable tourism industry.

For more information please visit: www.STRATEGICPLANNINGandMOBILISATION.org

Chapter 1: Strengthening the Knowledge of Disaster Risk Reduction (DRR) practices. The main tourism destinations in the region have no history of institutional coordination on DRR issues.

Chapter 2: Public-Private Partnership Model 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 depend on the tourism sector for their livelihoods. Loss of this source of revenue will undoubtedly drive swaths 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 Volcan de Fuego in Guatemala led to a number of joint initiatives between the public and private sectors in recovery and reconstruction processes that highlighted the importance of coordination in implementing resilient plans. 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 (CETUR) and Nicaragua (CANTUR). Universities (UNAN-UNI), Governing Bodies in charge of DRR, tourism entrepreneurs, Municipal Governments and regional authorities (SITCA and CEPREDENAC). It represents an example of public and private sector research, discussed and modified to work that has improved resilience in Central American destinations.

Chapter 3: 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 hypophysical 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 to reconcile the 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 belief that business people concerning responsibility and commitment to civil society and 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 Resilience in Guatemala.

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The Future of Tourism Resilience
The coordination between these sectors has led to a new stage of interaction at the regional level. 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. DRB 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, Action Against Hunger has been deployed in the sub-region (Mali, Mauritania, Niger) for fifteen years, present in the sub-region (Mali, Mauritania, Niger) for fifteen years1, and Briklé. Action Against Hunger faces in the region is that of malnutrition. 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.

**CONTEXT**

Action Against Hunger has been present in the sub-region (Mali, Mauritania, Niger) for fifteen years, 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 COMUNITIES**

Action Against Hunger uses a 5-step mediation tool 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 have integrated nutritional security into their social, economic and cultural development programmes (PDESEC). For example, the commune of Goudou in Kayes has built two maternity wards, and recruited

1 In Mali, in the Kayes region, these interventions started with Vita Care (2007) before reaching Kayes Care (2016) and Buybalo Care (2016). In Mauritania, Action Against Hunger is present in Guélmvah, Souahlelli, Hod El Chargi and Gorgor. In Niger, interventions have been deployed in Tahoua, Maradi and Diffa since 2005.
two obstetric nurses, while the commune of Séléka-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 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 in the commune of Tabakki 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.
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 crowdfunding 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 create awareness about their project to one on one support on how they can work to promote community ownership. They works to promote community ownership understanding of how crowdfunding can also be involved in the procurement/finance process.

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

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 mental health challenges – especially among the most hidden and vulnerable in the community. Action Against Hunger will assess the impact of this approach in Action Against Hunger Southern Ethiopia southwest drought recovery end line evaluation. The findings of the etiologies 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) to create awareness on the approach’s viability and promote confidence in the contributors to support future funding for such initiatives.

Reports on the mental health of South Sudanese refugees in camps in the region (UNHCR, 2016) showed high levels of moderate to severe mental health including Post Traumatic Stress Disorder, major depression, acute anxiety, psychosomatic symptoms1, adjustment disorder, negative behavior, 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, 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 infant and child care practices.

Community Management of Acute Malnutrition (CMAM) practices and Psychosocial Support (PSS) range of activities in the next round of PDP was developed as a pilot under the psychosocial support sub-activity named Community Management of Acute Malnutrition (CMAM). As there was no mental health provision in the camp, a special psychosocial support sub-activity named “The Psychosocial Distress Programme” (PDP) was developed as a pilot under the BFS range of activities in the next round.

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

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of funding, that involved establishing a small team of psychologists to link into the community. 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 (MHPS) 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 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%), posttraumatic stress disorders (19%), sexual violence (24%), alcohol use (self or partner) (55%), 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 (36 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 nutrition sector.

This pilot helped us understand how we can reach and better assist those who are most vulnerable. We found that fathers 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 described 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 was the effectiveness of the BFS as a linkage between nutrition, (YCF, child care practices and psychosocial support. As most mothers used the BFS, they had already experienced a more psychologically oriented service. In contrast, they appreciated 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 challenges 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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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 younger than five years old are stunted, 7% are wasted and 22% are underweight. UNICEF estimates that one million Nigerian children aged 6 to 23 months are wasted and 22% are underweight. Of these, 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 the WFP, the WPP and the local government.

ASSESSMENT OVERVIEW
A mixed methods study comprising 800 households in the five intervention communities, a smaller rural intervention community in Tarmua, who did not receive the package. His were conducted using an Open Data Kit platform, and complementary feeding items and child play mats, acceptance of the 'tippy tap' remained questionable. If children in households with improved 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 practical, day-to-day level, using sterilised, boiled water at all times during baby care was not easily achievable.

EVALUATION
The Baby WASH package was implemented in longitudinal studies 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 practical, day-to-day level, using sterilised, boiled water at all times during baby care was not easily achievable.

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

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The Baby WASH Approach
A baby’s development is significantly influenced by the living environment in which they develop, particularly nutrition, health, and hygiene. A child’s nutritional development, with a number of studies signalling the need for stronger integration of the WASH and nutrition programmes of sectoral programmes. In line with this evidence, a Link Nutrition Causal Analysis (LHNCa) conducted by Action Against Hunger in 2017 found inadequate access to safe WASH is a key factor in malnutrition in Nangere Local Government Area (LGA), Yobe State. The study revealed that 99.3% 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 soaps and detergents for handwashing. Among the participants surveyed, ash was used as an alternative soap, and knowledge of water treatment practices was minimal. The findings called for a multi-sectoral approach, underlining the potential that a more integrated approach from the target group was matched against that of a non-intervention community in Tarmua, who did not receive the package.

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 LHNCa’s findings by providing pregnant and lactating women (PLWs) with basic hygiene and nutrition items and knowledge of water treatment practices.

TheBabyWASHapproach

In Nigeria, Department of Health

Implementation and Monitoring

...
of the Baby WASH package in Nangar LGA, emphasizing 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 emphasized 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 emphasize 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 HSI, FGDs, and KIs suggest that more direct stakeholder engagement in interventions, coupled with a greater focus on capacity building initiatives that aim to empower 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 KIs that interventions need to target all caregivers (including fathers and the elderly) to ensure that the full impact of Baby WASH training is realized.

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

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Zuhra Aman Action Against Hunger Gender Unit Canada

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 organization has taken steps to promote gender equality with initiatives such as the organization’s Gender Minimum Standards and to look at ways to prevent and mitigate GBV in its 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 sensitizing humanitarian teams on core gender equality and GBV concepts;
2. Standardizing 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;
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 management in Action Against Hunger country offices. The project approach 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 these 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 Action Against Hunger network, partners, and community leaders and members.

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 their 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 required transforming existing approaches. Fitting gender into nutrition work means identifying issues that are critical and includes 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 workspaces, 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 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, and local context 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 shared 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.
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 programmes in the South Caucasus have 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 methodologies, 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 programmes. At the heart of these lessons is the value of qualitative research in development programmes.

WHAT HAVE WE LEARNED?

The South Caucasus experience elicited a number of useful lessons. These include:

- **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 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 implementing the programme activities. This helped to improve 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 be improved. The team learnt that such insights can be instructive and carry pertinent guidance on how a programme can be tailored and adapted to better meet the needs of beneficiaries.

- **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 here aim to provide a basis for the development of a comprehensive framework around 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 elicits valuable insights 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**

**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 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 could 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.

4. **STRENGTHENING DATA COLLECTION AND ANALYSIS**
   - **CHALLENGES:** A pilot of the SAT in Action Against Hunger’s stabilisation centre in Malualkon, Aweil 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 oversight.

5. **LACK OF DATABASE FOR PARTNERS TO DIRECTLY UPLOAD THEIR ASSESSMENTS**
   - **CHALLENGES:** 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 SAT 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.
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.

**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.

**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.
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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Action Against Hunger
France

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-EASTERN NIGERIA

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 face-to-face activities. This strategy enabled one nutrition promoter to reach between 5,400–8,100 household 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 care attendance and facility utilisation rates. This included an increase in antenatal care visits. Changes in indicators were modeled over time and compared between baseline (2015) and post-implementation of the Care Group approach (2018).

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.

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.

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

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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 tasks. Promoters 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.

**CONTROL**

| Category                          | Mean | Median | Increase
|----------------------------------|------|--------|----------
| Coverage of one antenatal visit  | 58%  | 52%    |          |
| Coverage of four antenatal visits| 2.10%| 1.40%  |          |
| Percentage of postnatal visits (within 3 days) | 21% | 14%   |          |
| Facility utilisation rate        | 0.2% | 0.4%   | Decrease |
| Infant mortality rate            | 17.01%| 6.70%| No change |
| Low birth weight rate            | 15.83%| 11.60%| Decrease |

**ECHO**

| Category                          | Mean | Median | Increase
|----------------------------------|------|--------|----------
| Coverage of one antenatal visit  | 149% | -      | Increase |
| Coverage of four antenatal visits| 4.42%| 3.70%  | Increase |
| Percentage of postnatal visits (within 3 days) | 22% | 15.5%| Increase |
| Facility utilisation rate        | 0.18%| -      | Decrease |
| Infant mortality rate            | 14.80%| 8.20%| Decrease |
| Low birth weight rate            | 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
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.
The integration approach increased the livelihoods and psychosocial resilience of the 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.

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 employability programmes and considered the inclusion of mental health, wellbeing and resilience aspects. 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.

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

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

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The production of the Learning Review would not have been possible without the hard work and support of our Action Against Hunger staff both in the UK and around the world.

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FOR FOOD. AGAINST HUNGER AND MALNUTRITION.

FOR CLEAN WATER. AGAINST KILLER DISEASES.

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

FOR CROPS THIS YEAR, AND NEXT. AGAINST DROUGHT AND DISASTER.

FOR CHANGING MINDS. AGAINST IGNORANCE AND INDIFFERENCE.

FOR FREEDOM FROM HUNGER. FOR EVERYONE. FOR GOOD.

FOR ACTION. AGAINST HUNGER.