

**ACF INTERNATIONAL**  
**POLICY PAPER**

# **POLICY ON MENTAL HEALTH AND CHILD CARE PRACTICES**





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# ACF<sup>1</sup> global strategy

The mission of ACF is to save lives by eliminating hunger through the prevention, detection and treatment of malnutrition, especially during and after emergency situations such as conflict, war and natural disaster. From crisis to sustainability, ACF tackles the underlying causes of malnutrition and its effects. By integrating our programmes with local and national systems, and through advocacy and research, ACF further ensures that short-term interventions become long-term solutions.

ACF's global technical strategy is based on and adapted from the UNICEF conceptual framework of the causes of malnutrition<sup>2</sup>, and takes into account the immediate, underlying and fundamental causes that determine the nutritional status of individuals and populations. A number of technical sectors (nutrition, medical, water-sanitation and public hygiene and food security) work together to provide the best possible response to the specific needs of populations in different contexts and ensure an integrated fight against malnutrition.

ACF's intervention policy in child care practices and mental health is part of ACF's global strategy and contributes to the fight against hunger.

## Définitions

In the humanitarian sector, the terms mental health and child care practices cover a broad area that include mental health, counselling, psychosocial, care practices and psychology. *For detailed definitions of terminology, please refer to Appendix 2.*

*The vocabulary that best represents the ACF approach has to do with child care practices and mental health.*

1. For further details, refer to the general and technical strategy of ACF  
2. See p. 5.

# The ACF approach in child care practices and mental health<sup>3</sup>

There are at least four strong connections between ACF's mandate, its technical policy and mental health and child care practices:

→ **ACF intervenes above all in emergency situations** during which human lives and social and family ties are affected and individuals are vulnerable. These situations lead to changes in both child care practices and the environment's capacity to provide them;

After a natural disaster, the percentage of people suffering from moderate to severe mental problems increases from 12% to 23-24%; and 30-50% of the population suffers from psychological distress, which can also lead to decompensation<sup>4</sup>.

Over the past 20 years, a number of studies have demonstrated clear interactions between poverty-related factors and poor psychosocial health. Evidence indicates a cyclical relationship between the two<sup>5</sup>.

→ **Child care practices and mental problems as causes of malnutrition;**

Several studies (for the most part conducted in developing countries in Asia and in non-emergency situations) have demonstrated that children with depressed mothers face a greater risk of malnutrition and delayed growth; the risk of infant mortality also increases.

Approximately 30% of women in developing countries suffer from depression during pregnancy or following childbirth; these rates increase in emergency situations<sup>6</sup>.

→ **Hunger leads to psychological changes and behaviours that handicap individuals** (adults and children) in their ability to adapt in their day-to-day life, and which have a negative impact on social relationships;

→ **Malnutrition has medium - and long-term consequences on child development** (delayed development, impacts on cognitive, intellectual, emotional and social functions, etc.) that can be lessened<sup>7</sup>.

The UNICEF Conceptual Framework for the causes of malnutrition, adopted internationally since 1992 (see *Figure 1*), contains several interesting elements:

- Nutrition is not separate from the growth, survival and development of the child, demonstrating that malnutrition is only one of the consequences of contextual, environmental, family and other factors – and not the only one.
- Malnutrition rarely has a single cause, but is rather the result of a series of factors connected within a given context. A systemic approach is therefore more suitable for understanding malnutrition than a linear causal interpretation: thus a cause can have several effects and then, later on, an effect can modify risk factors.
- For each beneficiary, it is important to look for the causes having led to malnutrition so as to provide him or her with adequate responses.

3. See Appendix 2 for a definition of these terms and their place in the humanitarian field.

4. WHO: Mental Health and Psychosocial Relief Efforts after the Tsunami in South-East Asia. 2006.

5. WHO : [http://www.who.int/mental\\_health/policy/development/en/index.html](http://www.who.int/mental_health/policy/development/en/index.html)

6. WHO: Improving Maternal Health. 2008.

7. LANCET.2007 Jan: Developmental potential in the first 5 years for children in developing countries. Grantham-McGregor S et al.

- This flow chart focuses on child malnutrition, but can be used for all vulnerable populations.
- Alongside food and health, it shows a third underlying factor – child care practices. Each of these three conditions is necessary, but insufficient in itself for a child’s survival. It is on these three conditions that we shall now focus: they are the least known in both the explanatory analysis of malnutrition and the implementation of programmes.

Adequate child care practices (and/or mothering behaviours)<sup>8</sup> are, therefore, all the more important in a poor environment, since they enable the best possible use of resources available.

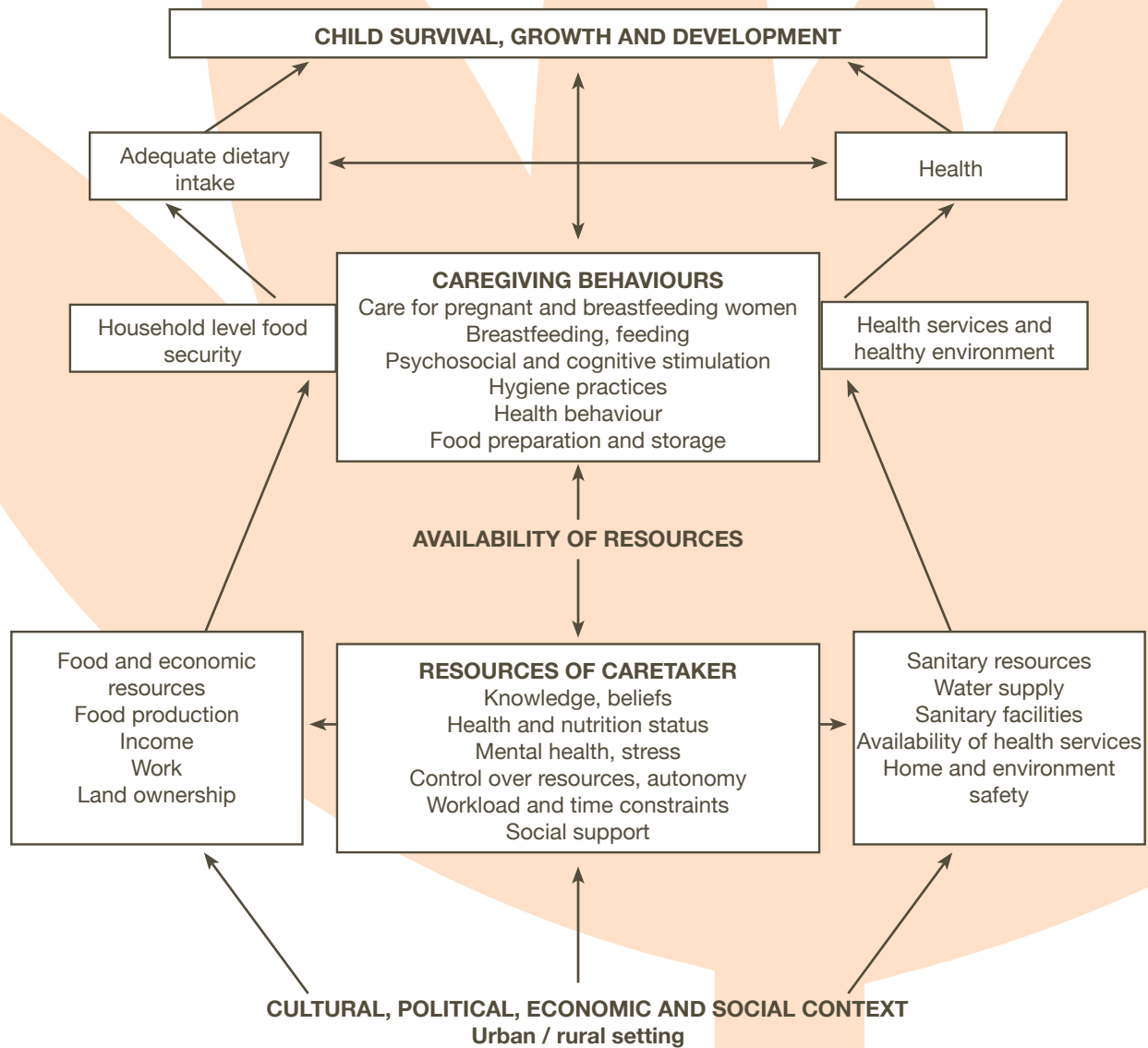


Figure 1 – The extended care conceptual framework (Source: Engle<sup>9</sup>)

In most societies, the mother is the primary carer, who bears most of the burden, both material (time, resources, etc.) and spiritual (knowledge, culture, etc.). The status of women in the community is, therefore, fundamental.

8. See Annex 2.

9. Engle, P. (1997) « The care initiative: assessment, analysis, and action to improve care for nutrition” – UNICEF.

Six child care practices are defined in the Care Initiative Manual published by UNICEF in 1997 (*for details see Table 1, in the appendix*):

- Care for women
- Breastfeeding and young child feeding
- Psychosocial care
- Preparation of food
- Hygiene practices
- Home health practices

Some of these care practices, such as preparation of food, hygiene practices and child care practices, are at the interface of food security, water, sanitation and hygiene, and medical, and highlight the importance of joint efforts with other technical fields.

Aspects in child care practices must be considered at two levels:

- in regard to time spent with child: effective availability
- in regard to quality:
  - responses, sensitivity and continuity of responses to child's needs
  - warmth, affection and acceptance
  - investment of child
  - encouragement of autonomy, exploration, learning

The four elements above interact and will be constructed by the relationship between the mothering environment and the child, depending on cultural factors.

Three types of factors facilitate or hamper child care practices: human resources, economic resources and organizational resources.

Human resources	Knowledge, beliefs and schooling
	Physical health and nutritional status
	Mental health, stress, self-confidence
	Role of fathers and of the families
Economic resources	Access to management of family income and property
	Workload and time available
Organizational resources	Alternative for keeping and caring for children
	Community commitment

Table 2: Care resources (based on Engle<sup>9</sup> et al)

The child care approach developed by ACF has three strong features:

- It is intended to be **holistic**, taking into account the whole range of care practices (in quantity and quality) without limiting itself to one of these as is so often the case in humanitarian contexts.<sup>10</sup>
- It is intended to be **global**, dealing with the practices themselves, but identifying and also acting on the factors/resources that block or facilitate implementation, so as to reinforce the impact of our intervention.
- It is heavily **focused on the psychosocial and social dimensions** that have a major influence on care practices. The specificity of the contexts of ACF interventions gives a special character to our care practice approach, since the populations concerned are usually experiencing periods of destabilization, loss (material, human, land, points of reference) and extreme destitution, resulting in social and family re-organization that affects mental health and mental well-being in adults, children and babies. **That is why we pay particular attention to psychological (mental health), family and social aspects, and in particular the resources and capacities of the child's mothering environment and its autonomy** in our analysis of child care practices and population needs, as well as in our intervention methods

9. Engle, P. (1997) « The care initiative: assessment, analysis, and action to improve care for nutrition" – UNICEF.

10. Care practices are often reduced to breastfeeding and feeding practices.



# Six main objectives covered by the ACF child care practices and mental health

## **To improve prevention of acute malnutrition by reinforcing positive child care practices and assisting in changing practices**

The analysis of the causes of malnutrition considers care practices as potential factors. When inadequate practices are identified, support is proposed to make people aware of more suitable practices and help them find solutions to problems in their daily lives that may hinder adequate practices (e.g. how can a mother organize child care when she is the sole provider and must be out at work all day?). Interventions proposed always aim to reinforce practices that benefit the child's health. The approach deals with the reality of situations (does the child eat alone, or does he eat from the family's communal dish, even though he or she does not have the psychomotor capacity to eat enough before all the others have finished the food?), and includes a strong psychological and psychodynamic component (for example, groups, families or individuals at risk are identified and given a specific follow-up). When inadequate care practices are influenced by deep-rooted beliefs, support is respectful of these beliefs and seeks to provide other solutions if people do not want to change their behaviour.

## **To prevent the deterioration of child care practices during disruptions**

ACF intervenes when disruptions lead to social, family and individual upheavals that contribute to the deterioration of care practices. Psychological and psychosocial interventions minimize the impact of these disruptions on social and individual health and help maintain protective care practices for children. When crises persist or when we intervene later, the aim is to consolidate or restore individual and/or group resources in order to favour the establishment – or re-establishment – of appropriate practices. In other contexts (notably post-crisis and reconstruction), socio-economic changes can engender new ways of life that cause care practices to change radically, whereas usual practices had been adapted to the needs of the child. In such cases we need to meet the groups at risk in order to raise awareness of the possible consequences of these changes in practice.

## **To improve treatment and limit the negative impacts of malnutrition on children's health**

Whether acute, chronic, or related to micronutrient deficiencies, malnutrition can:

- have serious and irreversible consequences for early childhood development. Most studies conducted on acute malnutrition show delayed intellectual development that can last until adolescence and greater difficulties, once adulthood has been reached, in finding skilled work. There are fewer studies on social and emotional impacts. We should also mention the rare studies that demonstrate an over-representation of psychiatric pathologies in adults having suffered episodes of malnutrition in utero. The same applies for chronic malnutrition and micronutrient deficiencies, although the repercussions are specific to the kind of deficiency experienced.
- affect the capacity of the mothering environment to care for children and respond to their needs in an appropriate and adequate manner (systemic approach).

**For example, a mother's tiredness resulting dietary deficiencies can make it difficult for her to manage household tasks as well as child care, and the result can be a competition between the two.**

### **Proposed programmes aim at:**

- improving the reception of patients and health worker-patient relationships so as to promote a holistic approach to patients, to guarantee their well-being, and to promote compliance with programmes that treat acute malnutrition;
- support and stimulate children directly and indirectly by reinforcing parenting skills, in order to limit delayed development related to malnutrition and potential environmental deficiencies.
- provide parental guidance and reinforce the parent-child relationship.

All of these activities improve treatment and limit the negative impacts of malnutrition while promoting children's survival and health.

## **To provide psychological support for populations in the event of natural disasters or conflicts**

ACF is a member of the IASC (Inter-Agency Standing Committee) Task Force on Mental Health and Psychosocial Support in Emergencies that has developed synthesis tools for good practices in emergency situations for all humanitarian actors, whatever their field of expertise.

The purpose of disseminating these tools is to ensure that a minimal analysis of the psychosocial situation is included before any type of programme is set up, so as to consolidate the environment and avoid causing further damage.

In cases of natural disasters or conflicts, ACF assesses psychosocial needs in coordination with other institutions involved, and organizes psychological support and counselling. A mental health approach is also included in disaster risk reduction programmes by training teams and relay persons in the community and by setting up natural disaster support networks.

**Involving key members of the community from the initial assessment stage and seeking their opinions on the usefulness of a given programme contributes, on the one hand, to a better definition, according to the local culture, of needs and target population while, on the other, supporting the local authorities and reinforcing their social position so that the whole community knows to whom it can refer.**

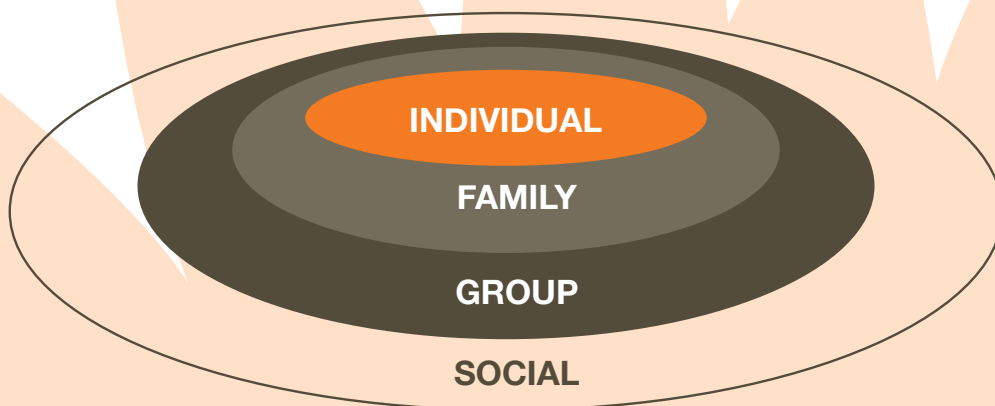
## **To reinforce the quality of ACF programmes**

ACF programmes in other technical areas or on topics such as HIV can be complemented by mental health activities or care practices, according to identified needs. For example, HIV prevention practices are only effective if they deal with stigmatization, individual defence mechanisms surrounding diagnosis, and the consequences of the diagnosis once announced on choices such as breastfeeding – an area in which a combined psychological, anthropological and social approach is essential. HIV/AIDS sufferers are also at greater risk of mental health problems, and these problems can in turn affect their general health (e.g., greater risk of poor compliance with treatment).



## **To improve our understanding of the context by incorporating the social and psychological impact into our analysis and adapting our programmes in consequence, so as to reinforce adaptation mechanisms and avoid further disruption of the social and family environment**

Natural disasters, conflicts, extreme poverty and discrimination/acts of violence create contexts in which society is disrupted, populations are displaced, bearings are lost, family structure changes, the mental make-up of individuals is shaken up, etc. Deprivation, material loss, changed living conditions and assistance also have an influence at these different levels (social, group, family and individual). As explained above, psychiatric morbidity increases significantly in such situations. The more the group is affected, the more the individual is at risk. However, each level can also be affected independently.



This impact must be taken into account in context analyses and in defining varied technical projects.

The following must also be taken into account:

- the pre-crisis situation;
- the type of crisis, its duration and immediate consequences;
- post-crisis living conditions, their development and repercussions
- the existing resources in the community.

**If people are struggling to survive, it is difficult to ask them to think about the future or to set up think-tanks; if people are living in fear, it is difficult to ask them to put themselves at risk by working ...**

# Intervention modalities

## General principles:

Project cycle management (PCM) provides the structure for interventions.

Care practice and mental health strategies are integral parts of the technical strategies defined for each mission in every country.

**The paragraphs below aim to clarify the methods of intervention that are specific to each stage of the mental health and child care practice project cycle.**

## Needs analysis and adapting approaches to cultural contexts

### • Type of needs to be analysed

The criteria for launching a needs analysis for mental health and child care practices are linked with either major malnutrition or drastic disruption (natural disaster, conflict or “oppression”) or both.

A needs analysis can address early childhood care practices or the mental health of local populations, or a combination of both. The choice between options will depend on ACF’s technical strategies in a country and on preliminary analyses based on knowledge already accumulated and available contextual information.

Tools and approaches will vary according to the objective of the needs analysis, when it is carried out<sup>11</sup>, and the geopolitical, cultural and social context. For example, determining the psychological needs of HIV-affected persons, measuring the repercussions of a conflict on the capacity of a group of mothers to care for their under-three-year-olds, or the risk of malnutrition linked with breastfeeding difficulties following a natural disaster will target different groups and call for different methods, tools and even competences.

When possible and appropriate, joint assessments with other technical and operational sectors are privileged so as to obtain a more comprehensive view of the situation and facilitate the preparation of an integrated response.

### • Preferred approach

The qualitative approach adopted for the needs analysis will, in certain cases, be accompanied by a quantitative approach.

As a general rule, epidemiological studies in mental health are not favoured without the gathering of additional information on health, psychosocial factors, crisis upheavals and suchlike. They are only valid if they can be compared with a previous situation or other similar contexts; the main reservations regarding epidemiological studies lie in the use of tests or psychological scales that have not been culturally validated or that provide insufficient information for a diagnosis<sup>12</sup>.

An assessment of mental health needs is not merely the interpretation of psychological and social problems in individuals; it must target collective changes and major trends (e.g. suicide rate in the population, alcoholism and other addictions, domestic violence, etc.) with their potential risks for the society and the individual.

Assessment tools must take into account the fact that psychological symptoms differ from culture to culture, as do child development and child care practices. We must therefore adapt our interpretation and assessment scales. Emic and etic are used as complementary approaches<sup>13</sup>.

11. For example, the phenomena assessed immediately after a natural disaster are not the same as those assessed 3 months afterwards.

12. Certain scales (such as the SRQ, GHQ or HTQ) are validated by a number of experts for epidemiological purposes. However, the conditions that determine their validity (inquiry/clinical maintenance) are not necessarily explicit.

13. Emic: relativist; describes a point of view specific to native populations; Etic: universalist; describes an outsider's point of view of the culture.



## • Choosing the right time for an assessment

It is vital to take account of the temporal difference between psychological time and chronological time: psychological disorders are not necessarily simultaneous with contextual or political events (the signing of a peace accord does not signify an end to mental suffering or the recovery of an earlier healthy, functioning society for example). In extreme situations, there is often a momentary “putting aside” or “freezing” of disturbances or suffering while the mind concentrates on immediate survival. Psychological difficulties are more likely to appear in the aftermath, when the situation has improved, which is why it is important, when assessing future risks, to give careful consideration to the right time to act.

## • Needs and resources analysis

Part of the assessment deals with resources – both collective and individual. Collective resources can include community dynamics, mutual aid and solidarity networks, and the usual resources – the existing care system, including traditional practitioners, local beliefs, recourse to faith healing and magic, etc. –, as well as international NGOs on the ground and their field of intervention. Interventions respect individual and group capacities to cope, and priority is given to supporting these means of resilience.

## • Mental health assessments –specificities

Psychological needs are not determined on the sole basis of a grid of potentially traumatic events. This grid is necessarily complemented by a clinical interpretation of the situation among the population. To obtain this, a psychopathological scale<sup>14</sup> can be used, but not exclusively, and careful consideration must also be given in the needs analysis to acute and diffuse psychological suffering. For cases where the use of a psychopathological grid is willing the ICD-10<sup>15</sup> is preferred over the DSM IV-TR<sup>16</sup> for adults, and the 0-3 classification is recommended for children under 3.

## Project definition and setting up – principles and limits

### • All projects

- Projects are defined after a detailed assessment of needs and resources in accordance with the terms above. Needs can to some extent be anticipated on the basis of information gathered concerning the intervention zone and of existing reports, but there must also be a field evaluation by qualified staff to specify objectives and activities and to estimate resources needed for project implementation, as well as assessment indicators and measurable impact.

- Based on identified priority needs, interventions tend to privilege mental health, care practices and/or child development.

- For ACF interventions, factors that prevent or hinder the setting up of adequate child care practices – particularly psychosocial factors – are taken into account.

- ACF does not favour a single therapeutic approach, but prefers an eclectic approach tailored to the specific issues affecting the population, to the patients and to the type of programme planned. However, close attention is paid to the fields of competence and theoretical reference frame of expatriates, with a supporting training plan to ensure that international teams receive a coherent body of training.

- Programme and treatment objectives must be clearly defined and measurable, particularly the goal and major limitations. ACF does not produce standard protocols applicable to all mental health and child care practices interventions, since the aim is to keep real flexibility in meeting needs, but it does encourage the creation of tools such as mission databases and manuals in order to structure interventions. The use of culturally sensitive tools is encouraged when these exist.

14. Crises lead to all kinds of psychological distress. Trauma is only one form of this distress and affects about 20% of populations in conflict situations. There is also an observed increase in depression, anxiety, psychosomatic disorders and long-term mental suffering. This calls for a psychodynamic interpretation of mental suffering.

15. ICD: International Classification of Diseases developed by WHO.

16. DSM: Diagnosis and Statistical Manual of Mental Disorders developed by the American Psychiatric Association.

- ACF's preferred intervention method is to support local resources, and projects always rely on a national team or local structures. The local team, however, is not necessarily made up of psychologists. When a country has a psychology curriculum and its own psychologists, the technical competence and real level of candidates' qualifications must be verified, using evaluation scales. In some cases it will be preferable to recruit motivated, sensitive persons with good listening skills rather than under-motivated, poorly qualified psychologists. Once a programme is established, training national teams is one of its vital components, taking several months – sometimes several years – with theory, including practical exercises with role playing, alternating with periods of joint work with the expatriate psychologist.

- Learning through mentoring is one of the keys to the system. National teams initially work with the expatriate during individual or group therapy sessions. Then, gradually, they begin to take their own sessions, with interventions as and when needed by their particular trainer (either during sessions because of specific difficulties, or for particularly difficult cases) until they are able to work on their own. However, mental care is so difficult that national and expatriate teams need a great deal of close monitoring and support, and there will be regular briefings, debriefings, team meetings and case reviews. Supervision for national teams – either by the project manager or from outside when possible – must be set up. Particular care must be given to the future of trained nationals and to ensuring that their knowledge and experience receive recognition by taking account, for example, of the official national curriculum and the naming of posts during their work with ACF.

The expatriate psychologist can treat patients directly, particularly when national professional expertise is unavailable or in the most complex cases that the team is unable to handle on its own. In certain situations, treatment can be facilitated by people from outside the community, perceived as neutral and uninvolved in local conflicts. Patients may feel more relaxed and reassured about the confidentiality of counselling sessions, although they will in any case be using an interpreter trained for this approach.

- The project's objectives must match the on-site team's competences and be adapted accordingly.

- ACF favours networking, both internally with other ACF technical departments and with other care and support facilities. A system for referring patients to outside programmes is set up as soon as possible, following an assessment of the quality of services offered based on our parameters. Preference is given to the most sustainable systems.

## • **Mental health**

- Respect for individuals (culture, beliefs, etc.) and guaranteed confidentiality are necessary prior to the implementation of any psychological support programme.

- Programmes do not compete with, but complement, other local care practices, particularly traditional practices except when these are dangerous. This means keeping to our own reference system: ACF does not replicate "traditional" therapies, such as breaking spells, witchcraft or religious rituals.

- Therapy can be individual, family or group. The type of treatment depends on the culture, the population's response to the type of therapies we offer and operational possibilities.

- Focusing on the social dimension by strengthening bonds and resilience is – depending on the context and needs – a possibility.

- Psycho-education used in isolation and on a large scale is not favoured. It is, however, possible to include a screening component in programmes for certain cases, particularly if we are able to treat or refer identified patients<sup>17</sup>.

- Therapeutic mediation is possible, and even encouraged, for treating certain populations

17. It may be possible, for example, to train community workers to identify cases of depression so that they can refer sufferers for a psychological consultation, where a diagnosis can be made and treatment arranged if necessary.



## • Specific limits to ACF mental health interventions

- ACF does not treat patients with chronic psychiatric disorders, but refers these patients to existing local facilities or other NGOs on the condition that these prove to be properly operational. Occasional support is possible in very specific circumstances – for example, at a therapeutic feeding centre under the following conditions: a doctor is present, referral to an appropriate facility is not possible, the patient is in crisis, ACF has the necessary medication and the doctor in charge can provide follow-up.
- ACF does not hold “mass debriefing” programmes (sometimes incorrectly called “counselling” in the humanitarian sector). Fast-track training programmes for unqualified staff and in the identification and treatment of “victims”, especially survivors of natural disasters, are ruled out. They are considered dangerous for intended recipients (e.g. risk of decompensation or, to a lesser extent, stigmatization) and for the workers (risk of secondary trauma) and have not proven effective.

## • Child care practices

- Treatment can be curative or preventive.
- Certain activities are systematically included in treatment for severe acute malnutrition. There is a “basic package of care practices”, and the Nutrition departments, both at headquarters and in the field, are in charge of implementation. Operating methods for acute malnutrition outpatient programmes are more complex to define and thus more dependent on the approach selected.
- ACF care practice approach takes the form of support and counselling services of proximity and goes beyond the limits of an education or awareness-raising programme, because its main objective is to strengthen and/or change behaviours. ACF favours a prevention approach, home visits rather than health centres, and a family rather than an individual approach. Ideally, for greater impact, we work on several levels – group, family and individual.
- With regard to prevention programmes, there are many intervention methods and activities vary, depending on the care practices and the major factors influencing them. For example, information and discussion sessions were organized in secondary schools in Monrovia, Liberia, with a view to preventing unwanted teenage pregnancies – an issue that had been identified previously as a major malnutrition risk factor. In many Muslim communities and in war situations, widows and rejected women lose their status and social recognition, and have great difficulty in finding sources of income. As a result, they no longer have the means to care for their children properly. ACF support services are adapted to the daily tasks that women have to do, their mobility, etc. In other situations, the work involves the family group, especially as a child can be in the care of several family members.

## Monitoring and evaluation

- Project monitoring tools must be set up.
- Activity indicators are established at the beginning of projects and are tailored to programme objectives.
- The quantitative indicators are included in the monthly reports (APRs).
- Teams are encouraged to evaluate the impact of each project.
- The qualitative indicators for measuring project impact are largely based on subjective criteria, due to the varying cultural expressions of psychopathology and psychological suffering, but also due to the actual object of the assessment, the mind itself, which escapes any objective, definitive assessment.
- Programmes and activities are regularly readjusted (2 or 3 times a year) in accordance with changes in the context, the population’s response to therapeutic services offered, and existing needs and resources.



## Expertise and principles shared with other humanitarian actors

**Multiple forms of suffering:** the psychological disorders or problems that can appear in the wake of events such as violence or natural disasters are not limited to post-traumatic stress disorder. Psychological suffering can express itself in many forms: multiple, recurrent physical pains in the absence of illness, depressed immune response or an increase in somatic illnesses, for example, are very common. Inappropriate behaviours, such as alcohol and drug abuse, are also common. In terms of mental health in the narrower sense, depression and anxiety are the most widespread disorders, and often occur together (co-morbidity).

**Psychological suffering, mental disorder, not mental illness:** the disorders that develop in these contexts do not fall within the scope of psychiatry, except when they lead to confirmed mental illness. Sociocultural, economic, political and spiritual factors have a crucial impact on their potential to progress (i.e. worsen or become chronic) or regress. A holistic approach is therefore more effective.

**Need for an intercultural approach:** definitions of mental health, of mental disorders and of their symptomatic expressions are part of a cultural context to which mental health care professionals must always adapt their expertise. There is, therefore, no standard programme or method: each programme needs to be invented in cooperation with the beneficiary community, even if each participant has his or her own approach.

**Need for coordination:** coordination between the different mental health actors within a given population is essential; the aid offered must be consistent.

**Promoting intervention from the start of the emergency:** we now recognize the tremendous impact of conflicts on the mental health of individuals and groups. We therefore need to promote early intervention, when the effects can still be remedied. It is vital that psychosocial aspects are taken into account when setting up any type of emergency programme (temporality is not always the same as for the emergency pool). This means, for example, that proposed interventions must respect the beneficiaries' culture, and strengthen – or at least not hamper – its social resilience mechanisms and traditional social organization. This requires that the beneficiaries or key people be involved (when they are able) from project definition onwards.

**Recognizing workers' psychological support needs:** Professionals now recognize that humanitarian workers – especially those who have experienced first-hand the events leading to the intervention – need psychological support, and it is the responsibility of NGOs to take this into account.



# ANNEX

## 01

### Child care practices

(from Engle et. al., 1997)

CATÉGORIES	SUB-CATÉGORIES	CHILD CARE PRACTICES
Care for women	Care during pregnancy and lactation	Provision of extra-amount of family foods
		Workload reduction and support
		Facilitating prenatal care and safe birthing
		Post-partum rest
	Reproductive health	Delayed age at first pregnancy
		Support for birth spacing
	Physical health and Nutritional status	Provision of a fair share of family food at all ages
		Protection from physical abuse
	Mental health, stress and self-confidence	Reduction of stress
		Enhanced self-confidence and esteem
		Protection from emotional abuse
	Autonomy and/or respect in the family	Adequate decision-making power
		Access to family income, assets and credit
	Workload and time	Shared workload
Education	Support of equal access to school for girls	
	Support of women's access to information	
Breastfeeding and feeding practices	Exclusive breastfeeding	Exclusive breastfeeding for about 6 months
		Initiation within first hour to hour after birth
		Breastfeeding on demand
		Development of skills of breast milk expression
		Protection from commercial pressures for artificial milk
	Complementary feeding and sustained breastfeeding	Timely introduction of complementary foods
		Breastfeeding into the second year
		Adequate complementary foods (energy and nutrient density, quantity)
		Frequent feeding
	Active complementary feeding practices	Adaptation to psychomotor abilities for feeding
		Feeding responsively
		Adequate feeding situation
	Adaptation to family diet	Ensuring adequate intra-household food distribution
		Appropriate response to poor appetite in young children

CATÉGORIES	SUB-CATÉGORIES	CHILD CARE PRACTICES
<b>Psycho-social care</b>	Responsiveness to developmental milestones and cues	Adaptating behavior to child's development level
		Attention to low activity levels and slow development of child
	Attention, affection and involment	Frequent positive interactions (touching, holding, talking)
		Maintenance of valuable practices
	Encouragement of autonomy, exploration and learning	Encouragement of playing, exploration and talking
Adoption of a teaching or guiding role		
Prevention of and protection from child abuse and violence		
<b>Food preparation</b>	Household food preparation, cooking and processing	
	Storage	
	Food hygiene	
<b>Hygiene practices</b>	Personal hygiene practices	Hand-washing
		Bathing and cleaning child
	Household Hygiene practices	Cleaning of house and children's play area
		Adequate disposal of child's wastes
		Use of sanitary facilities
		Making water safe, and choosing safe water
	<b>Home health practices</b>	Home management of illnesses
Diagnosis of illness		
Providing home treatment		
Utilization of health services		Preventive and promotive health services
		Timely seeking of curative health services
Home-based protection		Control of pests
		Avoidance of accidents
		Prevention of abuse/violence

## Short glossary of terms used

### • Mental health

The term “*mental health*” can refer to different, yet juxtaposed, realities: problems that disrupt the social equilibrium, to be managed by the government; pathological disorders to be treated by psychiatrists; and mental suffering, to be eased by healthcare or social work professionals. ACF uses WHO’s broad, public health-related concept of mental health: a state of mental well-being, and not just the lack of mental disorder or addictive behaviours (drugs, alcohol, etc.). As such, it applies to all human beings and forms an integral part of their health, determined by social, environmental, biological and psychological factors.

Because everyone has mental health, good or bad, mental health interventions need not apply only in the context of “mental health problems.” Rather, we can integrate this dimension, which is part of every individual, into how we understand contexts and define ACF programmes, and into how we look at the populations with which we work. Many non-professionals misunderstand and misinterpret the term, however, associating it only with mental illness and psychiatry.

### • Child care practices

“*Child care practices*” encompasses all aspects of child care, both practical and emotional. The term “mother-child relationship” is sometimes a simpler way to explain child care practices, but can be inadequate here too since it basically implies a dual mother-child or caregiver-child relationship, while in the context of ACF work it is not uncommon for child care to be provided by multiple caregivers. In addition, it fails to highlight the organizational or decisional aspects within the family and social system that should be emphasized in child care practices. To define these, we rely on the definition proposed by Engle (1995): Care refers to the behaviours and practices of caregivers (mothers, siblings, fathers, and childcare providers) to provide the food, health care, stimulation, and emotional support necessary for children’s healthy survival, growth, and development. These practices translate food security and health care resources into a child’s well-being. Not only the practices themselves, but also the ways they are performed - in terms of affection and responsiveness to the child - are critical to a child’s survival, growth and development. It is impossible for caregivers to provide this care without sufficient resources, such as time and energy.”

### • Psychosocial

A term that describes an individual’s psychic development (cognitive, affective and emotional) and his or her interaction in a social environment. In the human sciences there are a variety of approaches in which the psychological and social converge. One of these is assistance to people during critical events, such as disasters. Psychosocial assistance - in its original sense - is a process that aims at helping people recover through a collective approach centred on knowledge of individual needs and of the grieving process. While psychological and social aspects are often affected in situations where ACF intervenes - and justify an analysis of the situation’s impact on both social and family organization and the individual - the term is often broadly (indeed incorrectly) used in humanitarian contexts for any programme that in any way aims at improving the well-being of the population. For example, ACF rules out purely recreational activities, despite the fact that these contribute to a certain well-being. Every ACF intervention is aimed at providing care and support.

## • **Counselling**

Counselling is an approach in which therapists or experts offer advice and support to someone for a specific problem. The term encompasses multiple approaches in the field, from actual treatment by qualified personnel to large-scale projects staffed by unqualified personnel, trained in a few days to “get victims to talk,” especially after natural disasters. ACF implements listening and support operations for populations, the aim of which is therapeutic, using personnel trained over a long period and supervised by expert psychologists; but does not subscribe to the large-scale counselling or debriefing strategy, whose limits and risks to both victims and teams have been demonstrated and published.



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