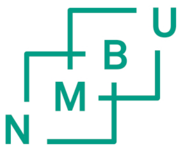

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Mapping the possibility to apply the Red Cross Red Crescent ERU psychosocial support module to address feeding practices for infants and young children in post disaster contexts: A qualitative study

Josefine Vacker

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Declaration

I, Josefine Vacker, declare that this thesis is a result of my research investigations and findings. Sources of information other than my own have been acknowledged and a reference list has been appended. This work has not been previously submitted to any other university for award of any type of academic degree.

Signature…………………………………..

Date…………………………………………

Preface and acknowledgement

Global public health and the understanding of how people can manage life's adversities are of my particular interest. Thus, I feel privileged to have been given the opportunity to write my master thesis in cooperation with the Norwegian Red Cross Disaster Management Unit. To immerse myself into the interesting fields of psychosocial support and infant and young child feeding, have kept my motivation up during this, sometimes confusing process of completing this master thesis in public health. I have learned a lot.

First of all, a huge thanks to all you experienced and knowledgeable informants for sharing your expertise within the field of psychosocial support and infant and young child feeding in post disaster contexts and humanitarian disaster response. Your personal and professional engagement, interest and willingness to share your perceptions and perspectives, have been my main encouragement.

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Dear Jørn Tore and Isak, thank you for your unconditional love, patience and for being in my everyday life. To my family, thank you for your encouragement and for believing in my capabilities. To my amazing friends, thank you for cheering along the way. A special thanks my oldest and very advisable friend Johanna Davidson, for your feedback and inputs at the end of this process. Finally, I would like to proudly thank myself for achieving my long-term goal of completing a masters degree in public health.

Tønsberg, 13 May 2014

Josefine Vacker

Abstract

Background: Child undernutrition constitutes a major global public health challenge to children's chances of physical and cognitive development and survival. Disasters affect millions of people every year and have devastating impacts in the lives of those affected. Caregivers capabilities to care for, and feed their infants and young children, may be disrupted due to changes in the environment and psychosocial challenges. The Red Cross Red Crescent ERU - psychosocial support module have recently been identified to have a potential to address feeding practices for infants and young children in post disaster contexts. The objective of this master thesis is to map professionals' perceptions and perspectives of how to possibly apply the psychosocial support module to address infant and young child feeding practices in future ERU deployments.

Theoretical framework: The chosen theoretical framework function as an analytical and interpretative tool to understand and add meaning to the informants' expressions and perceptions. A biocultural perspective of human diet and nutrition, deriving from anthropology and epidemiology, were chosen as the overall theoretical view. The theoretical descriptions of psychosocial support [PSS] and infant and young child feeding [IYCF] will function as applied theory, where the concept of Baby Tents is exemplified as an activity combining PSS and IYCF.

Method: An ethnographic research perspective with an inductive qualitative study design, using semi-structured interviews was chosen to explore the perspectives of 15 key professionals experienced in PSS, IYCF, Baby Tents and humanitarian disaster response. Systematising, coding and categorising the audio-recorded interviews resulted in five main categories; divided into four stages and one overarching dimension. The analytical interpretation of the study findings in light of the theoretical framework was guided by a hermeneutic approach.

Findings: The study findings disclosed several perspectives of how to possibly apply the psychosocial support module to address feeding practices for infants and young children in future ERU deployments. Stage 1 is about how psychosocial support delegates, prior to deployment, may be prepared to address feeding practices in post disaster contexts. Stage 2 highlights how psychosocial support may be applied to understand existing feeding practices. In stage 3, it is presented how psychosocial support activities may be designed to support feeding practices in post disaster contexts. Effects and means to make the activities sustain and have positive public health outcomes are discussed in chapter 4. The overarching dimension 5 is related to stage 1-4, and presents the perceived role of local Red Cross Red Crescent community volunteers as the link between the psychosocial support delegates and disaster affected communities and individuals.

Conclusion: The presented study findings highlights some prominent aspects, which may be perceived as a starting point to further discuss its practical implication in future ERU deployments. The Red Cross Red Crescent Movement Disaster Response management is recommended to

consider how to possibly implement the study findings in practice, and furthermore evaluate its applicability continuously.

Keywords: Baby Tents, Child undernutrition, Disaster response, Emergency Response Unit, Infant and Young Child Feeding, International Federation of Red Cross Red Crescent, Psychosocial Support, Psychosocial Support Module

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Abbreviations

ACF	Action Contre la Faim eng. Action Against Hunger
ERU	Emergency Response Unit
IASC	Inter-Agency Standing Commitée
ICRC	the International Committee of the Red Cross
IFRC	the International Federation of the Red Cross and Red Crescent Societies
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
WHO	World Health Organization
RCRC	Red Cross Red Crescent
NS	A Red Cross or Red Crescent National Society
PS centre	International Federation Reference centre for Psychosocial Support
PS delegate	Red Cross Red Crescent Psychosocial Support delegate
PS professional	Psychosocial support professional
PSS	Psychosocial Support
UNICEF	United Nations Children’s Fund

1. Introduction

Public health is a multidisciplinary area with the objective to improve the health of populations, managing health problems, and promote positive health outcomes of both individuals and communities (Action Contre la Faim [ACF], 2012). In 2012 approximately 6.6 million children died before their fifth birthday (United Nations Children's fund [Unicef], 2013a). Undernutrition is a lead cause of child mortality, directly or indirectly, and constitutes a major public health challenge (Unicef, 2013a; World Health Organization [WHO], 2013b). Maternal and child health are identified as special research topics of interest to improve the global public health (WHO, 2013c).

The number and impacts of disasters increases due to climate changes and population growth (Leaning & Guha-Sapir, 2013). Environmental changes, limited access to clean water and sufficient food due to the disastrous event may jeopardise feeding practices for infants and young children (World Vision International, 2012). Additionally, disasters challenge the psychosocial wellbeing of caregivers due to social disruption and distress which in turn may influence their means to care for and feed their children (Inter-Agency Standing Commitee, [IASC], 2007). WHO and Unicef (2003) stresses that international organizations should prioritise infant and young child feeding on their global public health agenda and recognise its importance for the realisation of children and women's rights.

The International Federation of the Red Cross and Red Crescent Societies [IFRC] have recently had their disaster response capacity reviewed, based on the public health significance of reaching the fourth Millennium Development Goal to reduce under five mortality, by responding to children's nutritional needs in disasters (Bush & Dent, 2013). The review highlighted a potential to utilise the Emergency Response Unit [ERU] - psychosocial support module to address feeding practices for infants and young children. An ERU is a disaster response tool and a part of IFRC's global disaster response system and available to be deployed to post disaster contexts at short notice (IFRC, 2012a). Therefore, the theme of this master thesis is to map perceptions and perspectives of how the psychosocial support module can be applied to address feeding practices for infants and young children, in post disaster contexts, by interviewing key professionals.

The first chapter aim to introduce the rationale and to frame the theme of this master thesis by presenting background information, study objectives and research questions. Chapter two will present the study methodology followed by a presentation of the theoretical framework in chapter three. The theoretical framework will be applied to interpret the study findings in chapter four. The conclusion, and further suggestions of implication of the study findings are found in chapter five.

1.2 Background

As a background to the theme of this master thesis, this chapter will outline the global nutritional situation for children and highlight why disasters might challenge feeding practices for infants and young children, and the psychosocial wellbeing of the affected people. This outline is followed by an explanation of why psychosocial support might have significance to address feeding practices for infants and young children. Further, the Red Cross Red Crescent Movement's disaster response capacity and the ERU psychosocial support module will be introduced. Finally, the study objective, research questions and study limitations will be presented.

1.2.1 Children's right to food and the global challenge of child undernutrition

The fundamental right to food, health and wellbeing for everyone are stated in The Universal Declaration of Human Rights article 25 (United Nations [UN], 1948) and within the International Covenant on Economic, social and cultural rights, article 11 (UN, 1976). Children's right to healthcare, safe drinking water, food and safe environments is stated in the Convention of the Rights of the Child (UN, 1990). Although food is one of the most basic human needs for survival, approximately ten percent of the world's population is not getting their need for food covered (World Food Program [WFP], 2012). However since 1990 we have seen a significant progress in the efforts to reduce under-five deaths, i.e. the mortality rate for children under the age of five years; thanks to more affordable treatments, effective interventions and political commitment, though the under-five survival are unevenly distributed around the world (Unicef, 2013a).

80 percent of all under-five deaths occur in South Asia and sub-Saharan Africa (Unicef, 2013a). Sub-Saharan Africa is the region with the least progress in increased child survival, and there are differences within the region. In West and Central Africa, less children survive their fifth birthday compared to Eastern and Southern Africa. To reach the fourth Millennium Development Goal to reduce the under-five mortality rate by two thirds before 2015, faster progress in child survival is necessary.

It is estimated that more than 100 million children under the age of five are underweight, and children under two years of age is the group most affected by undernutrition (WHO, 2013b). Undernutrition is defined as the "*outcome of insufficient food intake or repeated infectious diseases, often due to economic, political and socio-cultural factors" (ACF, 2012, p. 74).* Malnutrition is the collective name for unbalanced nutritional status, where undernutrition is one type of malnutrition and a status of deficit (ACF, 2012). The nutritional status of children may be endangered in periods of stress, disease and food shortage. Young children as well as pregnant and lactating women are expressed to be more vulnerable to disease and undernutrition because of their need for increased energy intake.

An understanding of what causes undernutrition in a given context is crucial in order to provide the right support and a sustainable solution that meets the needs of affected populations (Unicef, 2013a). The conceptual framework of the determinants of child undernutrition, developed by Unicef, is commonly used to illustrate the different causes and consequences of child undernutrition, see figure 1.1 (Bush & Dent, 2013; The Sphere Project, 2011; Unicef, 2013b). The conceptual framework implies that inadequate food intake and disease are immediate causes of undernutrition (The Sphere Project, 2011; Unicef, 2013b). The immediate causes can be a result of the underlying causes, food insecurity, inadequate feeding practices and care, and lack of access to water and healthcare, poor hygiene and sanitation. Basic causes, underlying causes and immediate causes, increase the risk of both maternal and child undernutrition where the short-term and long-term consequences, presented in the framework, can feed back to the underlying and basic causes of undernutrition underpinning the risk of future undernutrition (Black arrows in right of figure 1.1)

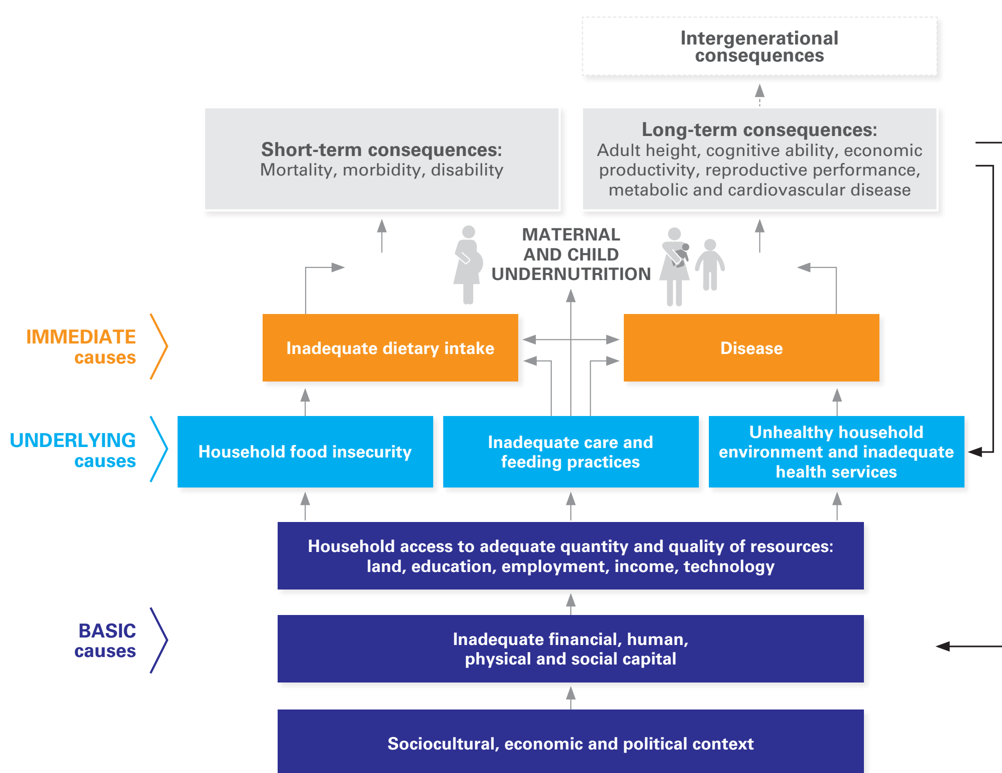

Figure 1.1 Conceptual framework of the determinants of child undernutrition (Unicef, 2013b)

To reach sustainable change, actions must be targeted to different causes of undernutrition through a comprehensive approach, also including interventions to improve the nutritional status of pregnant and lactating women (WHO, 2013b). WHO and Unicef (2003) have developed the Global Strategy for Infants and Young Child Feeding to raise attention to feeding practices and its impact on children's health, development, growth and survival. The strategy is builds on the "Baby-friendly Hospital Initiative" from 1991, "The international Code of Marketing of Breast-milk Substitutes" from 1981 and the "Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding" from 1990. In

addition, the Innocenti Declaration on Infant and Young Child Feeding, call for action to reach the Millennium Development goals by 2015 and for realisation of children's universally recognised human right of highest attainable standard of health and development (Unicef, 2005). The publications are based on scientific and epidemiological evidence on the significance of nutrition in early months and years of life, and the importance of appropriate feeding practices to achieve optimal health, and thereby form a policy framework and global approach on how to promote recommended feeding practices for infants and young children (Unicef, 2005; WHO & Unicef, 2003).

1.2.2 Disasters, psychosocial wellbeing and feeding practices

Throughout the world, millions of people are affected by disastrous events, both natural disasters and armed conflicts every year (WHO, 2013a). It is estimated that more than 245 million people were affected by natural disasters globally in 2011. A disaster can be described as a sudden overwhelming and unforeseen event, and is classified into natural disaster, natural hazard increased by humans and disaster caused by humans (The John Hopkins & RCRC, 2008). Those disastrous events can result in large-scale injury and death, displacement of people, and disruption of economic, political, social and health systems. Disasters might cause, or enhance already existing, problems experienced at; the individual, family, community and societal levels, when normal support systems are undermined or destroyed (IASC, 2007; Yigen, Johansson, & Christensen, 2012).

Psychosocial impacts of disastrous events might be less visible than the destruction of physical infrastructure (Yigen et al., 2012). In addition, may the social and emotional trauma from disasters take far longer to overcome than material loss (IFRC, 2012b). Factors influencing on individuals levels of stress, stressors, can be of extreme character in disasters (The John Hopkins & RCRC, 2008). Displacement, lack of basic needs, social disruption and exposure to violence are mentioned as serious and severe stressors influencing the wellbeing and behaviour of the ones affected. So depending on the type and impact of a disaster, some groups of people can be of particular risk of experiencing psychosocial difficulties due the severe stressors (The John Hopkins & RCRC, 2008; Yigen et al., 2012). When an individual does not have the ability to adapt to the experienced stress, the stress becomes distress which can lead to a number of different reactions of physical, emotional and behavioural character (Yigen et al., 2012). Such reactions include: physical pain like headache and stomachache, disturbed sleep and shortness of breath, emotions of fear, anxiety and hopelessness, loss of energy and motivation, behavioural appearances like temperament change, unwillingness to socialise and inability to work.

To help coping with stressors, individuals and populations are believed to have protective factors. The protective factors are defined as *"qualities in a person, or in the surrounding environment that shield a*

person emotionally and mentally from the full force of a stressful event" (The John Hopkins & RCRC, 2008, p. 204). Prior level of functioning, social support, ability to cope and moral belief systems is mentioned as protective factors. Protective factors, assets or resources supporting mental health and psychosocial wellbeing differ depending on age, gender, socio-cultural and the disaster context (IASC, 2007). Protective factors, or resources, are also considered necessary to take into account when planning emergency response and interventions. Returning to some kind of normal life, as soon as possible, is perceived to help people cope with the disastrous event and ease functioning (IFRC, 2012b). WHO (2013a) highlights that the psychosocial wellbeing of disaster affected people is getting more attention from national and international agencies. Agencies show willingness and ability to provide psychosocial assistance when needed, and thereby present a possibility to introduce, and make psychosocial support services accessible in communities.

The Global Strategy for Infant and Young child feeding, identifies infants and young children as being among the most vulnerable victims in disasters (WHO & Unicef, 2003). Uncontrolled distribution of breast-milk substitutes, disrupted breastfeeding practices and unsafe complementary feeding can be considered to heighten the risk for undernutrition, illness and mortality among infants and young children in disasters (Interagency Working Group on Infant Feeding in Emergencies, 2007). Although, program strategies to prevent undernutrition and improve child growth, through promotion of appropriate infant and young child feeding practices are often overlooked in disasters (The John Hopkins and RCRC, 2008). Since all the underlying causes of child undernutrition can be directly affected in disasters; food access and feeding practices to maintain adequate nutritional status are important determinants for child survival, especially if the children are under the age of two years and already at risk for undernutrition, as illustrated in figure 1.1 (The Sphere Project, 2011; Unicef, 2013b). Interventions to ensure access to safe, sufficient and nutritious food in disasters may determine children's nutritional status and wellbeing in short-term, and health and survival in long-term. The importance of actions to protect, promote and support recommended feeding practices, for breastfed and non-breastfed infants and young children in all emergencies, are emphasised (Save the Children, 2012).

Children's wellbeing is stated to depend largely on their family and community situations, and early childhood is mentioned to be the most important period for physical, cognitive, emotional and social development (IASC, 2007). Since, disasters might disrupt children's social bonds with their main caregivers, the long-term social and emotional development can be undermined. It is recognised that adequate nutrition, in combination with physical, emotional stimulation and care, optimises the conditions for children's physical and cognitive development (IASC, 2007; World Vision

International, 2012). Thus, families and caregivers, experiencing challenging situations, might require support and practical guidance to feed and care for their children adequately (WHO & Unicef, 2003).

1.2.3 International humanitarian disaster response and context sensitivity

Even though most countries have some disaster response capacity, it may be very limited in low-income countries, generating more dependency on the assistance of international humanitarian organizations (The John Hopkins & RCRC,2008). To manage larger scale disasters, assistance from international organizations and government agencies might be required. Public health interventions, and use of epidemiological methods to reduce morbidity and mortality, in humanitarian disaster response has gained increased focus since the 1970s (Leaning & Guha-Sapir, 2013). Besides, health care practitioners were increasingly engaged in development of international ethical norms, human rights and humanitarian law in disaster contexts. Today, public health is a major component of international disaster response, and a multidisciplinary field ranging from disease control and emergency care to reproductive health and psychosocial support.

To maximise positive public health outcomes of assistance provided to disaster affected populations by international humanitarian organizations, a context sensitive approach is believed to be important (The John Hopkins & RCRC, 2008). A context sensitive approach aim to understand the interaction between planned interventions and the environment in which the organization operates. Furthermore, to take a context sensitive approach is to consider, and respect the values of a particular culture or population (Lützen, 1997). Beliefs about health and accepted healthcare are influenced by those values, whereas the importance of a context sensitive approach when providing healthcare is highlighted. A context sensitive approach focuses on how to implement theoretical knowledge into specific contexts, in a way that is acceptable regarding social norms, and with respect to the needs of the individual receiving the assistance. Differences in the cultural beliefs and values, of the provider of assistance and the recipient, may create a mismatch of what "doing the right thing" is perceived to be (Lützen, 1997).

In this study, the term post disaster context is used to describe the whole context in the aftermath of a disastrous event. Based on the above presentation on how a disaster may influence on the psychosocial wellbeing of the affected population, feeding practices for infants and young children and the chances of child survival and development; a post disaster context can be perceived to be a context of adversity. According to Panter-Brick and Fuentes (2010) can a context of adversity be defined as *"a social or physical environment that create hardship or affliction"(Panter-Brick & Fuentes, 2010, p. 1).* Health, the risk of poor health and contexts of adversity is described to be linked (Panter-Brick & Fuentes, 2010). Since adverse contexts and environments cause large scale human suffering, and may

worsen the already unequal distribution of health disparities, considerations in intervention are requested.

In this study, the presented definition of a context of adversity and the description of a context sensitive approach is of central significance. Hence, in contexts of adversity, such as disasters, a context sensitive approach in humanitarian disaster response may guide intervention to maximise the chances of positive public health outcomes in a way that is socially accepted by the disaster affected population.

1.2.4 The Red Cross Red Crescent Movement

The Red Cross and Red Crescent Movement is the world's largest humanitarian network and is dedicated to; "*preventing and alleviating human suffering in warfare and in emergencies such as epidemics, floods and earthquakes" (International Commitee of the Red Cross [ICRC], 2013)*. The Movement consists of three components; The International Committee of the Red Cross [ICRC], the International Federation of the Red Cross and Red Crescent Societies [IFRC] and National Red Cross and Red Crescent Societies (ICRC, 2013). There are Red Cross and Red Crescent National Societies represented in 189 countries worldwide. The seven fundamental principles of the International Red Cross and Red Crescent Movement unite all components. The principles are; Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity and Universality.

In the fundamental principle Voluntary Service state; "*It is a voluntary relief movement not prompted in any manner by desire for gain" (IFRC, 2012b, p. 3).* The large network of approximately 18 million community volunteers, responding to humanitarian needs, worldwide is perceived as one of the main strengths of Red Cross and Red Crescent Movement*; "National Society community volunteers live within the communities they are supporting. Their understanding of local culture and customs can improve the quality of community actions" (Bush & Dent, 2013, p. 24).* Building a strong volunteer group is viewed as an important asset in disaster response, since local communities and organizations are often the first to respond to disaster in their own areas, to save lives and to provide first aid and shelter (John Hopkins & RCRC, 2008).

1.2.5 Emergency Response Unit [ERU] - A disaster response tool

When international disaster assistance is needed, IFRC in cooperation with the Red Cross or Red Crescent [RCRC] National Society [NS] represented in the affected area, i.e. the operating NS, coordinate deployment of Emergency Response Unit's [ERU's] to provide assistance to disaster affected populations (IFRC, n.d). ERU is a module based disaster response tool and consists of pre-trained personnel and standardised, pre-packed equipment (IFRC, 2012a). The ERU's are an

integrated part of IFRC disaster management system, which refer to; emergency response, preparedness and recovery. The primary goals for the ERU's are to provide lifesaving health services, support water and sanitary conditions and logistics, to improve conditions for disaster affected populations in areas where infrastructure and facilities have been damaged or destroyed (IFRC, 2012a). The ERU's cover seven different sectors: Logistics, IT & Telecommunication, Water & Sanitation, Basic Health Care, Referral Hospital, Relief and Base Camp (Yigen et al., 2012). The health ERU's aim to meet the needs for medical and health care and includes the components Rapid Deployment Hospital, Field Hospital and Basic Health Care, and the modules Psychosocial Support and Community Health. The Psychosocial Support and Community Health modules can be deployed as stand-alone-units or together with other ERU components.

The ERUs can be deployed within 48-72 hours to a disaster affected area and have the ability to operate for up to four months (IFRC, 2012a). The different ERUs contain various components and modules, which refer to the needed equipment for specific functions of the ERU. The composition of components or modules can be adjusted in order to adapt the emergency response to different kinds of disasters, contextual needs and conditions. All ERUs require locally hired staff, water and fuel supply. Deployment of ERUs, aims to contribute to build future response capacity and preparedness within the operating NS.

1.2.6 The ERU Psychosocial support module

Psychosocial support is identified as an area of special concern in disaster responses, and it is described as necessary to *"organise locally appropriate mental health and psychosocial supports that promote self-help, coping and resilience among affected people" (The Sphere Project, 2011).* The optional and additional ERU - the psychosocial support module, was developed by the IFRC Reference centre for Psychosocial support in 2008, supported by The Norwegian Red Cross (Yigen et al., 2012). The term "module" covers the psychosocial support activities, kits and materials, training of volunteers, community outreach and awareness raising undertaken by the psychosocial support delegate [PS delegate]. The psychosocial support activities can be housed in one or two tents close to other ERU's, for example the Referral Hospital, or be launched as outreach activities in communities.

The PS delegate's purpose is to facilitate resilience, emotional and psychosocial wellbeing of disaster affected populations (Yigen et al., 2012). The PS delegates works in cooperation with the operating NS, local health authorities and other ERU delegates. The PS delegates participate in a five day training which aim to prepare them for fieldwork and includes; knowledge on how to identify, train and supervise volunteers, assess psychosocial resources, cooperate with the operating RCRC NS, and

launch psychosocial support activities (International Federation Reference centre for Psychosocial Support, [PS centre], n.d.).

1.2.7 Applying psychosocial support to address feeding practices, a future possibility?

The 1000 days, including the period from conception to the child's second birthday is the most important period of time to meet nutritional needs from a life-cycle perspective, where healthy nutrition and growth have life lasting benefits (Unicef, 2013a). To promote healthy child development, it is advised that psychosocial support needs to be included when responding to children's nutritional needs to promote healthy physical, cognitive and social development. To address the multiple causes of undernutrition; coordination of different disciplines in humanitarian disaster response is believed to be crucial (Bush & Dent, 2013; Save the Children, 2012). Suggested future priorities to address feeding practices for infants and young children in post disaster contexts, reflects a comprehensive approach. Interventions on different levels, from policy development and needs assessment, to provide information, education and psychosocial support to caregivers are proposed. To protect and support the nutritional, physical and mental health of lactating women is perceived essential for the psychosocial wellbeing of both the mother and child (The Sphere Project, 2011).

The psychosocial support module, have recently been identified to have a potential to be applied to respond to infants and young children's nutritional needs, and address feeding practices in future ERU deployments (Bush & Dent, 2013). However, what the identified potential consists of, and how the psychosocial support module can be applied, is yet to be explored.

1.3 Study objective and research questions

The overall purpose of present study is to contribute to the body of knowledge of how to address infant and young child feeding practices, prevent child undernutrition and promote child survival, by applying psychosocial support in post disaster contexts. The specific objective of this master thesis is to map perceptions and perspectives of professionals', experienced in psychosocial support and infant and young child feeding, of how the ERU psychosocial support module may be applied to address; understand and support feeding practices for infants and young children in post disaster contexts. The study also aims to explore the professionals' ideas of the role of local volunteers within the psychosocial support module during ERU deployments. The following research questions will be highlighted:

1. How are the professionals suggesting psychosocial support delegates to be prepared to; understand and support feeding practices for infants and young children when deployed to post disaster contexts?
2. How is psychosocial support explained to be relevant and useful in order to understand how feeding practices for infants and young children are influenced by environmental and cultural elements in post disaster contexts?
3. What are the professionals' perceptions on how to design activities within the psychosocial support module to support feeding practices for infants and young children?
4. What elements, are described by the professionals, to influence a successful implementation of psychosocial support activities and Baby Tents to achieve positive public health outcomes?
5. How is the role of local volunteers perceived by the professionals, regarding their potential to understand and support feeding practices for infants and young children within psychosocial support activities in the post disaster context?

The global public health challenge of child undernutrition may be approached and managed in many different ways in disasters. With regard to the study objective, this study is limited to focus on how infant and young child feeding practices can be addressed within the psychosocial support module, as a part of the disaster response of the Red Cross and Red Crescent Movement. The concept of Baby Tent, which will be introduced as part of the theoretical framework in the following chapter, will function as a guiding example of an activity where promotion and support of recommended feeding practices for infants and young children, can be combined with psychosocial support, in post disaster contexts.

2. Theoretical framework

This chapter aim to introduce the theoretical framework applied in the interpretation of the study findings in chapter 4. A biocultural perspective on diet, nutrition and feeding practices, influenced by epidemiology and anthropology, will provide a theoretical view to further understand feeding practices for infants and young children in relation to growth and development in adverse contexts. The description psychosocial support [PSS], infant and young child feeding [IYCF] provide theoretical insight into the professional fields of humanitarian disaster response in which professionals operate and reason. The Baby Tents will be applied as an example of an intervention and activity where PSS and IYCF can be combined.

2.1 The Biocultural perspective

Within a field of research where medical, biological and nutritional anthropology meets epidemiology, the biocultural perspective is about how biological, social and cultural factors influence health outcomes and distribution of health inequalities (Panter-Brick & Fuentes, 2010). The biocultural perspective covers both social-cultural aspects, and biological and physiological features in the evolution and lifespan of human beings, and can be applied to explore diet, nutrition and feeding practices in relation to public health (Moffat & Prowse, 2010; Panter-Brick & Fuentes, 2010). Diet and nutrition are topics well anchored in both biological and cultural aspects throughout life, whereas the biocultural perspective contributes to understand and explain child growth and child mortality, in relation to nutrition and feeding practices (Moffat & Prowse, 2010). The human body needs food to survive, but our cultural environment will influence what we eat, how we prepare, and consume it.

Growth indicates a child's response to the quality of the experienced environment (Sellen, 2010a). Environments, more optimal regarding nutrition, disease and psychosocial interactions increase growth and development, are perceived as high-quality environments. Child growth can therefore be seen as an integrated measure of health, summarising the responses to the environment from a life course perspective. Regarding a young child's environment, the mother's care and social context is mentioned as maybe the most biologically relevant feature effecting child growth and survival. Furthermore, growth retardation is perceived an outcome of adversity in the child's social or physical environment, and a predictor for morbidity, mortality and poor cognitive and physical development. Poor growth results from undernutrition (see Figure 1.1), caused by mainly disease or inaccessibility to nutrients, or a combination of both (Sellen, 2010a). Even though there exists clinical and epidemiological evidence for evolved patterns for optimal of infant feeding, humans are labile in their feeding practices and behaviours, which are influenced by various factors ranging from political and economical to cultural beliefs and social contexts (Moffat & Prowse, 2010). According to Sellen

(2010b) an evolutionary perspective can be valuable to understand how patterns of breastfeeding and complementary feeding have evolved, and why most infants and young children are not fed according to existing recommendations. Due to more choices in today's contemporary societies, existing patterns of feeding of infants and young children derives from what is perceived as optimal and constitutes a major public health challenge (Sellen, 2010b). Casiday, Hampshire, Panter-Brick and Kilpatrick (2010) emphasise the need to strengthen the linkage between short-term humanitarian disaster interventions and long-term sustainable solutions, when responding to food crisis situation and child malnutrition.

2.2 PSS and IYCF

The theoretical descriptions of PSS and IYCF inform the professional field of disaster interventions and humanitarian response in which professionals operates, and will therefore be implemented as applied theory. The descriptions of PSS and IYCF provide guidance to international humanitarian disaster response to affected populations and are found in central agency publications; strategies, handbooks, manuals, guidelines and minimum standards.

2.2.1 Psychosocial support in post disaster contexts - PSS

In the strategic operational framework - Psychosocial support 2011-2015, PSS is defined as *"a process of facilitating resilience within individuals, families and communities"*, where resilience is further defined as *"an individual's or community's capacity to recover from, adapt to and remain strong in the face of adversities, that have the potential to disrupt or destroy successful functioning or development of the person or the community"(PS centre, 2011, p. 3)*. PSS is concerned with enabling people to cope from the impact of disasters or critical events (Hansen, 2009; PS centre, 2011).

The term PSS is used to describe *"any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent mental disorder" (IASC, 2010, p. 1; Yigen et al., 2012, p. 7)*. PSS aims to promote restoration of social cohesion and infrastructure by respecting, individuals and communities; independence, dignity and coping mechanisms. The term psychosocial implies an interconnection between social and psychological processes, which are perceived to interact and influence one another (IASC, 2010). PSS is further described as both preventive and curative; preventive in terms of decreasing the risk of the development of mental health problems, and curative in terms of assisting individuals and communities to cope with the psychosocial problems caused by disasters or critical events (PS centre, 2011). PSS in RCRC disaster response has a community-base approach based on the idea that; *"if people are empowered to care for themselves and others, their individual and communal self-confidence and resources will improve" (PS centre, 2011, p. 3)*. The social bonds of people in affected communities may then be strengthened, and the psychosocial

wellbeing increase; resulting in positive recovery and increased ability to deal with existing and future challenges and circumstances (Christensen, 2010; PS centre, 2011).

In disasters different kind of support is required due to people being affected in different ways (IASC, 2007; IASC, 2008; The Sphere Project, 2011; Yigen et al., 2012). Hobfoll et al. (2009) have identified five evidence based, post-disaster psychosocial support intervention principles, following immediate and mid-term mass trauma. Those five principles are to promote a sense of safety; calming; a sense of self- and community efficacy; connectedness and hope. All of the five principles are mentioned as being core elements in PSS interventions, and to guide policy and strategy development. The principles can be applied to different levels of intervention, from addressing the individual to broader community-based interventions. It is also stressed that interventions need to focus on stopping the loss of psychosocial, personal, material and structural resources. Hobfoll et al. (2009) highlight the importance to design PSS intervention in a way that fits the culture, customs, place and type of disaster, and to consider the preferences of individuals receiving the services, which can be compared to the context sensitive approach presented in section 1.2.3

To support young children and their caregivers psychosocially in disasters, four key actions for minimum response are presented, to highlight the connection between the wellbeing of both child and caregiver (IASC, 2007): 1, Keep the children with their caregivers and family members by preventing separation, reunify children and their family members or facilitate alternative care arrangements when no other options of care is available. 2, Promote the continuation of breastfeeding of infants to support the child's cognitive development, comfort the child and strengthen the mother-child bond. 3, Facilitate play, nurturing care and social support by activities including parent education, home visits, child care and play groups and 'safe spaces'. 4, Care for caregivers by organising meetings where caregivers to young children can discuss, share problems and support each other.

To meet the needs of different groups, PSS and mental health interventions and activities can be organised into a layered system, illustrated in the pyramid (Figure 2.1). Ideally, all the layers should be implemented simultaneously (IASC, 2007; IASC, 2008; The Sphere Project, 2011; WHO, 2013a; Yigen et al., 2012).

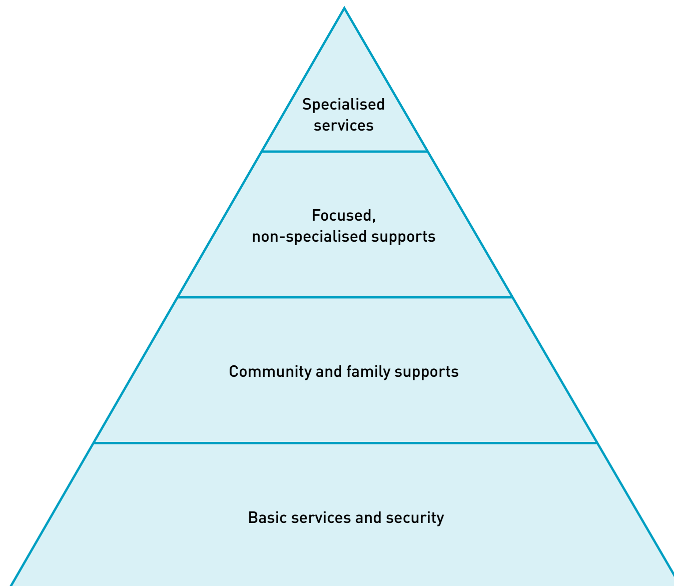

Figure 2.1. The Intervention pyramid for mental health and psychosocial support in emergencies (IASC, 2007)

The first layer, basic service and security, highlights the importance to protect the wellbeing of all people affected by activities to (re)establish security and provide basic services to meet basic physical needs such as food, water and shelter (IASC, 2007). The services should be provided in a way that promote mental health and psychosocial wellbeing and be socially appropriate, enable participation and community mobilisation, protect the dignity of people and strengthen local social support. The second layer, community and family support, the response focus is for people with the ability to maintain their psychosocial wellbeing; if they are supported socially to maintain community networks and reunite with family members. Activities in second layer includes family tracing and reunification, healing ceremonies and mass communication on constructive coping methods, supportive parenting programs, formal and non-formal educational and activities to activate social networks. Layer three, focused and non-specialised supports, aims to provide support to individuals, families or groups in need of focused emotional and livelihood support by trained workers. Activities in the third layer can include psychological first aid and basic mental health care. The fourth layer, specialised services, represent the support to a small percentage of the affected population; suffering from mental disorders, and have severe difficulties to function in everyday life. Assistance in the fourth layer, include psychological or psychiatric support to individuals suffering from severe mental disorder (IASC, 2007).

2.2.1.1 Function of the ERU psychosocial support module

The overall aim with the ERU psychosocial support module, further referred to the psychosocial support module, is to improve the psychosocial wellbeing, protect and prevent further harm (Yigen et

al., 2012). The specific purpose of the module is to *"enable a positive, safe, social and physical environment where children and adults find opportunities for stimulation, skill building and socialisation" (Yigen et al., 2012, p. 8).* A central psychosocial support principle is that most acute stress problems arising in disasters can, and should be, managed without medication by using the basic techniques of psychological first aid. Those basic techniques include non-intrusive emotional support, to cover basic needs, organise social support and networks, and protect from further harm (Yigen et al., 2012). Activities within the psychosocial support module relate to level one to three in the intervention pyramid, figure 2.1. Psychiatric or psychological care, like individual or group counselling or group therapy, presented in the top layer of the pyramid, is not included in PSS activities in the psychosocial support module. The non-inclusion of this level has to do with a differentiation made between PSS and psychiatric care, based on the perception that individuals' suffering from mental disorders require more specialised services by medical personnel, see layer 4 of the intervention pyramid for mental health and psychosocial support in emergencies in figure 2.1. The psychosocial support module has four main functions; where three are related to activities for disaster affected populations, and one concerns training interventions for community volunteers (Yigen et al., 2012):

1. Play and recreational activities can include playing games, sports, drama, art and non-formal education. Play and recreational activities aim to both offer support and care to children, but also to keep them occupied while they, or their parents, are waiting to be examined or treated in one of the other health ERU's or a local hospital. (See layer 1+2, Figure 2.1)

2. The second main function is to assist adults with practical information, emotional and social support. Activities can include assistance to find missing family members, practical help and information about the disaster, and emotional and social support. Supportive listening, psychosocial first aid, and information about local resources, are central element in the service provided. (See layer 2+3, Figure 2.1)

3. Community outreach is the third main function, where the psychosocial support module is used to reach out to surrounding communities and launching activities, where support groups is one example. Community outreach is often done in cooperation with the operating NS other organizations, local health authorities or other. Community outreach is a way to provide access to PSS to as many people as possible. (See layer 1+2, Figure 2.1)

Training interventions is described as the fourth main function of the psychosocial support module and consists of training of local community volunteers in supportive listening and psychological first aid. The volunteers are also trained in how to use the material included in kits, as part of the PSS

module's material. Trainings are given continuously by the PS delegate to train newly recruited volunteers and provide refresher trainings.

2.2.2 Infant and Young Child Feeding in emergencies - IYCF

In the process of developing the Global Strategy for infant and young child feeding, a policy framework emerged stating that *"Mothers and babies form and inseparable biological and social unit; the health and nutrition of one group cannot be divorced from the health and nutrition of the other" (WHO & Unicef, 2003, p. 3)*. The strategy is moreover based on the human rights principles where nutrition is described as a "*crucial, universally recognised component of the child's right to the enjoyment of the highest attainable standard of health" (WHO & Unicef, 2003, p. 5).* The strategy also highlights women's right to proper nutrition, their right do decide how to feed their children and the right to have information and conditions to realise their decisions (WHO & Unicef, 2003). The overarching aim of the Global Strategy for Infant and young child feeding is to *"improve, trough optimal feeding, the nutritional status, growth and development, health and thus the survival of infants and young children" (WHO & Unicef, 2003, p. 6)*. Infant and Young Child Feeding [IYCF] is the collective name for *"The feeding of infants (age<12 months) and young children (age from 12<24 months)" (Global Nutrition Cluster, 2011, p. 7)*. Internationally recommended optimal feeding practices for infants and young children consist of initiation of breastfeeding the first hour after birth, exclusive breastfeeding for 6 months, continued breastfeeding 24 months or beyond, and introduction of safe and adequate complementary foods at 6 months (ACF, 2012; NutritionWorks, Emergency Nutrition Network, & Global Nutrition Cluster, 2011; The Sphere Project, 2011; Unicef, 2005; Unicef, 2011; WHO & Unicef, 2003).

IYCF in emergencies regards protection and support of optimal feeding for infants and young children in all emergencies (IFE Core Group, 2007; NutritionWorks et al., 2011; Save the Children, 2012). Recommended IYCF practices, described above, are the same in disaster situations as in non-disaster situations (NutritionWorks et al., 2011). However, IYCF practices in post disaster contexts may be of particular importance due to adversities in the environment undermining caregivers capability to feed their children (Interagency Working Group on Infant Feeding in Emergencies, 2007; NutritionWorks et al., 2011). WHO (2013b) emphasise the importance to facilitate breastfeeding, identify ways for continued breastfeeding for babies being separated from their mothers and that breast-milk substitutes, teats and bottles never should be distributed to disaster affected populations on general basis. However, interventions to support and promote recommended IYCF practices aim to protect the nutritional needs of both breastfed and non-breastfeed children under the age of two years.

2.3 The Baby Tents

In recent disasters, setting up so called Baby Tents have gained increased focus (Bush & Dent, 2013). Baby tents were set up in large scale in the aftermath of the Haiti earthquake in 2010 (Ayoya et al., 2013; Featherstone, 2010; Unicef, 2013b). The Baby tents provided assistance to detect and treat malnutrition and promote recommended IYCF practices. In total 230 000 children, pregnant and lactating mothers received services in approximately 200 Baby tents in 2010 and 2011 (Unicef, 2013b). Baby Tents are also called baby-friendly corners, mother-baby-friendly tent or baby-friendly tents, and target caregivers, mainly mothers, to infants and young children under the age of two years. Activities within Baby Tents aim to; promote recommended IYCF practices, prevent malnutrition, morbidity and mortality among infants and young children, assist families to adapt their care practices to the post disaster context, improve the wellbeing of both caregiver and the child by providing PSS, reduce negative effects of distribution of breast milk substitutes, and provide assistance to find sustainable solutions for infants who are not breastfed (Ayoya et al., 2013; Filorizzo, 2012). Baby Tents are set up to provide a safe, private and low-stress area where women can breastfeed their babies, receive skilled support, information and training in IYCF practices of both breastfed and non breastfed babies (World Vision International, 2012). By creating a place and space where caregivers are welcomed and supported; Filorizzo (2012) highlights, that Baby Tents can promote the child caregiver bonding and reinforce the caregivers capacity to care for their infants and young children and provide PSS to assist caregivers in emotional distress.

Filorizzo (2012) refers to the IASC intervention pyramid for mental health and psychosocial support in emergencies, and how to link PSS in Baby Tents to the different layers of the pyramid (Figure 2.1). The pyramid has been adapted to fit the Baby tent concept and divided into three layers instead of four (Filorizzo, 2012). Where the pyramid's firs layer addresses all caregivers with children under the age of two years and pregnant women, and includes access to the Baby Tent to meet, chat, relax and breastfeed. It also includes group activities with education sessions, group discussion, relaxation exercises and play activities. The second layer, in the adapted pyramid, refers to basic individual guidance and support for caregivers with children under the age of two years, or pregnant women, having difficulties. The third, and top layer of the adapted pyramid refer to specialised care for caregivers with children under the age of two years, or pregnant women, with difficulties seriously threatening their health and/or the health and development of their child (Filorizzo, 2012).

The Baby Tents can be seen as a type of activity and interventional context, where the biocultural perspective come into practice by combining the professional fields of PSS and IYCF. In Baby Tents, professionals from the two fields can collaborate, and both contribute to promote feeding practices and enhance the psychosocial wellbeing among caregivers of children under the age of two years in

post disaster contexts. Disasters, perceived as contexts of adversities, are environments explained to contain social, cultural and physical features influencing on why feeding patterns of infants and young children may derive from what is evidentially recommended, to ensure optimal child growth and development. Thus, may PSS and IYCF represent a tension and contrast between the different professional fields since PSS aim to promote psychosocial wellbeing, whereas IYCF main focus is to promote recommended feeding practices for infants and young children.

3. Methodology

This chapter will present the chosen methodology, research design and how the collected data material has been analysed through systematisation, categorisation and interpretation in light of the chosen theoretical framework. A discussion of the study methodology is also to be found in this chapter.

3.1 Choice of method

Since this master thesis aim to explore professionals' perceptions, perspectives and ideas on how psychosocial support can be applied to address infant and young child feeding practices; an inductive qualitative approach was chosen to guide the collection of data material. According to Nilsen (2012), qualitative research is characterised by the researcher wanting to get hold of the perspectives and perceptions of the informants' reality. To answer the research questions, it was found considerate to collect perceptions, perspectives and ideas of the study theme by interviewing professionals experienced in psychosocial support [PSS], Infant and young child feeding [IYCF], Baby Tents and humanitarian disaster response.

The chosen research perspective is based on an ethnographic approach. Ethnography is derived from anthropology, and study human beings in relation to culture and social interactions (Crosby, DiClemente, & Salazar, 2006). Culture is described as the knowledge that people use to interpret their experiences and create social behaviour. Using ethnography as a qualitative research perspective, focuses on giving a description of practices, values and behaviours from a group of people's point of view. The group of people whose practices, values and behaviours are researched in this study, consists of a professional network of individuals having relevant knowledge and experiences concerning the study theme. Thus, I have viewed the professionals through an ethnographic lens and explored their knowledge, practices and values acquired in humanitarian disaster response. From the ethnographic perspective, an informant is someone that might work as a teacher for the researcher, providing information and communicate knowledge from his or her experiences (Crosby et al., 2006). The researcher would then try to describe the informants lives related to the culture they are influenced by. In this study I describe the perspectives, experiences and knowledge existing within the professional network and obtained by the informants in different post disaster contexts worldwide, as delegates and professionals in humanitarian organizations.

The role of the researcher in ethnographic qualitative research is not only to study people and observe behaviour, but also to understand the meaning of certain behaviours and practices where a professional culture and knowledge base work as a guiding framework (Crosby et al., 2006). In this thesis, this framework refers to values and practices within humanitarian organizations expressed by

the professionals interviewed. It is desired for the researcher, trough the expressed experiences of the informants, to highlight ways to understand why things are done in a certain way in post disaster contexts, and how the doing is influenced specific ideas, values and theories. The epistemological point of the qualitative researcher is therefore that reality is multifaceted, complex and reconstructed in the interaction between the researcher and the informant, where questions are answered and the data material is constructed (Nilssen, 2012).

3.2 Research design

To this study I conducted semi-structured interviews with 15 informants guided by an interview theme guide. A semi-structured interview is a conversation characterised by neither being completely open or fixed, and described a tool to collect and understand informants perspectives by using an interview theme guide (Kvale & Brinkmann, 2010). Thus, semi-structured interviews were considered to be a valid way to collect the desired experiences, knowledge and practices in order to highlight the research questions.

3.2.1. Identification and recruitment of informants

When conducting a study with a qualitative approach using semi-structured interviews as a method, the number of subjects to interview might vary. Malterud (2011) underline that an adequately recruited sample of informants should be sufficient to enable variations in the perspectives highlighting the research questions. There is limited knowledge on how to support feeding practices for infants and young children by applying psychosocial support within the IFRC emergency response management, hence this expertise had to be found partly outside the organization. An overarching goal when recruiting informants was to enable comprehensive and diverse collection of information in order to highlight the study objective from different perspective. Therefore, the informants have been recruited strategically, based on their professional expertise and availability. Such sampling is explained by Malterud (2011), as purposive sampling. The purposive sampling allowed me to recruit key professionals with desired experience and knowledge to possibly explore the professional fields of psychosocial support and infant and young child feeding. Hence, inclusion of informants has not been limited to their geographical location. To make it possible to collect information from several parts of the world in a short period of time, Skype; an Internet based communication software was used as a tool to conduct the majority of the interviews.

Based on the professional network of my co supervisor at the Norwegian Red Cross, contact was established with a person having comprehensive expertise within the field of management of child malnutrition globally. This person could further assist me to establish contact with potential informants through her professional network of key professionals experienced in IYCF and PSS from

the Baby Tents. Informants with knowledge in PSS within the Red Cross, was identified with the assistance of my co supervisor at the Norwegian Red Cross and staff at the PS centre in Copenhagen. In November 2013, when planning this study, the typhoon Haiyan struck the Philippines. A major international disaster response operation was carried out to assist affected populations and several ERU units were deployed to the Philippines. Therefore, Norwegian ERU health delegates, deployed to the Philippines, were identified and asked to participate when arriving back to Norway. The Norwegian ERU health delegates were recruited based on their expertise in both IYCF and experience from an ERU deployment.

When the initial contact had been established, potential informants were contacted directly with a formal request for participation. The study, the study objective and implication were also introduced more in detail. If the professional agreed to participate in the study, the consent form was sent, to be read and signed before the interview. The collaboration in identifying and recruiting informants resulted in that in total 15 professionals experienced in PSS, IYCF, Baby Tents and health ERU programming and response, agreed to participate. Eight of the informants are experienced in psychosocial support, either as psychosocial support ERU delegates [PS delegate] or as psychosocial support professionals [PS professional] mainly skilled in technical, strategic, training and educational aspects of psychosocial support. Three informants are experienced in IYCF and Baby Tents, and one informant in psychosocial support and Baby Tents. Two informants are experienced in IYCF and have been deployed as ERU health delegates, and the last participant is experienced in health ERU response and management (Figure 2.1). The informants did, at some occasions, name each other "as a good person to talk to", without knowing that the other person also had been recruited to the study.

3.2.2 Preparation and collection of data material - The interviews

The interview theme guide was developed by studying literature; considering PSS, IYCF and the Baby Tent concept in disaster settings with inspiration from the ethnographic perspective in order to understand practices, values and behaviour within the informants' professional fields in post disaster contexts. The themes to explore were also discussed with supervisors, and professionals with expertise in child undernutrition, infant and young child feeding and RCRC disaster response management.

There were two editions of the interview theme guide, based on if the informant mainly had had expertise in PSS or IYCF and Baby Tents (Appendix 1 and 2). The overarching themes were similar but the sub themes were adjusted according to the informants' main area of expertise. The theme guide was designed to be both focused on the study objective but still open and flexible for new

themes to emerge during the interviews. The interview theme guide was adjusted after being piloted with an experienced professional with expertise in management of child malnutrition also having a thorough understanding of the study objective. The theme guide was perceived to have too many questions considering the one hour expected timeframe of each interview, that some themes could be merged, narrowed down and more clearly expressed with greater focus on the study objective. The modified interview theme guide was slightly changed as interviews were conducted and worked as a help to keep the focus on the study objective. I did follow the suggestion by Kvale and Brinkmann (2010), to have a version of the interview theme guide in front of me with specific questions when doing the interviews. The specific questions were adjusted during the period of interviewing. The different interview guide themes were more or less highlighted in each interview with respect to the knowledge and unique experiences of the informant. The interviews were held in English, except for two held in Norwegian.

Due to the informants worldwide geographical locations, the interviews were conducted face-to-face and using Skype. In total, 15 interviews were carried out, four face-to-face and eleven using Skype. Three of the face-to-face interviews were conducted at the PS centre at the Danish Red Cross headquarters in Copenhagen. The centre has the primary function to inform future IFRC operations by developing strategic knowledge and highlighting best practice in the psychosocial support area. The fourth face-to-face interview was carried out in Oslo, at the residence of the informant. The Skype interviews were carried out using webcam if possible due to availability of webcam and quality of the Internet connection. One interview could not be completed due to unstable Internet connection in the country where the person was located. Instead there was a following email discussion where additional questions were asked and followed up subsequently. One of the informants withdrew a few days before the interview for unknown reason. A few potential informants with expertise in child malnutrition outside the Red Cross movement did not respond to my email when presenting the study. The 15 interviews were conducted from December 19th 2013 to March 25th 2014 and lasted from 40 minutes to 85 minutes. All of the interviews were audio-recorded. Figure 3.1 presents the informants, their main professional field of expertise in relation to the study theme, interview setting and language.

Area of expertise Informant	Health ERU	ERU PSS module	PSS	IYCF	Baby Tents	Interview setting: S = Skype S W = Skype with webcam F = Face to face Interview language: N = Norwegian E = English
1		X	X			S W + E
2		X	X			F + E
3			X			F + E
4		X	X			F + E
5		X	X			S + E
6		X	X			S + E
7		X	X			S W + E
8	X			X		S + N
9				X	X	S + E + email discussion
10				X	X	S + E
11		X	X			S W + E
12	X			X		F + N
13				X	X	S W + E
14			X		X	S + E
15	X	X		X		S + E

Figure 3.1: Presentation of informants 1-15 and interview setting

3.2.3 Ethical considerations

With respect to the integrity of the informants, three ethical guidelines have been of central significance in the study, informed consent, confidentiality and the implication of study participation (Kvale & Brinkmann, 2010). Before being included as informants the professionals were asked to give their signed consent for participation. The consent form contained information about the study and study objectives, how the data would be collected and handled during the writing process, also that recordings and notes from the interviews would be destroyed after completion of the master thesis (Appendix 3). The consent form also included information about confidentiality; that participation in the study were voluntary, and that the informants' had the right to withdrawn from the study at any time. To ensure confidentiality, the names or professional positions of the informants will not be used when presenting the study findings. Instead a link key was used to exchange all the informants names with a number and main area of professional expertise with respect to the study objective. When presenting the findings, I seek to keep the identity of the informants anonymous by changing

their names to a number and professional area of expertise. To provide information about the expected timeframe of the interviews, and the possibility to see the interview theme guide in advance of the interview, was a way to assure that the implication of study participation was clear for the informants. The informants were also informed when the study was expected to be completed and published. Since the collected data material would contain personal information, such as name and professional position, about the informants, the study was reported to Norwegian Social Science data services [NSD]. The study was approved after slight adjustments to the consent form according to the recommendations of NSD (Appendix 4).

3.3 Data analysis

The analysis process to systematise, categorise and interpret the collected data material from the 15 semi-structured interviews with the aim to explore the informants expressions in relation to the study objective, has been a circular process. I have moved back and fourth between, the data material, systematisation, categorisation and interpretation; a process informed by my evolving understanding of the study theme.

3.3.1 From a systematisation, to codes and categories

To systematise, code and categorise the collected data material are core activities in the qualitative analysis process (Nilssen, 2012). All of the 15 audio-recorded interviews were re-listened in advance of being coded and categorised. The topics discussed during the interviews were written down as key words and sentences in chronological order, and marked with minute and seconds. This provided a systematic transcribed overview of the material, which made it possible to easily go back into the different parts of the interviews to further explore nuances in topics discussed in the interviews during the analysis. The overview was read through several times while making notes in the margin.

The material was then coded in several steps using NVivo, a computer assisted qualitative data analysis software (CAQDAS). Using a CAQDAS can be helpful to systematise and code and categorise the collected data (Nilssen, 2012). NVivo was also helpful to easily navigate trough the different data material sources, document the analytical steps in the development of the main categories. The collected data; the recorded interviews, the field notes including email exchange with clarifying follow up questions to some of the informants, and the interview overview written in chronological order with keywords and themes discussed in the interviews, was imported into NVivo and systematised. NVivo also provided the possibility to code sequences of the recorded audio material directly. Nilssen (2012) describes an inductive coding process of the collected data material into categories, in three steps; open coding, axial coding and selective coding. During the process of coding and categorising the data material, analytical reflections and thoughts about the findings were

written down in memos continuously. The memos were helpful in the ongoing and circular analysis process, by providing an opportunity for me to captivate and recall my thoughts and ideas. A first step, open coding, resulted in approximately 150 codes. To reduce the number of codes from the first step coding, all codes were worked through and sorted. Codes only used once or twice, were recoded or merged into already existing codes if possible. Codes with synonymous names or meanings were merged together. Through the second step coding, axial coding, the codes were sorted into crude categories to make the data material manageable. Organising the codes into crude categories made it possible to see how to further condensate the number of codes, by creating codes with sub codes, merging codes together and recode if necessary. By doing the axial coding, the core categories representing the main findings started to emerge. In the final step coding, the selective coding; the codes in the crude categories were reorganised into five core categories, representing the most central perspectives in relation to the study objective. It was found useful to draw different models by hand during the analysis process in order to visualise how the different codes and categories could be further developed and related to each other. The models drawn when coding and categorising resulted in a model which illustrates the categories from the final step selective coding presented as main findings. The model has been further revised and developed throughout the whole analysis process. The five core categories; represents the main findings in four stages and one overarching dimension, these are presented in model 4.1 in chapter four.

3.3.2 Theoretical interpretation of study findings through the hermeneutic lens

When the process of categorising the data material is at end, the main study findings need to be interpreted in light of a theoretical framework to further analyse, explain, understand and add meaning to the informants' expressions and perspectives (Nilssen, 2012). The hermeneutic tradition is about interpretation and understanding of meanings in human expressions (Malterud, 2011). By taking a hermeneutic approach in the analytical interpretation of the data material, I as a researcher can add meaning to the informants expressions assisted by my own evolved understanding of the study theme in light of theory. Descriptions of phenomena are coloured by interpretations, and interpretations are based on descriptions. The hermeneutic approach emphasise that phenomena can be interpreted differently, and that there is not an actual "truth" (Nilssen, 2012). Understanding rather than explanation, is in focus, and the hermeneutic circle is a central concept. Nilsen (2012) explain that the hermeneutic circle indicates that all interpretation is composed of moving between the whole and the parts; between what is interpreted and the context, and between what is interpreted and our preconceptions. The interpretation of the whole is dependent on the interpretation of the parts, and vice versa. In this study the hermeneutic circle supports the interpretation of the different perspectives, experiences and perceptions expressed by the professionals, and form a holistic understanding of the themes to explore. Thus will the theoretical

framework presented in chapter 2 function as an analytical tool to interpret and explain the professionals' expressions in chapter four, guided by a hermeneutic approach. The biocultural perspective provides an overarching theoretical view of how feeding practices for infants and young children can be understood in contexts of adversity. The theoretical description of PSS and IYCF add meaning to the way the informants speaks about their professional fields and functioning in post disaster contexts. The concept of Baby Tents is theoretically applied as an example of intervention and activity that combines the professionals fields of PSS and IYCF.

3.4 Discussion of study methodology

According to Kvale and Brinkmann (2010) is research validity about if the chosen methodology is suited to investigate what is shall investigate. The chosen qualitative methodology, to collect data material using semi-structured interviews, is perceived to be both relevant and valid as the study objective was to map professionals' perceptions and perspectives on PSS, IYCF and Baby Tents. However, the chosen study methodology have both strengths and weaknesses which will further be discussed.

3.4.1 The researcher's role and pre understanding

In qualitative research the role of the researcher is of central meaning because the researcher is the key instrument in the whole research process (Nilssen, 2012). The researcher is influencing and is influenced by the research process; being the one collecting the data material, by interaction with the informants, by analysing the collected data material and interpret the study findings. In present study, the themes to explore were relatively unknown for me. I have a background in nursing science and had previous training in disaster management and care from the Red Cross University College in Stockholm in addition to voluntary experience from a Norwegian Red Cross branch. Although being interested in global public health and humanitarian disaster response, I had no practical experience from post disaster contexts prior to the study. My pre understanding of the themes to explore, is therefore mainly influenced by a theoretical perspective. My lack of practical field experience from post disaster contexts may have both advantages and disadvantages, which may possibly affect the type of questions asked and themes to highlight during the collection of data material. One advantage can be that I become less a spokesperson for the network of professionals being researched, and can maintain a critical and curious stance. A disadvantage of my practical inexperience of disaster response operations is that it may decrease my understanding of the complexity of working in post disaster contexts and influence how questions are asked. To prepare for the study and to gain an overall understanding of the themes to explore, I studied literature on RCRC disaster response, PSS, IYCF and Baby Tents. The preparation was done to provide me with

enough knowledge to understand and circle my field of research, but to remain open for emerging topics.

3.4.2 Identifying and recruiting informants

Nilssen (2012) highlights that the researcher needs to take several reflected decisions during the research process regarding recruitment of informants; developing instruments for collecting data material, and to report the findings. In the present study, I needed to rely on the comprehensive knowledge and professional network of the persons assisting me in the process of identifying and recruiting informants. To gain access to the professional network of those persons made it possible for me to identify, and recruit key professionals, with desired expertise regarding the study objective, both within and outside the Red Cross Red Crescent Movement. I am aware that professionals, outside mentioned professional networks, also could have been potential and relevant informants. A few professionals, initially intended as informants were not available for participation. A couple of informants advised me to talk to professionals working for Doctors Without Borders, regarding their work on nutritional interventions and psychosocial support, which was not done due to the time limit of the study. The selected informants did by several occasions name each other as having relevant expertise for the study objective, which can be viewed as strength in the study sample. It may indicate that the key professionals with relevance for the study was circled, recruited and positively affected the quality of the collected data material. Since the informants were purposively sampled, based of their professional expertise and not randomly chosen, the danger of selection bias in the sample is present. Nevertheless I argue that the selection of informants in it self, was one of the main ways to ensure that desired perspectives, experiences and knowledges were collected in the data material, and of central significance to possibly answer the research questions.

Since the aim of identifying and recruiting informants, was to comprehensively highlight different perspectives of the study objective, it is considered positive that in total 15 experienced and knowledgeable key professionals participated. In fact it was only one participant that first agreed to participate in the study, that later decided to withdraw. One possible disadvantage of having such a relatively high number of informants, regarding the scope and timeframe of this master thesis, is that the large amount of material might influence the quality of the analysis because of the large amount of data material may be more difficult to manage (Malterud, 2011). Yet, in order to map the possibility to apply the psychosocial support module to address infant and young child feeding practices, from different professional perspectives, it was perceived desired to include all of the 15 professionals. The informants often presented rich descriptions to specific situations experienced in post disaster contexts and thus highlighted certain statements and perceptions. Such examples are considered to

be beneficial for the credibility of the findings by connecting the reconstructed reality in the interview situation to the original post disaster context experience.

3.4.3 The interview setting

Qualitative research requires the researcher to be both systematic and creative, to have the ability to create an atmosphere of trust and have good communication skills to establish good relations with the individuals involved in the study (Nilssen, 2012). Since the data material is constructed in interaction between the informant and me, our relationship is of central meaning. An initial effort to create an atmosphere of trust was for me to give a clear and professional introduction of the study, when establishing contact with the potential informants. The communication with the informants prior to the interview was mainly by email. This was perceived to be advantageous allowing the, often busy, professionals to respond when they had time. This also made it possible to easily keep track of what information that had been sent out to whom and when.

Internet provides a social virtual arena to do interviews online, described by James and Busher (2012) as an innovative way of conducting research. Semi-structured one-to-one interviews from an ethnographic approach is mentioned as one possible form of doing Internet interviews. It might require the researcher to accommodate time zone differences when scheduling the interviews(James & Busher, 2012), which was perceived to be challenging in some occasions due to unforeseen events and the informants being professionals traveling to locations where Internet connection was not reliable. If needed, the interview was rescheduled and no informant was excluded neither because of time differences nor unforeseen events. Another way to increase the level of trust was to be flexible and to adapt the time of the interviews to the different time zones, working hours and availability of the informants. The fact that Internet is not equally accessible to all people, it can be seen as a risk to forbid participation of some potential informants and threaten the representativeness of the study sample (James & Busher, 2012). Among the professionals included as informants in this study, the Internet based communication software Skype is commonly used and did not endanger access to participation. All of the informants interviewed via Internet already had a Skype-account, which is free to use only requiring a computer and Internet connection.

The interviews were conducted in three different ways depending on the geographical location of the informant and the researcher, the quality of the Internet connection and the availability of a web camera. The different interview settings were face-to-face, or via Skype, with or without a web camera. Four interviews were face-to-face, in physical locations where the informants were familiar: In an office at the workplace of three of them and by the kitchen table in the residence of the forth informant. When doing the interviews via Skype, the researcher was located in her place of residence

and the informants in their workplace or at home. The different interview settings were perceived to have both advantages and disadvantages influencing the quality of study. To do face-to-face interviews was perceived to be more relationship and trust building, compared to the Skype interviews. The Skype interviews, independently of the use of web camera or not, created a sense of distance, and interestingly, that feeling of distance wasn't relative to the geographical distance but more to the experience of not being in the same room as the informant. To have regular contact by email prior to the interview was a way of getting to know one another and reduce the distance, build trust and develop a professional relationship. Developing a professional relationship with the informants, although quite temporary, made it easier to follow up and clarify things discussed in the interviews during the following process of analysing the data material and report the findings.

When doing the face-to-face interviews some interesting points and summaries where given by the informant after the recorder had been turned off in one of the first interviews conducted. Therefore I became aware of not turning off the recorder too early in the following interviews. Having the recorder on was perceived as making the interview situation more serious than a regular chat. Maybe it is difficult for both the interviewer and the interviewee to feel totally comfortable and relax in such a situation due to both parts focusing on what to say, how to say it and how the other person is experiencing the other. Having the role as the interviewer, I felt responsible to keep focus on the study objective and still be open for interesting perspectives to emerge by not asking to many questions and interrupt the informant. The possibility to discuss a topic being mentioned in passing, by the informant, was perceived to be more difficult when the interview setting was by Skype compared to face-to-face.

However, Internet interviewing offers opportunity for real-time response from informants and big level of participant involvement and can encourage spontaneous interactions between participant and researcher, in the same way as face-to-face (James & Busher, 2012). When interviewing via Skype, especially without a web camera, there was no possibility to use the body language to encourage the informant to further explain that particular topic of interest. A solution was for me to take notes and then return to the topic later into the interview. A satisfactory way to double check if important messages had been understood was for the researcher to give a brief summary of the communicated perspectives, where the informant could agree or make corrections. Described by Kvale and Brinkmann (2010) as a way to validate the findings continuously. James and Busher (2012) explain that by not using webcam the interview becomes more complicated because the researcher and participant are hidden from each other, providing visual anonymity. Use of web camera did provide a sense of meeting each other, but at some occasions, the Internet line was not good enough to transfer video, challenging the quality of the audio recordings. According to James and Busher (2012), absence

of face-to-face contact, can create barriers for a relationship of trust. To prevent this when the Internet connection seemed too unstable, the camera was on a few minutes so me and informant could see and to be introduced to each other. This might have increased the sense of trust and creating a relaxed atmosphere. Not having the web camera on was evaluated to be a better solution, than not doing the interview at all, if the possibility to use the camera was limited.

3.4.4 The process of data analysis and theoretical interpretation

Kvale and Brinkmann (2010) argue furthermore that a study's validity also depend on artisanal quality in the study and theoretical interpretation of the study findings. Regarding the artisanal quality, this was my first study of this scale and I consider myself as a novice. "Learning by doing" is a good description of the process. Qualitative research taking a hermeneutic approach to the interpretation of the collected data material emphasises that it doesn't exist one truth, but phenomena can be understood differently (Nilssen, 2012). Additionally, Malterud (2011) mean that analysis of qualitative data material prejudge for alternative interpretations to exist simultaneously, hence there will always be a possibility for alternative ways to systematise, categorise and interpret the collected data material in this study. To take an inductive approach to the collected data material in the analysis process was perceived to be both logic and intuitive. The knowledge on how to apply the ERU psychosocial support module to address infant and young child feeding practices is post disaster contexts was limited prior to this study. Therefore did the inductive approach enabled me to develop non predetermined categories, trough the three step open coding. Nilssen (2012) moreover highlights that inductive qualitative research requires both structure and creativity. Thus, I found it helpful, and a very useful analysis tool, to draw models by hand while I systematised, coded and categorised the data material. The models did evolve during the analysis process, in accordance with my evolving understanding of the study themes and study findings. The chosen theoretical framework was applied at the end of the, process of coding and categorising the data material to interpret the study findings. According to Nilsen (2012), the theoretical framework can assist the researcher to understand and describe the meaning of the informants' expressions, where the interpretation moreover implies to explain, and frame the informants' ideas in relation to theory. This was a step of the data analysis process in present study to display why the findings are important, and to make them understandable, also called a recontextualisation (Malterud, 2011). When preparing myself to collect the data material by studying literature related to the study theme, it became clear that the theoretical description of PSS, IYCF, found in central agency publications guiding international humanitarian disaster response and intervention, were of significant importance to understand how those two professional fields can be combined, as exemplified in Baby Tents. This is why the descriptions of PSS, IYCF and Baby Tents are an important part of the theoretical framework. The biocultural perspective link epidemiology and public health to the

understanding of social and cultural aspects in environments where child growth and development occurs. The biocultural perspective was therefore perceived to be a relevant theoretical view to frame human diet, nutrition and feeding practices in relation to contexts of adversities, and humanitarian action and interventions, in which my informants operates.

4. Presentation and interpretation of study findings

In this chapter, the main study findings will be presented, discussed and interpreted in light of the theoretical framework presented in chapter two. Categorisation of the data material from the 15 semi-structured interviews resulted in five categories; presented as four stages and one overarching dimension illustrated in model 4.1. The model presents the main perspectives highlighted by the informants of how to possibly apply the ERU psychosocial support module to address; understand and support feeding practices for infants and young children in post disaster contexts. Feeding practices for infants and young children under the age of two years will onward be referred to as feeding practices. The four stages range from pre disaster preparation of PS delegates, to possible sustainable positive public health outcomes of implemented activities. These four stages are described in section 4.1 trough 4.4. Activities within the psychosocial support module are launched in cooperation with local RCRC community volunteers, further referred to as volunteers. The informants' perceptions of the role of community volunteers in PSS activities will be presented in section 4.5 as an overarching dimension, related to stage 2 trough 4. The findings are presented schematically, although it may not be a clear chronological distinction between all of them, at all times in practice.

Figure 4.1. Presentation of main findings; stage 1-4 and the overarching dimension 5.

4.1. Stage 1 - Pre disaster preparation of PS delegates to address feeding practices

Stage 1

Pre disaster preparation of PS delegates to address feeding practices when deployed to post disaster contexts

Equip the PSS delegate with skills to address feeding practices for infants and young children in post disaster contexts:

* Needed knowledge
* Additional training
* Raise awareness
* Responsibilities

* Exploring the link between the professional fields of PSS and IYCF

The first stage highlights different perspectives of how PS delegates, trough pre disaster preparation prior to ERU deployment, may be equipped with skills to both understand and support feeding practices in post disaster contexts. This stage will also explore the link between the professional fields of PSS and IYCF to inform why, and how PS delegates possibly can extend their functioning to address feeding practices in future ERU deployments. Normally, PS delegates have a background in psychology, social work or nursing science, and as set up today, the five day pre disaster training of PS delegates does not include topics about recommended IYCF practices or child undernutrition.

In the biocultural perspective, the field of nutrition and diet is highlighted as being one of the topics most anchored in both biological and social-cultural aspects of peoples life (Moffat & Prowse, 2010). There are widespread global variations in feeding practices and internationally recommended IYCF practices are rarely implemented in full, despite the clinical and epidemiological evidence of such feeding pattern being the most optimal for child growth and development (Sellen, 2010a, 2010b). Taking into consideration the described link, between the psychosocial wellbeing of caregivers and their capabilities to care for and feed their children, in post disaster contexts (ACF, 2012; NutritionWorks et al., 2011), the professional field where PS delegates operates may be relevant to understand and support recommended IYCF practices. This leads to the question of how PS delegates may be equipped to address feeding practices prior to deployment. What skills, knowledge and additional training are PS delegates perceived to need, if they were to address feeding practices in post disaster contexts.

4.1.1. Pre disaster preparation: knowledge, training and responsibilities

RCRC PS professionals and delegates were asked what knowledge and skills they would need in order to address child undernutrition and support feeding practices in future ERU deployments. The answers were diverse and disclosed ambivalence; highlighting both an expressed need to have additional knowledge about recommended IYCF practices, and unawareness about what kind knowledge. One PS delegate stated that: *"I have no idea of what skills or knowledge that would be needed in order to get involved in nutrition"* and *"I am not going to play a role that I am not qualified for" (Informant 5, PS delegate).* The expressions indicate that the area of child undernutrition and feeding practices

may be unknown for the PS delegates, and that they might be reluctant to get involved in an area that they have little or no knowledge about. However the RCRC PS professionals and delegates generally expressed an openness concerning their limited knowledge about child undernutrition and recommended IYCF practices. Additionally they expressed willingness and a need to learn more about feeding practices; *"I would definitely need some knowledge. What I would need is all the knowledge about feeding practices, I have no clue what so ever. But maybe it is not for me to know that, because I don't necessarily need to know how to feed a baby to be a psychosocial support delegate. Because I don't know anything about feeding practices, I don't even know what I don't know" (Informant 2, PS professional).* The statement also discloses a hesitancy if addressing feeding practices belongs to the professional field and responsibility of PS delegates. On one hand did the PS delegates seem to acknowledge that feeding practices might be both important and relevant for them to address. On the other hand, they seemed hesitant to what their role and responsibility would be. Some RCRC PS professionals and delegates did not perceive having knowledge of how to support feeding practices, to be their main area of responsibility, but rather the responsibility of medically trained staff. It became clear that a few PS professionals and delegates perceived the field of IYCF to mainly belong to medically trained personnel; "*We can not expect from a psychologist to have all the knowledge and technical skills of nutrition. Definitely not. That is why we first need to seek where are the people that we can really collaborate with that have this knowledge and technical skills regarding nutrition" (Informant 3, PS professional)* and *"I don't think that I as such would need to be accomplished in that (trained in IYCF/child undernutrition), I don't have that special knowledge that a nurse would have. But I need to know that the problem is there, and that I need to get people onboard to work with me and handling it" (Informant 4, PS delegate).* The quotations highlight both a hesitancy if addressing feeding practices lies within the responsibility of PS delegates, and the perceived necessity to cooperate with a professional having knowledge and technical skills in recommended IYCF practices. As suggested, the role and responsibility of PS delegates could be to know who to cooperate with, if knowledge and technical skills to support feeding practices was needed. Community health professionals, such as the delegate linked to the ERU community health module [CHM], were given as an example repeatedly of who to possibly cooperate with to address feeding practices.

Several informants mentioned the possibility to add basic level information about child undernutrition, and recommended IYCF practices in the five day training of PS delegates prior to ERU deployment. In contrast, one informant mentioned that it would not be necessary to train all PS delegates in IYCF prior to future ERU deployments. She highlighted the possibility to have a couple of PS delegates trained in IYCF practices to be deployed in disaster contexts where such expertise was particularly needed. For PS delegates to study existing statistics related to feeding practices and child

undernutrition, from the country or area affected by the disastrous event, was suggested as a way to prepare oneself just before being deployed.

Based on the expressed perceptions of the informants, to raise awareness about undernutrition and feeding practices, and add some basic level technical guidance about IYCF, into the PSS training material and delegate manual, may be relevant and seemingly possible. Two PS professionals said *"It should definitely be something in the training manual about feeding practices" (Informant 2, PS professional)* and *"We are not supposed to be specialists (in nutrition), but we need to be aware to be able to say, not do this, do this. To me it is pretty simple it is not that complicated but I need to get the idea to also address breastfeeding mothers" (Informant 4, PS delegate).* Information to include were suggested to be; how feeding practices and food in general could be addressed by PS delegates, how to understand eating behaviour and feeding practices in different contexts, and the link between psychosocial wellbeing and feeding practices. Training material for PS delegates was also suggested to contain information, and a clarification of responsibilities, on how to possibly cooperate with local and international community health professionals to address feeding practices in post disaster contexts. One PS delegate said; *"The PSS delegate should have some knowledge about nutrition...to encourage breastfeeding and the importance of breastfeeding and the link to the attachment of child and mother" (Informant 1, PS delegate).* Hence, to train a few PS delegates more comprehensively, or provide all delegates with the possibility to receive basic knowledge in recommended IYCF practices trough training, and raise awareness about child undernutrition and feeding practices in training material and manuals, appears to be main points of future consideration.

Given the perspective presented by RCRC PS professionals, it gives meaning to further explore how professionals experienced in IYCF and Baby Tents, perceive the necessity for PS delegates to be trained in how to address feeding practices prior to future ERU deployments. It was proposed that the "Unicef Nutrition in Emergencies" e-learning course, could be added to the training curricula of PS delegates. One PS professional with experience from Baby Tents, informed that all their PS professionals are equipped with basic training in nutrition and how to support recommended IYCF practices, before being deployed to post disaster contexts. The informants experienced in IYCF did express quite a determination about the importance to have theoretical knowledge, and practical skills, to possibly support feeding practices. One health ERU delegate experienced in IYCF questioned the possibility for a PS delegate to psychosocially support a mother's feeding practices, if he or she doesn't have basic knowledge of the physical and technical aspects of feeding in general, and breastfeeding in particular. The informant also highlighted the difficulty to support a feeding mother psychosocially and to ensure her that the infants gets enough food, without having knowledge on how to clinically assess that the infant actually is fed sufficiently. Does the determination expressed by IYCF professionals, and the expressions of hesitance by RCRC PS

professionals unveil a perception that addressing feeding practices require medically trained professionals? A question to bring further into the next section, exploring the informants' perceptions on the linkage between the two professional fields of PSS and IYCF.

4.1.2 Exploring the professional fields of PSS and IYCF

Imagine two partly overlapping circles, one representing the professional field of PSS, and the other one the professional field of IYCF. The area where the circles overlap represents the link between PSS and IYCF; where the two professional fields are interrelated and can be combined. Exactly what the overlapping area consists of, and what proportion of the circles that overlap, is not totally clear but will explored throughout chapter four. Hence, several informants spoke about the close link between psychosocial aspects of caregivers' wellbeing and their capabilities to care for and feed their infants and young children in an affirmative way, independently of professional area of expertise. It seems like the link and overlap between the two professional fields is perceived as a matter of course. To better understand how PS delegates may be prepared to possibly extend their field of intervention into the professional field of IYCF in future ERU deployments, it is necessary to take a look on the informants' perceptions and beliefs of how PSS and IYCF may, or may not, interrelate. Based on the description of nutrition and diet at as being well-anchored in biological, social and cultural aspects of life (Moffat & Prowse, 2010), will feeding practices probably be a theme PS delegates will meet in one way or another while addressing psychosocial aspects in the life of disaster affected individuals. In fact, several RCRC PS professionals and delegates could give examples where they had supported or discussed feeding practices with caregivers in post disaster contexts. May this be an indication that feeding practices, and the professional field of IYCF, to some extent already overlap with the professional field of PSS?

PS delegates expressed feeding practices and the psychosocial wellbeing of caregivers to be closely linked, but they didn't seem to have considered their potential role to support feeding practices in previous ERU deployments. One PS delegate gave her view on her skills to address feeding practices and highlighted the central position of feeding, and the possible linkage between the wellbeing of mother and child; *"If I was a nurse or a mother, I probably would have more tools for that (to support feeding practices). It is not my domain or background, but it is basic stuff; it is important to feed the children and you know it is important for the mother to feel proud and responsible to do it" (Informant 1, PS delegate).* The statement visualises a perception that the bond between the mother/caregiver and child, have more dimensions than plain physiological. This idea is in line with the description of mother and child as an inseparable biological and social unit with their status of health and nutrition influence each other (WHO & Unicef, 2003), and the central position of the mother as one of the most important biological features in a child's environment regarding development and survival, described

by Sellen (2010a). Additionally, breastfeeding is described as a safe and natural way of feeding a child, promoting the cognitive and physiological development of the infant and protects it from infectious diseases (ACF, 2012; Filorizzo, 2012).

The Baby Tents is exemplified as a type of activity, combining the two professional fields of PSS and IYCF in post disaster contexts, intervening in the area where the circles overlap. Professionals with experience from Baby Tents seemed to have a clear vision of the importance to support caregivers psychosocially in regard to feeding practices. Mothers believing that they are not producing enough breast-milk to ensure the growth of their breastfed baby, were described by informants as one of the most common concerns about breastfeeding practices, a view theoretically supported in publications regarding IYCF (ACF, 2012; Interagency Working Group on Infant Feeding in Emergencies, 2007; NutritionWorks et al., 2011). Another common belief is that malnourished women can't breastfeed their babies, which is stated to be a misconception (NutritionWorks et al., 2011). High levels of stress due to disastrous events might affect the milk flow negatively, although not preventing the production in itself, but rather challenge a stressed mothers's ability to respond to her infant needs and letting down breast-milk (Filorizzo, 2012; Interagency Working Group on Infant Feeding in Emergencies, 2007; WHO, 2013b). When a woman breastfeed her baby, the milk flow is affected by both the infant's suckling and the lactating woman's feeling (Interagency Working Group on Infant Feeding in Emergencies, 2007). Feelings of confidence and the pleasure of seeing, touching and hearing her baby are described as beneficial for the milk flow. Informants suggested that an important aspect to psychosocially support feeding practices, would be to ensure the lactating mother she has enough milk, and enhance her feelings of confidence by enabling her to feel that she is doing a good job; *"What we need to do is to enable mothers to feel that they are doing a good job...what can we do to allow them to feel that they are competent mothers (Informant 6, PS professional).* The expression indicate that a PS delegate may have a future role to support and enhance the confidence of lactating mothers or caregivers.

Based on the expressions given by professionals experienced in Baby Tents, the professional fields of IYCF and PSS appears to be interrelated but still different, which can be related back to the imaginary circles of the professional fields of IYCF and PSS overlapping to some extent. Thus, the professional fields of PSS and IYCF do have some commonalities, but do not appear to be completely equal. Delegates working in Baby Tents in post disaster contexts were described to have different tasks depending on their educational background. Nutritionist or nurses, with a mainly medical background, supported feeding practices and conducted clinical measurements, and the PS professional, such as a psychologist, followed up mothers with an identified need for additional counselling due to psychosocial difficulties. This division of work is also supported by Filorizzo (2012)

and Ayoya (2013). Another interesting aspect related to the different professional fields of PSS and IYCF emerged in the interviews. Apparently, the professional field of IYCF was perceived easier to get involved in, for a professional without previous educational background related to nutrition, than for a nutritionist to extend her or his professional role into the professional field PSS. A couple professionals with experiences from Baby Tents, expressed it to be easier to train somebody in basic nutrition skills and feeding practices than to train a nutrition professional in PSS; *"Because you do not make people psychosocial support workers in a week" (Informant 13, IYCF & Baby Tent professional)*. The statement discloses, once again, a conception of the two professional fields being diverse and additionally an idea that to acquire basic skills and knowledge in recommended IYCF practices is perceived less demanding than acquiring skills to support someone psychosocially. Since the statement is given by an IYCF professional, it may reveal awareness that IYCF professionals' capabilities to provide psychosocial support may be limited, event though psychosocial aspects of feeding practices appear to be acknowledged as important. The above statement also implies that PS professionals have some capabilities and skills that may not be learned "in a week". Other informants experienced in Baby Tents expressed that services functioned better if there was a PS professional working in the tent.

The professional fields of PSS and IYCF have undoubtedly several commonalities and are perceived interrelated. An attempt to generalise the two professional, based on how they are described by informants and supported by the theoretical framework, follows. The field of IYCF can be described to be more biological, physiological and disease preventive, which can be perceived to be more in line with modern medicine and epidemiology, and represented by professionals such as nutritionists, nurses and midwifes. To promote recommended IYCF practices, is presented important to prevent child mortality and morbidity (ACF, 2012; The Sphere Project, 2011; Unicef, 2005; WHO & Unicef, 2003). PSS on the other hand, may present a more health promoting perspective, where focus lies on enhancing psychosocial wellbeing by focusing on peoples ability to cope with adverse life events, reinforce resilience and empowerment within individuals and communities (Hansen, 2009; PS centre, 2011; Yigen et al., 2012); represented by professionals such as psychologists and social workers. Interestingly, PSS is also described as aiming to prevent mental disease (IASC, 2010; Yigen et al., 2012), and to support recommended IYCF practices aim to promote children's physical, cognitive and social development and chances of survival (ACF, 2012; Unicef, 2005; Unicef, 2011; Unicef, 2013b; WHO, 2013b; WHO & Unicef, 2003). Therefore, it may be important to clarify the aim, expectations, responsibility and tasks for PS delegates if they are going to support feeding practices in general and promote recommended IYCF practices in future ERU deployments, in cooperation with, or compared to, mainly medically trained personnel. How these tasks and responsibilities are defined may

influence on what to add about child undernutrition and recommended IYCF practices in training, training material and the delegate manual for PS delegates.

The professional fields of PSS support and IYCF overlap, and PS delegates may to some extent already operate in the area where feeding practices is promoted in post disaster contexts. To raise awareness of recommended IYCF practices in PSS publications, add some basic technical and practical training in how to address feeding practices, clarify responsibilities and task allocation might be ways to prepare psychosocial support delegates to support feeding practices in future ERU deployments. So, it is interesting to further explore in what way PSS, and the role of PS delegates, may be applied to understand how the post disaster context may influence the psychosocial wellbeing and feeding practices among disaster affected individuals, which brings to the next stage.

4.2 Stage 2 - Applying psychosocial support to understand feeding practices

Stage 2

Applying PSS to understand feeding practices in post disaster contexts

Link PSS to understand of feeding practices in the post disaster context

* **Understand contextual barriers and opportunities**
* **Asking questions: explore feeding practices and psychosocial wellbeing**
* **PSS: approach, skills and communication (to learn from)**

Second stage aim to highlight how PSS, and the role and responsibilities of PS delegates, can be applied to explore and understand feeding practices in post disaster contexts. The stage will further place emphasis on how PSS support is described to be a way to examine the link between caregivers' psychosocial wellbeing and behaviour related to feeding practices. In this stage, the given description of a context of adversity as a *"a social or physical environment that create hardship or affliction" (Panter-Brick & Fuentes, 2010, p. 1)*, is of central significance to frame how the informants speaks about the post disaster context.

For professionals to explore and understand the cultural context, when working and intervening in post disaster contexts; with its traditions, beliefs, behaviours and customs were a central theme in the interviews, frequently highlighted and discussed with all informants. One of the main findings in this study of how to apply PSS to address feeding practices in post disaster contexts, was how the professionals spoke about the significance to understand the context in which they operates. To form such an understanding appeared to be of particular importance within the professional field of PSS.

4.2.1 The post disaster context: Barriers and opportunities

The biocultural perspective is concerned with how contexts of adversity, such as post disaster contexts, influence on health and the distribution of health inequalities, and therefore the risk of negative health outcomes (Panter-Brick & Fuentes, 2010). In order to understand how health is

formed, Panter-Brick and Fuentes (2010) emphasise the importance of defining features in every particular context that produces disparity in health outcomes, such as child undernutrition, morbidity and mortality. Furthermore, is child growth applied as an indicator of health in populations, and functions as a predictor of children's cognitive development, child morbidity and mortality (Sellen, 2010a). An evolutionary perspective on feeding practices and optimal child growth can explain why current internationally recommended IYCF practices are seldom followed in full (Sellen, 2010a, 2010b). Hence, in every post disaster context, there is a range of elements influencing the way children are being fed, how they develop and if they will, or will not survive their fifth birthday.

The informants introduced two interesting concepts of relevance for their professional fields within post disaster contexts, "barriers" and "window of opportunity". These concepts are perceived interesting because they present perceptions of the post disaster context as being both adverse but also provide opportunities for improvements. It was found applicable to explore how the informants referred to them in relation to the theoretical framework. The term "barriers" related to IYCF is described as "*What prevents the individual or community from performing the recommended practice (NutritionWorks et al., 2011, p. 48).* This definition is in accordance on how informants spoke about barriers influencing feeding practices, as different surrounding elements hindering a desired and beneficial behaviour, for example exclusive breastfeeding of infants younger than 6 months. Cultural beliefs, level of education, psychosocial wellbeing and family influence were given as examples of barriers. When designing activities to promote recommended IYCF practices; existing barriers, motivators and social norms related to feeding practices need to be determined (Unicef, 2011). Hence, to explore how different barriers influence the way infants and young children are being fed in every particular context, appear to be central to possibly support feeding practices.

In contrast was the post disaster context not only described as challenging and complex, causing difficulties and containing barriers. A PS professional introduced the term "window of opportunity", interpreted as an expression of a possibility to address feeding practices and prevent undernutrition, by gaining access to individuals in communities due to the disastrous event. She said;

"Let say you intervene in a community where infant malnutrition is a constant problem and then there is a disaster, then look at this as a window of opportunity. In this community we have a huge problem of infant malnutrition, now we have an emergency and suddenly getting all this young women to the clinic. Before the emergency they were not coming to the clinic. So lets use this opportunity to make an intervention, to educate them in the importance of breastfeeding and nutrition. This is a post disaster, people are coming for you" (Informant 11, PS professional).

To gain access to communities with its members might therefore offer an opportunity to address; understand and support feeding practices within the professional field of PS delegates. This view was supported by another PS professional's opinion; that caregivers are receptive for information and support since they are concerned about the survival of their children. The term "window of opportunity" is also related to recommended IYCF practices. The term refers to the 1000 days from conception to a child's second birthday as an important period to prevent lifelong consequences of undernutrition (ACF, 2012; Unicef, 2011; Unicef, 2013b). To use this "window of opportunity" means that *"optimal breastfeeding and complementary feeding practices together can allow children to reach their full growth potential and prevent irreversible stunting, as well as acute undernutrition" (Unicef, 2011, p. 7).* Accordingly, the "window of opportunity" is to be found in the description of IYCF, and expressed by PS professionals. Can the perception of "window of opportunity" expressed by the psychosocial professionals and the "window of opportunity" stressing the importance to promote recommended IYCF practices, be combined? Based on how "window of opportunity" is described, it could hypothetically be seen as an opening and a possibility, to understand and support feeding practices. Because when caregivers are searching for assistance, PS delegates may have an opportunity to both support the caregivers psychosocially and address their concerns about feeding.

To explore the link between the physiological/biological and psychological/social aspects of feeding, was perceived important by informants in order to know how to address feeding practices by applying PSS. Emotional impact of the disaster, such as distress and grief, was mentioned by several informants and described to be normal, but could potentially create difficulties related to feeding of infants and young children. Psychological factors relevant to food when providing services to disaster affected people is presented (IASC, 2007; The Sphere Project, 2011). These are based on the rationale that hunger and food insecurity may cause severe stress and challenge the psychosocial wellbeing, and that the psychosocial effects of an emergency may worsen food security and nutritional status (IASC, 2007). A PS professional said; *"When we can't provide food for our own children, it is kind of failure. Event though it may be due to a drought or flooding or a war. In some ways people will feel that they have failed, and some people, when they feel that they have failed, will feel despair. And not pick up the pieces and keep on going. So. I would say that you need to work around really vital concepts of the feelings of people" (Informant 6, PS professional).* The quotation shows that inability to feed your child may be one aspect causing additional psychosocial stress among caregivers in the aftermath of disastrous events. Applying PSS to enhance the confidence of caregivers, having feelings and emotions of despair and failure, may be a central aspect of how to support feeding practices. Hence, to consider emotional aspects when addressing feeding practices seems apparent.

4.2.2 Asking questions to understand existing feeding practices

PS professionals stressed the importance to explore the local meaning of psychosocial wellbeing; the affected populations own perception of doing well. PSS was expressed as a way to define the meaning of psychosocial wellbeing by welcoming local beliefs and perceptions. The informants furthermore suggested that this may be a way to understand how psychosocial wellbeing and feeding practices is influenced by, and interrelated with one another in a particular post disaster context. The presented perspective of PSS is comparable to the description about how to apply a context sensitive approach (Lützen, 1997; John Hopkins & RCRC,2008) in contexts of adversities (Panter-Brick & Fuentes, 2010).

Asking questions to understand how psychosocial wellbeing is defined appears to be central in PSS, and a specified central task for PS delegates in post disaster contexts. In Psychosocial interventions: A Handbook ; the importance to establish an understanding of how psychosocial wellbeing is experienced by the disaster affected individuals is highlighted (Hansen, 2009). Feelings of life-satisfaction, family roles and responsibilities, future dreams and confidence to deal with existing challenges is given as examples of important themes to explore. The PS professionals repeatedly highlighted that a core activity in PSS is to ask questions; what kind of questions, and how the questions are asked was underlined. Furthermore, Hansen (2009) mentions psychosocial wellbeing to be *"an interaction of psychological, social and cultural contextual factors" (Hansen, 2009, p. 173).* Although defining and measuring psychosocial wellbeing is described to be a challenge. Different scales, tools, indicators and definitions have come to short. Accordingly, the best way to understand psychosocial wellbeing, presented by the informants and supported by Hansen (2009), is to communicate with those affected. The informants suggested asking open ended questions in focus group discussions and interviews as ways to collect desired information of how psychosocial wellbeing may be explored and understood in the particular context.

Taking into account all different features influencing health adversities in every particular post disaster context, to explore and understanding the local populations own perception of psychosocial wellbeing, or doing well, may be fundamental. Especially in regard to the central biological and social significance of nutrition and diet in humans life, and our labile patterns of how we feed our infants and young children (Moffat & Prowse, 2010). Since nutrition and feeding is such prominent aspects of our lives, it seems reasonable that factors influencing on caregivers psychosocial wellbeing in turn will affect how they choose to feed their children. To disbelieve in your capability to feed your child may have negative impact on caregivers psychosocial wellbeing, and thus be relevant to address within the professional field of PS delegates.

Would it then be possible for a PS delegate to ask questions to explore existing feeding practices, when deployed to post disaster contexts? A PS professional argued; "*Are this group of malnourished people now at even greater risk, as a consequence of the disaster, and if so, what are the increased risks? And also, does the disaster create new areas of nutritional problems related to the emergency. Where psychosocial could develop interventions for. I would see this as an opportunity to intervene" (Informant 11, PS professional).* The statement indicates that PSS could be applied to understand behaviours related to feeding practices, by exploring in what way the disaster have created new challenges. The local population was described as the main source of information and could accordingly share information and perceptions about feeding practices prior to the disaster, as well as current needs and challenges. Caregivers of children aged 0-2, and local health professionals were given as examples of key persons to ask. To explore if changes in feeding practices, as a consequence of the disastrous event, have led to an increased risk for children to become undernourished may further clarify how PS delegates could move into the professional field of IYCF. Several informants underlined; when you ask caregivers, especially women or mothers, they are open to share their perceptions, their beliefs and concerns about feeding of their infants and young children. Destroyed livelihoods and houses, and lack of food and clean water were presented to disrupt normal practices, and thus possibly influence feeding practices. Environmental changes and emotional impacts depending on the type of disaster, was highlighted as important factors to consider when prioritising disaster response interventions. This is possible to relate to the biocultural perspective and how a range of social, cultural, physical and environmental features prior to, and post the disastrous event may influence feeding practices. PS delegates may be in a position where they can search the affected population's perspectives, concerns and desired interventions by asking questions to explore, and thus understand how the psychosocial wellbeing in every specific adverse disaster context is related to feeding practices. This may guide how to implement a context sensitive approach to address feeding practices in future ERU deployments. Thus, how can PSS and an understanding of the local definition of psychosocial wellbeing be further related to understand feeding practices in any particular post disaster context? An informant expressed her view on the interconnection between culture, beliefs, psychosocial and nutritional aspects; "*You can not do psychosocial support without the understanding of culture and beliefs...If you have a malnourished child, you can treat it. But you will have better results in preventing future problems if you take psychosocial aspects into consideration" (Informant 13, IYCF/Baby Tent professional).* The quotation once again highlights the perception of PSS as relevant to successfully address feeding practices, also in terms of preventing future problems. Based on the informants' expressions; to understand the culture and beliefs appears to exist in the imaginary circle representing the professional field of PSS, and thus one of the elements of PSS possible to apply, in interventions or activities positioned where the circles of PSS and IYCF overlap.

Even though informants frequently highlighted the importance of asking questions to explore and understand the cultural context, the local definition of psychosocial wellbeing, and assess the needs for psychosocial support services; a couple informants raised concern that there is not enough time spent to ask the affected people those questions. One informant expressed concern that international professionals from humanitarian agencies are rushing to do things they know how to, instead of doing what is perceived to be needed by the affected individuals. *"We are still very poor at taking the time and really build on community resources including their abilities, values and perceptions" (Informant 5, PS delegate)* When asking how that may be done, the informant answered; *"First, taking the time to do it. We are under pressure to deliver, so we rush things, that's why we do copy and paste...usually we don't even take time to ask people, basic things are sometimes ignored" (Informant 5, PS delegate).* The same informant also mentioned difficulties for local actors and stakeholders to participate in meetings where decisions, about the humanitarian response are made, due to the meetings being held in a language that locals could not understand well enough to ensure participation. So, the informants underlined the necessity to ask questions to explore and understand how psychosocial wellbeing is defined and how psychosocial support can be related to feeding practices. But on the contrary stressed their concern about that this is not done sufficiently. A professional experienced in IYCF and Baby Tents stated that; *"We do not always investigate why children are undernourished in emergency situations. It is not always because of lack of food that children become undernourished in emergencies. It is also about other things" (Informant 13, IYCF/Baby Tent professional).* The informant seems to disclose a discrepancy between what interventions and actions that are considered important by professionals operating in post disaster context, and the actions actually performed. Apparently, asking questions to explore and understand different aspects within the post disaster context, that influence caregivers psychosocial wellbeing and feeding practices, are considered and expressed important, although the informants are concerned that it is not done sufficiently, which is relevant to compare to a context sensitive approach (Lützen, 1997; The John Hopkins & RCRC, 2008). If the aim with disaster response interventions, is to maximise the chances of positive public health outcomes in accordance with a context sensitive approach, taking the time to explore the perceptions of affected individuals are essential. As highlighted by Casiday et al. (2010), this may possibly result in the distance between doing what is perceived to be "the right thing" by professionals compared to the affected population increase.

4.2.3 Approach, skills and communication

To explore and understand the post disaster context may be perceived a matter of course for all professionals with the intention to take a context sensitive approach. Hence, it is appropriate to search why PSS are considered to have a significant position to understand feeding practices. One informant with experience from Baby Tents expressed her perspective of why applying PSS is

important to understand and support feeding practices; "*It is also the way that you address them. It is like to open a door. When you start to discuss about how the breastfeeding is going, you might open doors to something that is about relationships, about of children that maybe are dead because of what have happened and things like that. So, It is an entry point""(Informant 14, PS/Baby Tent professional).* Thus, to include PSS in Baby Tents was described as a possible entry point to discuss both feeding practices and psychosocial concerns. When PS professionals were asked to describe the meaning and essence of PSS one of them said: *"I will probably take away the mystery. For me, psychosocial support is really nothing except humanity. Basically, it is just about good communication skills, it is really nothing else" (Informant 11, PS professional).* Communication, and how people are approached, meaning in what way they are met, talked to and listened to, appear to be an essential element in PSS, and repeatedly highlighted by the informants. To be nonjudgemental, take time to listen, be openminded, build trust and provide support to whatever topic important for the persons you are interacting with, was mentioned as necessary skills to provide PSS. The PS centre (2011) refer to some behavioural skills described to be in accordance with the seven fundamental principles of the Red Cross Red Crescent Movement. These skills are promoted in PSS interventions and training of volunteers and include; *"empathy, active listening, non-judgement, non-violent communication and peaceful resolution of tensions, operating from an inner peace and harmony" (PS centre, 2011, p. 4).*

Furthermore did PS professionals expressed why PSS may be effective to support feeding practices; "*We, psychosocial support professionals, often get trust, people tell us more" (Informant 11, PS professional); "I think we are in a unique position often, to get quicker to the core, to the essence of, why people really do the things they do" (Informant 6, PS professional).* When asking her why, the informant continued; *"It is the circumstances we create, it is often activities that focuses on feelings and emotions".* PSS might therefore be described as a way to get to the "bottom", or to the "core" about how feelings and emotions of caregivers to infants and young children may affect certain behaviour related to feeding practices. By getting to the "bottom", the informants referred to caregivers sharing explanations and information about a certain concern or behaviour, beyond the obvious and expected. Informants gave a few examples of beliefs about breastfeeding and sexuality: Women were concerned that breastfeeding ruin the breasts, or the physical appearance of the breasts, which in turn might influence the sexual relationship with a man or husband. Besides, women were expressed to be afraid that their men would go to prostitutes and receive HIV if they prioritised breastfeeding in favour for the sexual relationship. One informant said; *"That is not necessarily information that comes up when you bring your malnourished baby to the health clinic" (Informant 11, PS professional).* She further highlighted that when women are being questioned about their feeding practices in health clinics, they might give other reasons to why they are not breastfeeding, instead of telling about the cultural belief or actual reason to stop breastfeeding. PSS, and the way PS delegates approaches individuals, or groups of people, is

described as essential to what kind of perceptions and experiences people will share. To get to the bottom; to learn about the underlying reason explaining a certain behaviour related to feeding practices, where mentioned as typical information given when psychosocial aspects were taken into consideration and explored.

"*If you start really to discuss with the people, it will come up. If you are a bit openminded and there is an open discussion, most of the time you will have this information...you will see that all what is intervening in the relationship between the mother and the child is also affecting the breastfeeding. And in that case, infant feeding is something that is one aspect of the mother and child relationship or the mother involvement of the child. This is the type of things we work on when we are doing some psychosocial work on infant feeding" (Informant 14, PS/Baby Tent professional)*

Communication was also shown to be a theme with diverse perceptions, described slightly differently depending on the informants' main professional field of expertise. PS professionals compared to the informants mainly experienced in IYCF, presented somewhat ambiguous perspectives. The two main perspectives of communication expressed were; to understand feeding related behaviour and different factors influencing feeding practices by asking questions, to "learn from" (more often expressed by PS professionals) and to disseminate information and educate caregivers with the aim to promote recommended IYCF practices (more often expressed by IYCF professionals). To "learn from", i.e. to explore and understand cultural and environmental features of the post disaster contexts, how the disastrous event may have changed feeding practices, caused barriers and offers opportunities to intervene. As opposed to "learn from", the educational aspect, to "educate" is more about doing, how to intervene when providing PSS or promote recommended IYCF practices. These two perspectives of communication is relevant to compare with to; understand an environment which influence child growth and development (Sellen, 2010a) and how to possibly intervene in this environment by taking a context sensitive approach (Lützen, 1997; The John Hopkins & RCRC, 2008). The educational perspective of communication will be further highlighted in next stage. PS professionals expressed scepticism towards dissemination of information;

"I am not so much believing in disseminating knowledge, because this is the way it is done in the humanitarian context but like...I can give you an example... you have women that were exclusively breastfeeding before the typhoon, they all know that it is good to exclusively breastfeed and what we propose is to explain to them to exclusively breastfeed. Which they know already. So I don't see really that it is an issue there. So for me most of the time there is no real assessment before to see what is the knowledge of the population, what is the practices and to set up a proper behaviour change project" (Informant 14, PS professional, Baby Tent)

The above quotation summarises aspects discussed in this stage. Keeping the biocultural perspective in mind; it seems like it lies within the nature of PSS to explore aspects of the post disaster context, in which child growth and development occurs, as described by Sellen (2010a). To utilise PSS to explore and understand what elements in the post disaster context that may influence caregivers feeding practices appears relevant. Furthermore, for PS delegates to explore caregivers' behaviour related to feeding practices, and how the disastrous event have caused further challenges, or opportunities seems to be a future possibility. To ask caregivers about their beliefs, traditions, and concerns related to feeding practices of their infants and young children may be a future task for PS delegates, by using non-intrusive communication skills and listening to get to the "bottom", and understand the caregivers choices and behaviours. The informants expressed the necessity to first gain an understanding of existing feeding practices, and the factors influencing them before deciding how to address them. Thus, the expressed concern of not spending enough time to gain such understanding may be at odds with a desire to take a context sensitive approach professionals intervene in post disaster contexts. The next stage will discuss how feeding practices may be addressed in PSS activities aiming to enhance people's resources, ability to cope and be in better position to meet future life adversities.

4.3. Stage 3 - Design psychosocial support activities to support feeding practices

Stage 3

Design and launch PSS activities to support feeding practices in post disaster contexts

Support feeding practices in PSS activities

* **What to achieve: create a safe environment, coping and behaviour change**
* **Knowing who to target, vulnerability as an indicator**
* **Design PSS activities to support feeding practices**
* **Ways to cooperate and communicate: use of competencies and dissemination of knowledge (to educate)**

In stage 3, the informants' perceptions of how to possibility design and launch activities to support feeding practices within the psychosocial support module is presented. This stage also explores how interdisciplinary cooperation is a central theme, and present possible types and location of PSS activities to support feeding practices. Based on the informants descriptions of how the post disaster context contain "barriers" or challenges, and in addition a "window of opportunity" to address those challenges, it is relevant to explore how the "window of opportunity" may be used in practice to address feeding practices in PSS activities. Sellen (2010a) explain that high-quality environments optimise child growth and development, and highlight nutrition, disease prevalence and psychosocial interactions as central elements. Hence, the quality of the environment a child experience throughout life is crucial, but may be impaired by disastrous events.

4.3.1 Knowing what to achieve

The specific purpose of the psychosocial support module is to "*enable a positive, safe, social and physical environment where children and adults find opportunities for stimulation, skill building and socialisation" (Yigen et al., 2012, p. 8).* RCRC PS professionals spoke about the psychosocial support module as way to provide a welcoming, safe, calming and joyful area, where individuals or groups could get informal coaching, support and rebuild social relationships. Baby Tents aim to create "safe havens" or "corners" to provide a safe, relaxing and supporting environment where caregivers, especially lactating mothers, can feed in private and receive skilled support in recommended IYCF practices (ACF, 2012; Ayoya et al., 2013; Featherstone, 2010; Interagency Working Group on Infant Feeding in Emergencies, 2007; NutritionWorks et al., 2011; WHO, 2013b; World Vision International, 2012). Ayoya et al. (2013) describe the physical properties of the Baby Tents as spacious, clean, decorated with balloons and posters, having safe drinking water, mats and mattresses available. The creation of a safe, low-stress area where caregivers can receive skilled support, and support each other, can be described as similarities between the functioning of Baby Tents and the psychosocial support module. Potentially, the psychosocial support module may be utilised to provide a "micro" high-quality environment aiming to promote child growth and development, by focusing on both caregivers' psychosocial, and feeding related concerns. This would be a way to intervene in the area where the two imaginary circles, representing the professional fields of IYCF and PSS, overlap, and is to be compared with the functioning of Baby Tents. Although, PSS activities aim to promote psychosocial support wellbeing and prevent mental disorder among disaster affected individuals or groups (IASC, 2010; IFRC, 2012b; Yigen et al., 2012), in contrast to Baby Tents where promotion and support of recommended IYCF are one main focus (Ayoya et al., 2013; Filorizzo, 2012; Unicef, 2013b) Thus, may PSS activities be perceived to have a wider angle and aim compared to Baby Tents. To support caregivers psychosocially is a part of the Baby Tents' functioning, but not the main objective. Promotion of breastfeeding was mentioned to be a main focus in Baby Tents, and thus a possibility to address both physical and psychosocial aspects of breastfeeding. One informant gave her view on the objective with Baby Tents; *"And for me, the objective of the Baby Tents is not to disseminate knowledge for example. It is a tool to support adequate practices after an emergency and to see how you can adapt adequate (feeding) practices to the new context and to provide psychosocial support" (Informant 14, Baby Tent/PS professional).* The informant distinguishes between disseminate knowledge, to support adequate feeding practices and provide PSS. A differentiation in accordance with the two perspectives of communication presented in stage 2; to learn from, and to educate. The informant also speaks about adapting feeding practices to "the new context", which may be related to how RCRC PS delegate speaks about "creating a sense of normalcy". The expression furthermore reveals a perception of the possibility to support individuals to cope with the disastrous event, and adapt feeding practices in accordance with the post disaster context. The informants also spoke about supporting individuals

psychosocially to get back to normal, or rather to cope with the "new normal" as central in PSS activities, a view supported by IASC (2010), the PS centre (2011) and Yigen et al. (2012). Hence, PSS activities and Baby Tents share commonalities of what they aim to achieve both in terms of creating a safe environment, and provide assistance to disaster affected individuals/caregivers aiming to promote coping and adaptation to the "new context", or the "new normal". These are elements that may exist in the area where the imaginary circles, representing the professional fields of IYCF and PSS overlap.

Behaviour changes were another interesting aspect highlighted by both PS professionals and IYCF professionals. Informants suggested behaviour change to be one goal of activities promoting recommended IYCF practices and psychosocial wellbeing. However, several informants stressed that changing practices, and behaviours might take long time, additionally that change must come from inside. Furthermore was PSS described to be a "wheel" to behaviour change;

"Behaviour change is the goal. You can use psychosocial support as a wheel to behaviour change. Because changing behaviour requires change in attitudes. Because, if there is an attitude about something, people are not likely to change their behaviour around it. But psychosocial support can change attitudes...attitude change is a key to behaviour change. So psychosocial support can aim to influence attitudes, it might not be able to change the attitudes, but it might be able to influence it enough, so that the behaviour in some way changes. Although they might still hold on to their core beliefs, they might still think that there is not black and withe truth, but maybe something in between. Psychosocial support could be a key element to address nutritional situations" (Informant 11, PS professional)

The expression supports why PSS activities launched within the psychosocial support module may be relevant in order to explore, understand and possibly influence existing beliefs, attitudes and behaviours related to feeding practices. The description of how both Baby Tents and PSS aims to create a supportive environment, can be compared to how Sellen (2010a) describes high-quality environments. Although, unlike Sellen (2010a), who refers to a child's whole surrounding environment, both Baby Tents and the psychosocial support module aim to form a supportive "micro environment" as a way to intervene in environments and adverse contexts, challenging children's growth, physical and cognitive development, and chances of survival. The supportive environment Baby Tent and PSS activities aim to create, may be perceived a way to assist disaster affected people to adapt to the post-disaster context by; increase a sense of normalcy, support coping mechanisms and resources, promote psychosocial wellbeing and optimally influence behaviours related to feeding practices. Although the latter is yet to be tried out in PSS activities in future ERU deployments. In the

following section, informants' perceptions of which groups or individuals to target in order to support feeding practices in PSS activities are highlighted.

4.3.2 Knowing who to target

When discussing different target groups for PSS activities, the term vulnerability was mentioned several times. Infants and young children are a group being described as vulnerable frequently, both regarding their dependence on caregivers to receive care and get fed, and their susceptibility to disease and increased risk of death (ACF, 2012; Casiday et al., 2010; NutritionWorks et al., 2011; Sellen, 2010a, 2010b; The Sphere Project, 2011). Infants and young children's vulnerability in relation to feeding practices is described in terms of; *"Sub-optimal infant and young child feeding practices increase vulnerability to undernutrition, disease and death. The risks are heightened in emergencies and the youngest are most vulnerable" (NutritionWorks et al., 2011, p. 1)*. Mothers, undernourished and under stimulated children are mentioned as examples of groups at risk to experience psychosocial problems in disasters (Yigen et al., 2012). Hansen (2009) highlights that very young children is an example of a *"particularly vulnerable group that might be overlooked in the course of a crisis on the assumption that families are taking care of them" (Hansen, 2009, p. 84)*. In accordance with Hansen (2009), a PS professional expressed that to support feeding practices within PSS activities was a new topic to her, and she was therefore not used to recognise mothers and caregivers, having the responsibility to feed infants and young children, as vulnerable and a particular groups to launch activities for; *"What we are always keeping in mind is that we are looking for the most vulnerable, but maybe we didn't have our eyes open to feeding mothers, breastfeeding and other ways of feeding, as vulnerable. Maybe we didn't think of it in those terms, and didn't think that go out and to things particularly for that group, would be good and strengthening for the wellbeing and healthy development of the child. I think we jus assumed they were more or less okay. Well, okey some children are malnourished" (Informant 4, PS delegate).*

The description of vulnerability appears to be closely linked to be at risk for an undesirable outcome, for example mental illness, undernutrition, disease and death. To target young children, perceived as a particular vulnerable group, can be interpreted as a means to prevent these undesirable outcomes. Children under the age of two years, and their primary caregivers, often mothers, are described as the main target group in Baby Tents (Ayoya et al., 2013; Featherstone, 2010; Filorizzo, 2012; World Vision International, 2012). In the psychosocial support module, young children and their caregivers are mentioned as one possible target group, where children can join play activities while their caregivers attend support groups (Yigen et al., 2012). This view was supported by PS professionals mentioning that young children often are accompanied by their caregivers, which provide a possibility to support both the caregivers and their children;

"Young children will often be accompanied by a parent or an older sibling when they are under the age of two, that also helps for the sense of community. So, that means, if the mother comes, she is also getting support, it's sort of a side effect. And also the older siblings, when they come with younger siblings, they also get a sense of support from in the tent. I should also mention some kind of coaching. Parents would come with their very young children just to sit in the tent, just to be with other children that were drawing, playing, listening to music. Just for a sense of connecting with something normal. And also a lot of informal coaching, about who to put your baby to sleep under different circumstances, you are talking about breastfeeding. We had a nurse coming into the tent giving some informal coaching in the tent" (Informant 7, PS delegate)

But vulnerability in it self did not seem to function as the only criteria, when deciding what type of activities to launch and what groups to target. The informants also raised awareness of the importance to not only address women or mothers in activities, but to also include fathers and other family members such as grandparents and parents-in-law. The understanding of underlying causes to certain behaviour, or defined "barriers", was suggested to form a basis for whom to address in PSS activities. One PS professional said; *"If you want to change a certain breastfeeding habit, it is not the women you need to work with, it is the men. The women definitely know the best way to breastfeed is and how long they should do it for. Women are definitely a vulnerable group, but it is not the women you necessarily need to do the activities for" (Informant 2, PSS)*. The expression reveals a perception of feeding practices not only being influenced by the mother, but also by surrounding family members or other community members. To include more family members in activities were also perceived to increase the family cohesion;

"So, often we target women for so much stuff (regarding feeding and caring of children) that the men become isolated from this things, and it actually gives the men some kind of self respect that: "I'm also important in this program, not that It's all for women, but I'm important to, and they want me to be involved as well."(Informant 10, IYCF/Baby Tent professional).

"I believe it is important to address, not only the parents, but the whole family....Parents to a newborn child often listens to advise and beliefs given by their parents and grandparents, believing that is where experiences, and knowledge about best practices lies, and adopt those. But how do you get the whole family structure to understand the importance (of breastfeeding) and that is actually something you can do to avoid the newborn to get infections, and increase chances of survival....We need to think about including the whole family, not only the newborn's parents. It is important that we include the closest network of support" (Informant 12, IYCF/ERU delegate)

The informants expressions disclose awareness of how traditions and beliefs among different family members, or other individuals in a child's surroundings, may influence on the way the infant or young child is fed. However, mothers to infants and young children are most often mentioned as the target group in interventions aiming to support and promote recommended IYCF practices. Maybe that reflects a somewhat universal opinion of a child and mother forming an inseparable biological and social unit as described by WHO and Unicef (2003), and the mother as one of the most important biological features in the environment of infants and young children (Sellen, 2010a). On the contrary, did the informants stress the importance to also include and address other family members; based on a perception that feedings behaviours, beliefs and traditions are influenced by more individuals in a child's surrounding environment than the mother. Keeping in mind the perspectives presented by the informants on whom to target, the possibilities to design PSS activities to address feeding practices will be examined in the next section

4.3.3 Psychosocial support activities: a community-based approach

PSS activities in RCRC disaster response is described to have a community-based approach aiming to empower people, and accordingly strengthen their self-confidence and resources (PS centre, 2011). Informants highlighted the importance to launch PSS activities based on the expressed needs of those affected, which is to be compared with a context sensitive approach (Lützen, 1997; The John Hopkins & RCRC, 2008). According to Yigen et al. (2012), efforts must be made to involve members and groups of a community to take part in decisions, discussions and actions that might influence them. Furthermore, community mobilisation and participation is perceived to increase hopefulness, coping capability and the ability to use their resources to rebuild their lives (Yigen et al., 2012). This is in accordance with the principles of self- and community efficacy, connectedness and hope presented by Hobfoll et al. (2009), and a perspective expressed by the PS professionals interviewed. To design PSS activities in relation to the contextual understanding of physical, social and cultural aspects of disaster affected communities and individuals appears to be central, both in terms of being needed and to be justifiable. Thus, based on the description of a post disaster context as a context of adversity (Panter-Brick & Fuentes, 2010), with aspects challenging caregivers' feeding practices and psychosocial wellbeing; community-based activities to address these challenges may be designed and launched. RCRC PS professionals and delegates mentioned that what type of PSS activities that are designed and launched, might also be influenced by the knowledge and level of experience of the delegate, the environmental context, available material and space, human resources and the security situation.

PS delegates explained that the location of PSS activities may either be within the physical facilities of the psychosocial support module, such as a tent nearby other health ERU's, or be implemented as

outreach activities in surrounding communities, a description supported by Yigen et al. (2012). Outreach activities is one of the four main functions of the psychosocial support module, and often conducted in cooperation with the operating NS or local RCRC branch, and local health actors (Yigen et al., 2012). To conduct outreach activities that enables participation and community mobilisation appears to be of central significance in PSS activities, highlighted by the informants and theoretically supported (Hobfoll et al., 2009; The Sphere Project, 2011; Yigen et al., 2012). Outreach activities were highlighted as a possibility to visit caregivers, and provide individual follow up to support feeding practices, and psychosocial wellbeing in their homes;

"I think feeding practices can be addressed anywhere. If you have an ERU mobile clinic, you can have a psychosocial support activity going on which addresses young women with infants, or young parents with infants. You can also have an outreach activity, if you have the resources for it, were you visit the community and going to peoples houses, you have tea with them, sit down having small focus groups. Let them know that you are always there every day, at twelve o clock, and whoever is interested to come and talk can come. Usually a lot of people come. You have some form of structure, you have this message that you want to bring, and how do you want to bring it. For example that breastfeeding is lifesaving. Just have a message and think of the way to bring the message. Don't make it to compacted or bring too many messages." (Informant 11, PS professional)

The expressed significance of PSS activities being launched within communities, underlining the participation of its community members, may be a central element if the PSS module will be applied to address feeding practices in future ERU deployments. In Infant and Young Child feeding standard 2: Basic and skilled support it is stated; "*Designated shelters for mothers and caregivers enable access to peer-to-peer and basic IYCF support. Breastfeeding support should be integrated within key services such as reproductive health, primary healthcare, psychosocial services and selective feeding programs from the outset" (The Sphere Project, 2011, p. 161).* To gain a better understanding of how to utilise the psychosocial support module to address feeding practices, in accordance with the Baby Tents, it is relevant to refer back to the Intervention pyramid for mental health and psychosocial support in emergencies, figure 2.1 (IASC, 2007). By conducing a hypothetical exploration by applying the Intervention pyramid, it is possible to explain how the main functions, and activities, within the psychosocial support module may be adapted to support feeding practices. First of all, activities in Baby Tents and the psychosocial support module, refer to activities within the lower layers of the pyramid (Filorizzo, 2012; Yigen et al., 2012). In the first layer - Basic services and security; the psychosocial support module could possibly offer access to psychosocial support and informal support and advises regarding feeding practices in general, and available for all caregivers with children under the age of two years, with accompanying older siblings who could attend play

activities. As understood, layer one include activities aiming to provide accessibility for all caregivers with infants and young children (Filorizzo, 2012). Examples of activities could be; group discussions about feeding and care practices, providing a space for recreation, relaxation and feeding in favour of caregivers with infants and young children. Additionally, informants explained that mothers may have a potential to spread information about recommended IYCF practices among other mothers, which is based on the assumption that when people gather, they start to discuss and can support each other and share experiences and knowledge. This may be seen as an argument to utilise the psychosocial support module as a safe and supportive environment, easy accessible and attractive. Yet, since the informants highlighted the necessity to not only target women, or mothers, to understand and support feeding practices; the psychosocial support module may be a relevant mean to possibility target a wider range of individuals who influences on how infants and young children are being fed. This may be particularly relevant in community outreach activities, when there is less need to take into account the limited space of the psychosocial support tent. The psychosocial support module may thereby use the "window of opportunity" by having access to caregivers in the communities, to form an understanding of how existing feeding practices are influenced by elements in the physical and cultural context, including other family members than mothers. Another importance aspect related to layer one in the Intervention pyramid is accessibility. Inaccessibility to activities may create further "barriers", hindering caregivers from participating in activities that potentially could enhance theirs psychosocial wellbeing and promote recommended feeding practices. This is argued by Casiday et al. (2010) to increase the risk of interventions not being effective nor justifiable. Furthermore are Casiday et al. (2010) underlining that different perceptions of the characteristics of a vulnerable child, may differ between humanitarian professionals, and the caregivers; which may constitute a discrepancy between which infants and young children that are perceived vulnerable and thus within the target group, and whom is actually provided with assistance. Such diverging views may stand in contradiction to a context sensitive approach. Informants also mentioned that the tent, or designated area for PSS activities, could be used to offer a space for women to breastfeed in private, especially if it is not local custom to breastfeed in open.

The second and third layer; community and family support, and focused, non-specialised supports, refers to support being more targeted (IASC, 2007; Filorizzo, 2012; The Sphere Project, 2011; Yigen et al., 2012). The second and third layer can be assimilated to the second main function of the psychosocial support module; to assist adults with practical information, emotional and social support where nutrition is given as an example of a topic to address in support groups targeting caregivers (Yigen et al., 2012). Examples of activities in layer two and three can be to facilitate group activities where, bot male and female, caregivers of children under the age of two years, can share their experiences and give each other advices about care and feeding practices. Another example of

activities are, educational sessions and provision of information related to psychosocial wellbeing and recommended IYCF practices, and individual follow up for caregivers experiencing psychosocial challenges influencing on the feeding practices of their infants and young children. The four key actions to support young children and their caregivers psychosocially in disasters presented by IASC (2007), may be compared to the psychosocial support module's four main functions and activities. Keeping children's with their caregivers and restore family links, facilitate PSS to caregivers and provide "safe spaces" for child play and care, and possibly promote recommended IYCF practices, may furthermore be referred to level two and three in the Intervention pyramid (Figure 2.1), and the second main function of psychosocial support module. Although, it should be mentioned that the overall intention with the psychosocial support module is to improve the psychosocial wellbeing of disaster affected populations, where both children and adults are targeted in PSS activities (Yigen et al., 2012). Whereas main focuses in the Baby Tents are to support recommended IYCF practices and prevent undernutrition, reduce risks of unregulated provision of breast milk substitutes and promote child survival and development, where PSS to caregivers may be one type of services provided (Ayoya et al., 2013; Filorizzo, 2012; World Vision International, 2012). The focuses on PSS activities compared to Baby Tents are therefore different. One informant experienced in IYCF and Baby Tents expressed; "*Baby tents can focus on feeding activities, but they can combine that with other activities, such as mental health. Or mental health can be the main input, with some feeding activities. Feeding is such an essential part for the physical and mental health of infants and young children, that it would be difficult to do any activity around health or mental health without including the feeding component. Working on feeding, can also be the entry point to improve the wellbeing of the caretakers (Informant 13, Nutrition)*

The above quotation is in accordance with the description of the central meaning of diet and nutrition in peoples lives (Moffat & Prowse, 2010), and the described interrelationship between feeding practices and children's health, growth and development (WHO & Unicef, 2003). Hence, activities in the psychosocial support module may have a potential to address feeding practices. However, it may be necessary to consider the role and responsibility of PS delegates in relation to different levels of intervention presented in the Intervention pyramid, figure 2.1 (IASC, 2007). The first layers are described to be more community-based, having a wider target group, where the top layers are specialised with a narrower targeting of groups individuals in need of additional support. Hence, it is relevant to further consider how the professional field, and capacity, of PS delegates may be applied to support feeding practices according to the different layers. An interdisciplinary cooperative approach to collect the right skills and knowledge to address feeding practices in PSS activities was repeatedly highlighted in the interviews and will be discussed as follows.

4.3.4 Cooperation and communication as means to support feeding practices

Coordination and cooperation is the second of six core standards in the Humanitarian Charter and Minimum Standards in Humanitarian Response (The Sphere Project, 2011). Hence, coordination and cooperation, are central for actors and professionals involved in humanitarian disaster response stating that; *"Humanitarian response is planned and implemented in coordination with the relevant authorities, humanitarian agencies and civil society organizations engaged in impartial humanitarian action, working tighter for maximum efficiency, coverage and effectiveness" (The Sphere Project, 2011, p. 58)*. Cooperation with colleagues and different stakeholders was frequently discussed by all informants, and highlighted as a central part of working in post disaster contexts. Thus, much of the services provided to disaster affected individuals in post disaster context relies on different kinds of cooperation; within the ERU system, and at local, national and international level. The following statement underlines why cooperation and communication may be linked, and be of central significance in the professional field where PS delegates operates; *"Good communication skills enabling you to work closely with community leaders and representatives and good training skills for your work in orienting community volunteers are all essential in your task as a PS delegate. Your work should at all-time be based on the premise that culture, belief systems, established habits, attitudes, behaviour and religion are to be respected and leveraged, in order to facilitate improvements in the health and general wellbeing of the public" (Yigen et al., 2012, p. 24).*

The informants mentioned interdisciplinary cooperation as a possible way to share knowledge, and perspectives of crosscutting topics; for example different aspects of feeding practices and PSS. PS professionals said; *"I see cooperation as more ideal than trying to have one person knowing it all" (Informant 2, PS professional), "When you go out as an ERU delegate, you work as a team" (Informant 7, PS delegate), "We need people who know how to coordinate and to cooperate" (Informant 6, PS professional).* RCRC PS professionals frequently mentioned ERU CHM delegates as cooperative partners to possibly support and promote recommended IYCF practices in PSS activities. Two main reasons for the cooperation emerged in the interviews; IYCF is perceived to mainly belong to the professional field where CHM delegates function, and both CHM and PSS have a community-based approach;

> *"The CHM delegate. Actually, we work very closely together. Because we are both going out in the field (outreach in surrounding communities). While the other delegates stay within the hospital setting...We are basically doing the same thing, your focus is just different, one is more on psychosocial needs and the other more health related, but you are out in the communities, not in the hospital setting, that brings you together" (Informant 7, PS delegate).*

"If you know there is a need to educate parents about nutrition, if you for example combine (psychosocial support) with the community health module, and try to address the main health issues in this community, and at the same time listen to peoples main emotional and psychological concerns and decide to develop an activity...The overlap with the psychosocial support module and the community health module can never be avoided, there will always be a certain overlap (Informant 11, PS professional).

As the quotations highlights, the CHM was expressed to be overlapping with the psychosocial support module, which can be related to the imaginary circles of the professional fields of IYCF and PSS discussed introduced in stage 1. CHM and PSS share the community-based approach. Hence, PS delegates and CHM delegates may contribute with different but complementary perspectives how to understand and support feeding practices more holistically. Water and sanitation delegates, midwifes or nurses working in the field hospitals or basic health care units, were also mentioned as potential cooperative professionals. Cooperation between different ERUs also poses a potential for the different professionals to have an internal system for referral of individuals in need of extra attention and specialised support, both regarding psychosocial challenges, breastfeeding difficulties or other feeding related problems, which can be referred to the top layer in the Intervention pyramid (IASC, 2007), presented in figure 2.1.

Among local health professionals, several professional groups were mentioned as possible cooperative partners to address feeding practices in PSS activities. Traditional healers, lady health workers, midwifes, nurses and teachers were given as examples. Their possible health related skills and knowledge regarding nutrition and feeding practices, was mentioned as one of the main motivators for such cooperation. To train and cooperate with locally recruited staff was described important in order to build trust, and relationships with individuals within disaster affected communities, which is a part of the community-based approach. Approaching community leaders was also named as an essential cooperative link in order to successfully launch activities within disaster affected communities; *"Who are the leaders? Who do people listen to and trust? Try to get this people to cooperate with you" (Informant 11, PS professional).* The community leader was perceived to be a key person, and one informant stressed the need for a mutual, formal understanding on what type of activities design and launch, and the aim of the activities. To consult the community leader, before launching PSS activities, was expressed to prevent obstacles for successful implementation. The RCRC NS, with their local branches in the affected region was also mentioned to be an important cooperation partner, and an important source for information about the culture and local customs. The capacity and function of the operating NS were perceived to be important for cooperation and coordination of activities, highlighting the PSS focal point in the NS as a key person to also identify important groups to target and decide what type of activities to launch. Cooperation with local actors

appeared to be about trust and to build relationship in order to successfully implement activities within the communities, to enable participation of its members. Additionally, described as one of the main reasons to recruit local staff and volunteers into the activities as a way to integrate the PSS activities within a disaster affected community; *"You have to think about an intervention that is integrated into the community structures and preferably train people from the community to try to build some capacity that you leave behind" (Informant 11, PS professional).* Activities implemented, using a community-based approach appears to be important in order to build capacities that stays in the communities. However, it is reasonable to wonder in what way capacities are built, and how knowledge is communicated to potentially promote recommended IYCF practices from a psychosocial point of view.

In stage 2, the two perspectives of communication were introduced; to "learn from" and to "educate". To "learn from" highlighted how communication may be utilised as means to explore, and learn about the cultural context, perceived needs, and concerns related to both the psychosocial wellbeing and feeding practices in post disaster contexts. The second more educational perspective, to "educate" was recurrently expressed by the informants as a way of supporting by providing information and disseminate knowledge. Hence, it appears to exist a perception that educational communication, like counselling and provision of information, may promote beneficial behaviours related to feeding practices (Interagency Working Group on Infant Feeding in Emergencies, 2007; NutritionWorks et al., 2011; The John Hopkins & RCRC, 2008). Counselling related to feeding is described as *"the process of providing guidance to assist an individual in adjusting food consumption to meet needs...counselling skills include listening, empathy, providing sound information, support and helping the individual to decide what to do" (The John Hopkins & RCRC, 2008, p. 465).* A description in accordance with women's right to decide how to feed their children, and the right to conditions, and access to information in order to make their decisions a reality (WHO & Unicef, 2003). Moreover, may counselling to support feeding practices be seen as alternate process aiming to both support mothers/ caregivers in their choices on how to feed their infants and young children, and at the same time educate them about recommended IYCF practices. Thus, the two perspectives of communication appear to be interrelated and may occur alternately; to listen on one hand and provide information and educate on the other; *"Mothers are greatly helped to breastfeed and care for their infants if someone calm and friendly listens to them, and builds their confidence with reassurance and correct information" (Interagency Working Group on Infant Feeding in Emergencies, 2007, p. 30).* Although, some informants did not express much faith in dissemination of knowledge aiming to change a behaviour. The term "key messages" kept reoccurring, and PS professionals in particular questioned the effectiveness of information given as key messages; *"Information is not changing anything. Change must come from the inside...I think we are underestimating the power within the community and knowledge they*

already have. Sometimes you will see that it doesn't have a big effect for someone to come in and give ten key messages. When somebody says key message, I just want to leave the room. Come on"(Informant 4, PS delegate). The revealed reluctance towards the way information and knowledge is disseminated, provides an interesting and considerable perspective to the two perspectives of communication, and may perceived to be in contrast with the WHO and Unicef (2003) statement of women having the right to have information to realise their decisions on how to feed their children. Maybe information has a potential to transform existing knowledge, and beliefs about feeding practices, and thus support caregivers to decide how to feed their infants. As presented in stage 2, the post disaster context may provide a "window of opportunity" where you have access to caregivers receptive for information because they are concerned about the health and survival of their children.

However, the informants' various perceptions about dissemination of knowledge, information and key messages were not only about the messages in itself, but also about the way they were given. To consider psychosocial aspects when providing information about recommended IYCF practices, was expressed to not affect the information, but the way it is given; *"it means that it is given in a more compassionate manner than a midwife standing there with her story board and lecturing" (Informant 10, IYCF/Baby Tent professional)*. As the statement reveals, to take psychosocial aspects into consideration when addressing feeding practices, the way the information is given might differ, but message may be the same. There is something interesting about the way the informants talk about communication; giving key messages or not, understand practices and to change behaviour. A possible interpretation, concerning the highlighted perspectives of communication; is that it may be about how activities are designed and launched in a way, where the "window of opportunity" is utilised to communicate knowledge and information in compliance with a context sensitive approach. Although, based on the informants expressions, it is not very convincing that dissemination of information or "key messages" aiming to change feeding related behaviour or to enhance psychosocial wellbeing, is perceived to be very effective. This may reveal a discrepancy between the professionals' opinions of how support and information should be provided, and how information and support actually are provided. The Interagency working group on Infant feeding in emergencies (2007) means that existing breastfeeding practices can change as part of the adaptation to the disaster situation, but not overnight. The following quote provides a summary of topics discussed in this stage; cooperation, ways to intervene and communication of knowledge, also leading on to stage 4;

"It is very interesting to further investigate the mechanism of how to best cooperate, and that we don't become to stiff in our opinions about how things should be done, considering the particular post disaster context, local actors and existing local guidelines....and in almost every occasion, the guidelines are certainly based on recommendations from WHO, but the knowledge is not implemented...which can anyhow form an

important basis to further educate, and how that can be adapted to existing local knowledge, practice and knowledge gaps, and how to get the whole family onboard. Changing practices takes years. It is not done in no time". (Informant 12, IYCF/ERU delegate)

4.4 Stage 4 - Sustainability and potential positive public health outcomes

Stage 4

Sustainability and positive public health outcomes of PSS activities launched in post disaster contexts

Knowing the effect when addressing feeding practices in PSS activities

- **Evaluation of effects and expectations of achievements in relation to the ERU timeframe**
- **Activities being adapted with time, ongoing needs assessment and community implementation**
- **Sustainability: funding and ownership**

The fourth stage aim to present the informants' perceptions of knowing if activities launched in the post disaster context, to provide psychosocial support and address feeding practices, have been successful. This stage also highlights how activities potentially could sustain and have more long-term positive public health effects related to feeding practices and caregivers psychosocial wellbeing. One of the main points in this stage, is how the informants mentioned difficulties to evaluate short-term, and long-term effect of launched activities. Disaster response operations have a limited timeframe, and the timeframe for an ERU deployment is up to four months (IFRC, 2012a). Casiday et al., (2010), underlines that agencies' aspiration to provide humanitarian disaster response, aiming to save lives and protect livelihoods, may be in contrast to more long-term attempts to manage child undernutrition as a constant and underlying challenge caused by severe poverty. Despite of caregivers, communities, governments and relief agencies share the overarching goal to protect children's life, by managing child undernutrition, prevent morbidity and mortality; the need for sustainable interventions regarding children's health and their families' livelihoods are stressed.

4.4.1 Expectations of achievements in relation to the ERU timeframe

As previously highlighted, may professionals' perception of vulnerability differ form caregivers' perception, which may represent a potential challenge of how to prioritise use of economical and material resources in the humanitarian assistance, in relation the expectations of caregivers (Casiday et al., 2010). The informants' perception about expectations of what to achieve within PSS activities and Baby Tents, given the limited timeframe of disaster response operations, showed to have an overall consistency of the difficulty to do so. Thus, expectations in relation to time are a central theme. Informants stressed the need to have realistic expectations on what to achieve in the limited timeframe of ERU operations; *"We can not fix a situation in three months, when it needs two years" (Informant 5, PS delegate).* Both knowing if PSS activities and Baby Tents had been successful, and what type of effects to expect was explained to be hard. Informants with experience from Baby

Tents were asked to describe how to possibility know if activities have had an added value to the targeted group, they answered;

It's very hard to know! Data collection was a huge issue and as a person who sees value in monitor and evaluation, I did many trainings and supervision on correct data collection...It is also hard to verify if a woman who reportedly decided to exclusively breastfeed after receiving counselling from the baby tent was 1) lying to please the baby tent staff or 2) the baby tent staff was lying to make their results look good. But besides some of my scepticism of some of the data that has been reported, I did get the sense that especially in some of the communities, the baby tents did provide a safe space where mothers could get away from their problems, and the lack of privacy and heat of their own tents for some distraction/education/counselling. I do think that many messages were conveyed and some were applied, but it is hard for me to say how much. In Haiti, the new baby tent program did also renew the overall interest in IYCF in the country I think. (Informant 9, IYCF/ Baby Tent professional)

It is very very difficult to do this(measure impact), and again it depends on the perspective...we have tried to see if the feeding practices were being improved among the people that were coming into the Baby Tents. We saw if the women that mix-fed their babies under the age of 6 months before coming into the tent went back to exclusively breastfeed. We were not very confident with the results that we had. And as for now we don't have the response on how to measure the effect. It is also depending on what you are expecting. (Informant 14, PS/ Baby Tent professional)

The answers disclose a perception of the Baby Tents as being effective. The answers also disclose a hesitance to which extent they succeeded to both measure effect, and change feeding related behaviour. Even though behavioural change was mentioned to be one of the main objectives of both activities addressing psychosocial wellbeing and feeding practices, the difficulty to know if you have succeeded seems evident. On the contrary, some informants mentioned more observational means to measure effect, and at the same time kept returning to the limited timeframe; *"People are coming to your center, take note and you see the changes in the behaviour that means children are getting better nutrition. That they are ok. If they are not coming, or if they are coming and you see that they are not really feeding their children or the children spitting it up, and people are feeling even worse, you have got work to do...but you are only there for two or three months, you are only seeing the start of something" (Informant 6, PS professional).* Other examples given, of ways to observe if caregivers psychosocial wellbeing have been improved, was by their appearance and behaviour. The way caregivers represented themselves and interacted with their children was exemplified as a measure to know if they were doing all right or not. Another informant mentioned informal anecdotal stories as a pointer to if caregivers were provided with the right kind of assistance and support or not. Furthermore, focus groups discussions

with group participants, for example mothers or fathers, was mentioned as a way to explore what kind of knowledge that have been shared and topics that have been discussed, providing a kind of evaluation.

Informants also explained that changing behaviour takes time, long time, which can be compared to biocultural perspective on evolving IYCF patterns during lifespans (Sellen, 2010a, 2010b). Another aspect found in the bicultural perspective, is that existing feeding practices are influenced by various factors ranging from political and economical to cultural beliefs, and that humans are liable in their feeding patterns and behaviours (Moffat & Prowse, 2010). This may provide an indication to why it is difficult for professionals providing humanitarian disaster response, and to know if the interventions have achieved their goal and expectations. Hence, to measure changes in distribution of health, health disparities and child survival within a community or country, may not be possible to do within the timeframe of an ERU deployment. Therefore, to have exact measures of achievements might be to expect too much, considering the promotive and preventive approaches of the professional fields of PSS and IYCF. Maybe it lies within the nature of both PSS activities and Baby Tents, to address concerns in people's lives that are difficult to measure with simplicity. This does not make them less important or relevant, but rather indicate the need for an evaluative approach founded in expectations of realistic and desirable achievements. Still, informants did give their perspectives of how to maximise the possibilities for activities to be successful and sustainable.

4.4.2 Factors of success and activities being adapted with time

Baby Tents were perceived a good way to provide both PSS, and support feeding practices for children under the age of two years, especially during the first weeks after a disaster, in the first chaotic weeks of an emergency response operation. Characteristics of Baby Tents that worked well were described in terms of, strong capacity and competencies of the Baby Tent staff, and the capacity of the supportive humanitarian organization. *"The tents that worked well had well-trained and motivated staff, good supervision and were located in camps were the camp committee and the non-governmental organization had good relationships" (Informant 9, IYCF/Baby Tent professional).* The expression also highlight, that both personal skills and surrounding factors, such as cooperation with other stakeholders, influence how well an activity like the Baby Tents works. This point can be compared to the discussion about cooperation in stage 3. A couple informants mentioned that activities carried out in the Baby Tents, probably had to be adapted with time due to changed needs. For a service like the Baby Tent to be a relevant activity in disaster affected communities, it was described necessary that there is an expressed need for such. Areas where breastfeeding in public is not a socially accepted practice were given as example where Baby Tents could be of particular value. Factors influencing on the levels of success of PSS activities were explained to be; opening hours in the psychosocial support

tent, accessibility of services, and the variety of activities. When asking a PS delegate if the services provided in previous ERU deployments have had effect, the informant answered;

"I hope, it is hard to evaluate and monitor that because we were not seeing people for very long, it was one shot and then we were going somewhere else. If we could see the people every day it would be different, but that is not the purpose of an ERU. ERU is emergency, it is to give support as much as possible but to as many as possible. We can't spend hours with the same person or the same group unless we are in the same place and the person feel that they want to come back every day" (Informant 1, PS delegate).

The expression covers two main elements; first, the importance to provide services to as many as possible due to the disaster situation, and secondly, the limited possibility to follow up individuals if the activities are in different locations every day. In order to really make a difference and assess possible effects of psychosocial support activities, follow up was expressed to be essential by another PS professional. If the aim of PSS activities is to enhance the psychosocial wellbeing, by targeting those in need to be supported psychosocially; follow ups and revisits may be necessary in order to know if what you are doing is actually helping. On the contrary, will follow ups might limit the possibility to provide services to as many people as possible. Which may be the case if PSS activities also have a future objective to address feeding practices. Regarding follow up practices in the Baby Tents, one informant expressed the value of individual follow up as an effective way to reduce the number of people abandoning the program, and an opportunity to build stronger relationships with the caregivers.

Furthermore, the informants highlighted that when the lives and societal structures starts to rebuild, caregivers might not have the time to come to the tents anymore due to work or other duties. Sellen (2010b) explain that in contemporary societies, mothers are equipped with more choices on how to feed their children, and when to introduce complementary foods. This increased freedom of choices may create a mismatch between recommended IYCF practices, and the actual feeding behaviour and practice (Sellen, 2010b), which in turn might endanger the health of the child. On the contrary, the freedom of choices offer flexibility of how to feed infants and young children, with may in turn increase opportunities for mothers to be employed (Sellen, 2010b). Those choices, and how the choices are made, may be key elements to explore and understand in order to successfully support recommended IYCF practices in any post disaster context, where PSS, as presented in this study, may be applied as a mean to gain such an understanding.

4.4.3 Funding, ownership and sustainability

Funding was another theme discussed in relation to activities being sustainable and potentially have positive public health outcomes in a long-term perspective. The John Hopkins and the RCRC (2008)

highlights that any disaster response, need to have both the immediate and long-term needs of the affected populations in mind, a view supported by Casiday et al. (2010). Moreover does The John Hopkins and RCRC (2008) underline that it may be challenging to provide long-term funding possibilities, and resources to support recovery and rehabilitation phases. Thus, to incorporate skills into the disaster affected communities from the outset, plan and mediate exit strategies is therefore stressed to be important, in order to prepare both professionals' and those affected (The John Hopkins & RCRC, 2008). Informants mentioned the importance of having sufficient financial resources to set up programs and launch activities; if the activities were expected sustain after the most acute phases of the humanitarian disaster response was over. In contrast to funding and economical resources, was ownership mentioned as a key for activities to sustain more longterm;

"Funding is always a key. But, ownership a huge key. If the community feels that this is something they own and something they have developed and improved and contributed to, they will be much more likely to, firstly support it with human resources, or if they have any type of funding, or the volunteer time. So you have to think of an intervention that is interesting and is a nice social activity that people are likely to participate in even after you are gone. That it is not linked to you and the resources you bring, and the people that are running the activity are not external people, but internal people. And the external people are just there in the beginning, this is a trading element, and than as a supervisory element, and then as a supporting element and then as an audience. And you gradually step out of it. (Informant 11, PS professional)

Several informants expressed perceptions in line with the above quotation and stressed the necessity of the activities being implemented within the community provided with assistance. Ownership is an element which can be compared to the idea of PSS having a community-based approach and facilitate participation of the community members (Yigen et al., 2012). Thus, when community members have ownership to the activities, the chances may increase for the activities to be well anchored, and sustainable with positive public health outcomes within the community. In addition, informants expressed concern that, if the needs are not coming from the community members, and you are not using local knowledge, the probability for the activities to sustain within communities provided with support may decrease. This view is in accordance with a context sensitive approach (Lützen, 1997; The John Hopkins & RCRC, 2008). Hence, it seems like activities aiming to enhance psychosocial wellbeing and support recommended IYCF practices, needs to be well implemented and anchored within communities to possibly be sustainable and have positive public health outcomes, both from a short-term and long-term perspective; *"You have to be careful to design your intervention in such a way that you focus on capacity building and you will train local key people from the community. Train them in health education, give them as status as health educators. So when you leave, they can still continue with health education" (Informant 11, PS professional)*

Locally recruited staff and volunteers were repeatedly described to be the main link between international humanitarian professionals, and the disaster affected communities with its members. This explains why local RCRC community volunteers are described to be a key to sustainable positive public health outcomes of launched activities. The PS delegates kept returning to volunteers in the interviews, who are perceived a main pillar within the Red Cross Red Crescent Movement (IFRC, 2012b; Bush & Dent, 2013). The volunteers were presented as the link between the PS delegates, and the community members they aim to support. The following chapter will discuss informants' perceptions of the role of volunteers in PSS activities.

4.5 Overarching dimension 5 - The perceived role of RCRC community volunteers

Dimension 5: The perceived role of RCRC community volunteers
Being the link between PS delegates and the affected individuals and communities

* To form an understanding of how the physical and cultural context, and psychosocial wellbeing, influence feeding practices in cooperation with PS delegates
* Design, launch and run PSS activities to support feeding practices in cooperation with the PS delegate.
* How the role and motivation of the volunteer influence sustainability, and potential positive public health outcomes of PSS activities

The fifth category presents the informants' perceptions of the role of volunteers in PSS activities, as an overarching dimension being related to stage 2 trough 4. This overarching dimension will highlight why volunteers may play an important role in PSS activities possibly applied to address feeding practices. Bush and Dent (2013) states that; *"With the appropriate training, supervision and support, community volunteers can have a potential role in a nutrition response" (Bush & Dent, 2013, p. 20).* As earlier discussed; diet, nutrition and feeding practices may vary considerably in from one particular context to another (Moffat & Prowse, 2010). Volunteers may therefore be seen as representatives of the adverse context that PS delegates aims to understand, and thus the link between delegates and the disaster affected communities.

The findings from present study show that volunteers, involved in PSS, can be described having three main functions to potentially address feeding practices within the psychosocial support module; 1. In cooperation with PS delegates explore, and form an understanding of how the cultural context and psychosocial wellbeing may influence existing feeding practices for infants and young children (discussed in Stage 2), 2. In cooperation with the PS delegate; design, launch and run PSS activities to support feeding practices in the psychosocial support tent, or by doing outreach activities (discussed in Stage 3), 3. How the volunteers' motivation and role may affect the possibility for launched

activities to sustain in a long-term perspective, resulting in possible positive public health outcomes (discussed in Stage 4).

4.5.1 Community volunteers, a key to understand the post disaster context

When PS delegates arrives to a post disaster context; volunteers already involved in the operating NS, and trained in PSS may be available to be included in the psychosocial support module. If not, they need to be recruited. In accordance with the fourth main function of the psychosocial support module, does all volunteers receive training facilitated by the PS delegate. The volunteers are trained in supportive listening, psychological first aid, and how to use the material included in the module (Yigen et al., 2012). Informants suggested that the training of volunteers also could highlight ways to detect difficulties in feeding practices in general, and breastfeeding in particular. They further explained that volunteers might have different educational backgrounds and competencies, ranging from illiteracy to university degrees. However, certain skills and qualities of the volunteers were mentioned as being more important than their educational background. Having the talent to listen, knowing their limits, the ability to handle expressions of emotions, and difficult topics of discussions, were mentioned as beneficial skills of the volunteers recruited to the psychosocial support module and to run PSS activities. A person lacking empathy was not perceived as suitable to provide PSS. To be resourceful was highlighted as an important skill for volunteers, as one informant expressed; "*I would like the person to be resourceful...this quality in psychosocial volunteers is important. That they just try to do whatever needs to be done so that people can have a certain state of wellbeing (Informant 11, PS professional).* Another informant described volunteers being very good at what they are doing as ;*"People who are capable of listening, adopt new information, people who know their limits, have their own inner resources, sense of humour, knowledge, respect for other people. That's the basics" (Informant 6, PS professional).* By "knowing heir own limits" the informants was referring to the importance of volunteers being sensitive to their own capabilities and capacity, in order to prevent them from being overwhelmed and exhausted by their tasks and responsibilities. Several PS professionals mentioned to carefully look after the volunteers, and make sure they were not worn by the workload, was described an important task for the PS delegate. Informants stressed the importance to be aware that the volunteers also had been affected by the disastrous event.

To form an understanding of how the environmental and cultural context, and psychosocial wellbeing influence existing feeding practices, in cooperation with PS delegates, was highlighted as one important function of local volunteers. Since the volunteers most likely have experienced the disastrous event themselves, they also have first hand information about how the disaster has influenced the environmental and cultural context. Additionally will volunteers probably speak the language, understand social customs, traditions and beliefs of disaster affected populations and

communities. Hence, the volunteers are perceived to have an essential role to, in cooperation with the PS delegate, form an understanding of the psychosocial wellbeing and existing feeding practices. This can be compared to how the informants spoke about the informants as “the most important people”;

"The volunteers are the most important people when we have an intervention in an ERU. So these are the people that will give us information, and they would tell us what are the local practices before an emergency and after an emergency. Because we will see what is common practice in general, and what has changed, where it might be some needs because of the disaster or crisis event. And there is where we might need to have some intervention" (Informant 3, PS delegate).

As the quotation illustrates, asking the volunteers to share their knowledge about local practices, both before and after, the disastrous event was perceived important by PS professionals and delegates. The volunteers were further explained to have a potential role in gathering information about existing eating habits, food traditions and feeding related behaviour and challenges. This may further be a pointer of how to design PSS activities, and what issues related to feeding practices to possibly address. The following quote highlights why the information shared by volunteers is important; *“The psychosocial support volunteer can go into the communities and bring back information that is very useful to the mobile clinic, and you can for example ask them to go and identify barriers towards behaviour change, like; why aren’t women breastfeeding? Why do men keep on beating their wives? Like, what are the barriers, is it a cultural belief? That, if they don’t do it, something bad will happen. What are the barriers to behaviour change? (Informant 11, PS professional)*

As discussed in stage 2, the above quote also refers to how the volunteers might share knowledge to help explain underlying causes of certain behaviours related to existing feeding practices. Thus, may volunteers be a major source of information helping the PS delegates to understand underlying causes of certain behaviours, which furthermore may determine how, and for whom, PSS activities are designed. However, it is relevant to question if it exist an overall assumption that behaviours should be changed and recommended IYCF practices be promoted. A question relevant to compare to the two aspects of communication discussed in stage 2 and 3, to “learn from” and to “educate”. Is PSS about understanding underlying causes of certain behaviour, or collecting enough information in order to possibly change the behaviour? One explanation may be that if the behaviour is perceived harmful for the psychosocial wellbeing, or endangering children's chances of survival and development, delegates may see a need for, and be more willing, to address such behaviour. Then, the role of volunteers might be to share information about harmful behaviours; possible underlying causes and to whom the behaviour is harmful. One PS professional highlighted that the reason why a

woman decides to stop breastfeeding her two month old infant, might not be because she doesn't understand the importance of breastfeeding, but rather depend on other underlying causes such as roles, responsibilities and relationships within the family. The informant therefore argued that it might be more relevant to design a PSS activity that targets men, fathers and husbands. This view may be a main key to design PSS activities, that addresses underlying causes of unfavourable behaviours related to feeding practices, and thus be more effective and have positive public health outcomes. As suggested, such underlying beliefs shared by volunteers, may form a basis for how PS delegates, possibly in cooperation with CHM delegates can design PSS activities that support feeding practices.

4.5.2 Community volunteers in psychosocial support activities

Volunteers were mentioned by the RCRC PS professionals to have the main role in PSS activities and the ones mainly interacting with disaster affected individuals and communities, which is in accordance with the described role of volunteers in the psychosocial support module delegate manual (Yigen et al., 2012). PS professionals suggested that volunteers could be trained to do different tasks to support feeding practices. One informant underlined that sometimes the volunteers have more knowledge, and skills within a specific area than the delegate. Hence, the possibility for recruited volunteers to have competencies within the field of child nutrition is present. The possibility for volunteers to have competencies which is opposed to the PS delegate or other ERU delegates might potentially constitute a challenge, or a mismatch between the perspectives of volunteers and delegates. According to Yigen et al. (2012), should an approximate number of 15-20 volunteers be recruited to facilitate activities within the psychosocial support module. The informants gave various examples of how volunteers possibly can support feeding practices, which can be related to activities described in stage 3. Suggestively the volunteers could; lead support groups for caregivers of infants and young children, do home visits to families with children under the age of 2 years, provide information and have informal educational sessions about feeding practices. Bush and Dent (2013) describe three areas where community volunteers may have a central role in future disaster response operations related to nutrition; 1. In preventing risk of undernutrition by increasing the awareness of recommended IYCF practices within communities, 2. Contribute to preparedness and resilience by strengthening existing systems aiming to both prevent and treat child undernutrition in future disastrous events, and 3. Bring attention to and warn for aggravations and changes related to child undernutrition within their communities. Bush and Dent (2013) further argues that to possibly address multiple causes of child undernutrition, integration of different sectors are required, where volunteers may be a vital link between local health actors and ERUs such as, PSS, CHM, water and sanitation, and pediatric wards at the referral hospital.

4.5.3 Community volunteers, a key to sustainability

Volunteers motivation and role in their local community might influence the possibility for PSS activities to be sustainable in communities, and thus have positive public health outcomes. This may be described as a reason to why the informants speaks about the volunteers as the most important means for PSS activities to sustain in the communities where they have been launched. Sustainability was discussed in previous stage 4, and can be linked to the volunteers. Thus, if volunteers have ownership of the PSS activities in which they have been involved to design and launch, the probability of the activities continuing may increase. Another aspect mentioned by the informants is that volunteers may have obtained new knowledge about recommended IYCF practices and PSS, trough training and cooperation with PS delegates and other ERU delegates or volunteers. So, when the ERU delegates leave, the obtained knowledge may remain in communities trough the volunteers, and have positive public health outcomes;

"If we have a group of volunteers who are ready to continue devoting their time to the community, then we have a sustainable provision of psychosocial support services in the community. Either in "normal" times, but you can also train them to intervene in times of emergencies. So clearly, I link sustainability to a knowledge that stays in the community through the volunteer, but also to a non costly network of, I will call them practitioners as well. That creates sustainability (Informant 5, PS delegate).

Voluntary service is one of the seven fundamental principles of the Red Cross Red Crescent Movement stating that; "*It is a voluntary relief movement not prompted in any manner by desire for gain" (IFRC, 2012b, p. 4).* The volunteers are furthermore mentioned as one of the Movement's main strengths together with community-based expertise, independence and neutrality (IFRC, 2012b). The informants were asked to express their beliefs about volunteers' main motivation to provide their services, and to give of their time in disaster response operations. The answers revealed interesting perspectives on volunteerism. Some informants mentioned motivation for volunteers to provide their time and service in terms of; a desire to give back to their communities, creating a sense of meaningfulness by helping others, and a way to connect with their inner resources. Another emerging aspect was the divergent perceptions of payment, or remuneration, of the locally recruited volunteers during disaster response operations. On one hand was the remuneration described as a factor of motivation, and on the other hand mentioned as a risk of destroying long-term motivation, the voluntary spirit and local economy. In post disaster contexts, different humanitarian organizations may compete to recruit human resources, local staff and volunteers to providing services to those affected more efficiently. Therefore, may the size of the remuneration be a way to recruit volunteers more successfully, both in terms of number and desired competencies. In what way, and how much, the volunteers are compensated was explained to depend on the guidelines of

the operating NS. The Red Cross Red Crescent Movement was namely paying volunteers less than other organizations, but volunteers were still paid, often on daily or weekly basis, during the time for disaster response operations. Furthermore, an informant called for all humanitarian agencies and organizations to follow a joint interagency agreement on how to pay, or compensate, volunteers during disaster response operations. Additionally, the informant underlined long-term challenges regarding paying volunteers as much as doubled the minimum salary in the country. This was described a risk to ruin both local economy, voluntary spirit and thus decrease the chances of sustainable activities and positive public health outcomes. In a recent disaster response operation, the PS professionals decided to stop the payment of the volunteers because; *"it was undermining any hope for future involvement of those volunteers in the community. It was killing any kind of spirit of voluntarism in the community" (Informant 5, PS delegate).* The informant further presented a suggested solution on how to compensate community volunteers for the services they are providing during disaster response and ERU deployment; *I think we have two options, either we don't ask the volunteers to do eight hours a day, and they stay volunteers, and we only covers for example transportation costs and food. If we want them for eight hours a day, then we need to contract them. To really make the difference between them being employees during the emergency and then being volunteers afterwards" (Informant 5, PS delegate)*

Another concern about volunteers that arose in the interviews was the "drop out" of volunteers after approximately three months into the response, potentially endangering the possibility for activities to be sustainable. One given reason for volunteers leaving the activities, or services they are involved in, is that they get other jobs. Bush and Dent (2013) highlight the importance to understand what is motivating volunteers to retain in activities, which might be different from one disaster context to another. Supervision, recognition and coaching are described as important ways to reward the volunteers and enhance motivation (Bush & Dent, 2013). Although, as some informants expressed, may the volunteers' motivation to continue their services within their own communities after the emergency response is over, decrease when they suddenly are expected to provide these services unpaid. One PS delegate presented her view on how activities may continue and sustain, after the PS delegate has left the post disaster context; *"I think the secret is the training of the volunteer. Making sure you have a big enough pool of volunteers that can continue the activities once you have left. And that there is ongoing training and support" (Informant 7, PS delegate).* By "ongoing training and support" the informant referred to the ongoing training and supervision of volunteers during the time of deployment of the psychosocial support module.

In disaster contexts, RCRC community volunteers are expressed to be the "most important people" and the "key to sustainability". Because the volunteers are perceived to be the link between ERU delegates and the disaster affected communities and individuals. Additionally, volunteers share their

experiences and perspectives on how the disastrous event may have caused greater challenges regarding both feeding practices and psychosocial wellbeing. The informants stressed that the effect and sustainability of PSS activities, are highly dependent on the involvement and motivation of the volunteers. Since the volunteers stays when the PS delegates leaves and the disaster funding is at end, sustainability of activities and positive public health outcomes may be dependent on the volunteers' motivation, ownership and desire to continue the activities. Although, what motivates the volunteers to spend time and provide their services might vary. The informants expressed the role of community volunteers as being central to understand the post disaster context, and to provide services aiming to be community-based, and facilitate participation in a way that is locally accepted. A perspective relevant to compare with a context sensitive approach, whereas the delegates' and the community members' perception of "doing the right thing" may approach each other, through the local volunteers, in disaster response interventions in contexts of adversity.

5. Conclusion

The overall purpose of this study is to contribute to the body of knowledge of how to address feeding practices for infants and young children, prevent child undernutrition and promote child survival, by applying psychosocial support in post disaster contexts. The specific objective is to map professionals' perspectives and perceptions of to how apply the ERU psychosocial support module to address; understand and support feeding practices for infants and young children in post disaster contexts. The study also has the intention to explore the perceived role of community volunteers within psychosocial support activities during ERU deployments. Guided by an ethnographic research perspective, the data material was collected trough 15 semi-structured interviews with key professionals experienced in PSS, IYCF, Baby Tents, and humanitarian disaster response. An inductive three step coding resulted in five main categories, illustrated in a model of four stages and one overarching dimension; representing the informants' perceptions and perspectives of the research questions. The study findings are interpreted trough a hermeneutic lens, in light of chosen theoretical framework; the biocultural perspective on human diet and nutrition, and the theoretical descriptions of PSS and IYCF. Baby Tents are applied as a guiding example of an activity where the professional fields of PSS and IYCF may be combined in post disaster contexts. The four stages and the one overarching dimension highlights each of the five research questions respectively.

The first stage presents the professionals' perceptions of how PS delegates may be prepared to address feeding practices for infants and young children when deployed to post disaster contexts. One central aspect in this stage is how PS delegates possibly can be equipped with skills to address feeding practices by raising awareness about child undernutrition and recommended IYCF practices in the training curricula, and the delegate manual. The professional fields of IYCF and PSS are explored and the imaginary circles introduced. The second stage highlights how PSS is explained to be relevant and useful to explore and understand how feeding practices are influenced by environmental and cultural elements in post disaster contexts. One main aspect is how post disaster contexts includes "barriers", and how a "window of opportunity" may be used to address these barriers by applying PSS. The third stage explores how activities may be designed within the psychosocial support module to support feeding practices for infants and young children. To create a safe environment, and have a community-based approach are central aspects in PSS, which may form a basis for how to design psychosocial support activities with the intention to support feeding practices, possibly by interdisciplinary cooperation. In the fourth stage, aspects influencing a successful implementation of PSS activities, in relation to expectations of achievements within the ERU timeframe, sustainability and positive public health outcomes, are presented. The informants expressed it to be challenging to evaluate effect of the activities. The overarching dimension five, presents the perceived role of community volunteers and their central position in PSS activities.

Volunteers were described to be the "most important people" and a "key to sustainability", because volunteers comes from the disaster affected communities and can share valuable knowledge of how the affected populations' psychosocial wellbeing and feeding practices has been affected by the disastrous event, and additionally are the ones running PSS activities.

Several emerging perspectives are discussed, and disclose both divergence and consensus in the data material. A post disaster context can be described as a context of adversity, creating hardship for those affected; where a context sensitive approach emphasises disaster response interventions to be in accordance with the culture, values and social norms of those affected. To address feeding practices by applying the psychosocial support module appears to have two main aspects: 1. To explore and understand how the post disaster context with its culture, values and social norms influence caregivers' psychosocial wellbeing, and how infants and young children are fed; 2. To use "the window of opportunity" to intervene, by taking a context sensitive approach to support feeding practices and promote the psychosocial wellbeing of caregivers and their children. These two aspects can further be compared to the two highlighted perspectives of communication, to "learn from" and to "educate". The two communicative perspectives; to "learn from" and to "educate", are somewhat contradictory and disclose a clear tension in the data material. Though, psychosocial support professionals expressed a scepticism towards dissemination of information, but at the same time suggested to use the "window of opportunity" to intervene and educate. Some psychosocial support delegates were reluctant to if addressing feeding practices really was their responsibility, but rather the responsibility of medically trained ERU delegates. To raise awareness of the public health challenge of child undernutrition and recommended IYCF practices in psychosocial support training material and publications, add basic technical and practical training of how to address feeding practices, and clarify responsibilities and task allocation, might be ways to prepare psychosocial support delegates to support feeding practices in future ERU deployments. From a biocultural perspective it is important to pay attention to how existing feeding practices in a particular post disaster context have evolved trough generations and derives from what is internationally recommended. Hence, to possibly support and promote internationally recommended IYCF practices, it may be essential to understand the underlying causes of feeding behaviours, and why caregivers chooses to feed their infants and young children in certain ways. The study findings showed that psychosocial support may be in a prominent position to understand the specific environment in which child growth and development occurs, and how the post disaster context have caused further, or new challenges to caregivers' psychosocial wellbeing and abilities to care for, and feed their infants and young children. Psychosocial support activities and Baby Tents share commonalities of what they aim to achieve, by creating a safe environment with the intention to facilitate behaviour change and promote coping, adaptation and psychosocial wellbeing. Mothers

were explained to have a potential to spread information about feeding practices among other mothers, which is based on the assumption that when people gather, they start to discuss, can support each other and share experiences and knowledge. This may be seen as an argument to utilise the psychosocial support module, as a safe and supportive environment, easy accessible and attractive to support feeding practices. Different levels of intervention to address feeding practices in psychosocial support activities were presented trough a comparison with the Intervention pyramid for mental health and psychosocial support in emergencies (IASC, 2007); the first layers are described to be more community-based, having a wider target group, where the top layers are specialised with a narrower targeting of groups individuals in need of additional support. These layers are relevant to take into consideration in order define how the professional field, and capacity, of psychosocial support delegates may be applied to support feeding practices in future ERU deployments. Interdisciplinary cooperation and to combine professional perspectives, were suggested repeatedly as means to address feeding practices in psychosocial support activities. Furthermore, may the psychosocial support community-based approach be central for the activities to be both sustainable and context sensitive. The cooperation with local community volunteers in psychosocial support activities are essential, but for the activities to be sustainable and have positive public health outcomes, beyond the limited timeframe of the ERU response, ownership and motivation for long-term voluntary commitment may be required.

This study has mapped professionals' perceptions and perspectives of how to possibly apply the psychosocial support module to address feeding practices for infants and young children in post disaster contexts. The presented study findings highlights some prominent aspects, which may be perceived a starting point to further discuss its practical implication in future ERU deployments. However, there are most likely aspects of significance for the study objective, which have not been highlighted in this study. I therefore stress the importance to use the findings with care when applying the psychosocial support module to address feeding practices for infants and young children. My further recommendation is for the Red Cross Red Crescent Movement Disaster Response management to consider how to possibly implement the study findings in practice, and furthermore evaluate its applicability.

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Appendix 1. Interview theme guide Psychosocial Support

”Psychosocial support, infant and young child feeding and Baby Friendly tents in disasters”

Background and study objective

Malnutrition is a major risk factor causing disease and death among millions of children worldwide every year. In a recent review of the Red Cross Movement’s opportunities to address malnutrition in their emergency health programming, the Psychosocial support component of the Emergency Response Unit (ERU) was identified to having a potential in strengthening and supporting feeding practices for infants and young children. As suggested, this could be done by adapting the Psychosocial support component to provide services similar to Baby Friendly tents.

The aim of the study is to investigate how to combine psychosocial support activities and the practice of Baby Friendly tents into the Psychosocial Support component of the Red Cross Emergency Response Unit (ERU).This study will also explore the role of the Red Cross Red Crescent community volunteer within nutritional and psychosocial activities in disaster settings.

The results might be used to gain a wider understanding of how to successfully combine the psychosocial support and the nutrition perspectives, when responding to a disaster affected community, with the aim to: Support child development by strengthening the psychosocial well-being among caregivers to small children, and enhance child survival by supporting appropriate feeding practices.

The interviews will also be used to further investigate if the experiences of the informants is in accordance with central agency documents guiding emergency response.

Introduction

You will be asked to give a brief presentation of your experiences working with psychosocial support in disaster settings.

Interview themes A-I

(The themes are to be seen only as guidance of topics desired to be covered during the interview. Other themes and topics might also emerge during the interview depending on your unique knowledge and experiences)

A: Understanding terms and concepts

- The meaning of psychosocial support

- Aim and objective of psychosocial support activities
- Main target group of psychosocial support activities - how to prioritize

B: The disaster context and psychosocial support activities

- Psychosocial support activities and contributions to the affected people within the disaster contexts
- Possible links to activities supporting feeding practices
- Type of disaster (rapid or slow onset critical events) affecting priorities and needs
- Possible activities considering the psychosocial support tent/area vs outreach activities

C: The disaster affected community and environment

- Local culture, traditions, values (and link to food and eating/feeding behaviors)
- Links between emergency response, psychosocial support and the community
- Possible links to nutrition support activities
- Outreach activities and psychosocial support

D: Cooperation and coordination

- Cooperation and coordination with the National Society, Ministries of Health, other NGO's and other local health authorities - possibilities and constraints
- Possible cooperation and coordination with other ERU components or professionals to support nutrition activities (CHM, BHC, WatSan, Field hospitals)

E: Child-Caregiver relationship

- Link between child development, the caregiver's well-being and nutritional status
- The significance of the child-caregiver relationship in psychosocial support activities

F: Sustainability

- Factors of success, to keep the activity going when the emergency response is over
- Added value to the community in a longterm perspective

G: Knowledge and skills of the delegate

- Skills and competencies needed to give psychosocial support to caregivers with small children - possible link to nutrition
- Additional skills, knowledge and training needed to support feeding practices for small children (< 2 years)

H: The role of the community volunteers in giving psychosocial support

- How to involve the network of community volunteers and use their potential in psychosocial support activities (and possible links to nutrition activities)
- Training, supervision and support of volunteers
- The link between the volunteers, the community and other stakeholders/sectors

I: Important agency documents guiding psychosocial support in emergency response

- Any documents of particular importance giving guidance on how to give psychosocial support in disasters (for example handbooks, strategies, guidelines)
- Accordance between guiding documents and your experiences from the field

Summary

The interviewer will give a short summary of the interview. You are welcome to add or further highlight important topics that have been missed or overseen.

Thank you

Your contribution to this public health master thesis is very much appreciated. Thank you for sharing your valuable knowledge and experiences. I hope it will be okay if I contact you again if there is a need to follow up something discussed in the interview.

On the behalf of the Norwegian University of Life Sciences and the Norwegian Red Cross Disaster Management Unit, thank you for your cooperation!

Josefine Vacker

Appendix 2. Interview theme guide IYCF and Baby Tents

”Psychosocial support, infant and young child feeding and Baby Friendly tents in disasters”

Background and study objective

Malnutrition is a major risk factor causing disease and death among millions of children worldwide every year. In a recent review of the Red Cross Movement’s opportunities to address malnutrition in their emergency health programming, the Psychosocial support component of the Emergency Response Unit (ERU) was identified to having a potential in strengthening and supporting feeding practices for infants and young children. As suggested, this could be done by adapting the Psychosocial support component to provide services similar to Baby (Friendly) tents.

The aim of the study is to investigate how to combine psychosocial support activities and the practice of Baby Friendly tents into the Psychosocial Support component of the Red Cross Emergency Response Unit (ERU).This study will also explore the role of the Red Cross Red Crescent community volunteer within nutritional and psychosocial activities in disaster settings.

The results might be used to gain a wider understanding of how to successfully combine the psychosocial support and the nutrition perspectives, when responding to a disaster affected community, with the aim to: Support child development by strengthening the psychosocial well-being among caregivers to infants and young children under the age of two, and enhance child survival by supporting appropriate feeding practices.

The interviews will also be used to further investigate if the experiences of the informants is in accordance with central agency documents guiding emergency response.

Introduction

You will be asked to give a brief presentation of your experiences working with supporting feeding practices for children under the age of two years in disaster settings or major critical events.

Interview themes A-H

(The themes are to be seen only as guidance of topics desired to be covered during the interview. Other themes and topics might also emerge during the interview depending on your unique knowledge and experiences)

A: Understanding terms and concepts

- The meaning of the term Infant and Young Child Feeding in Emergencies (IYCF-E)
- Aim and objective of the Baby tents/IYCF-E activities
- Main target group for Baby tents/IYCF-E - how to prioritize

B: The disaster affected environment and activities to support feeding practices

- Linking psychosocial support to activities supporting feeding practices and behaviours - correlations and connections between psychosocial support and feeding practices
- Type of disaster (rapid or slow onset critical events) affecting priorities and needs
- Baby tent/area vs outreach/community based nutrition activities - when to do what
- Local culture, traditions, values (and link to food and eating/feeding behaviors)
- Links between emergency response, malnutrition and the community
- Understanding barriers to appropriate feeding practices within a community

C: Cooperation and coordination

- Cooperation and coordination with the ministries of health, other NGO's, The Red Cross movement and other local health authorities

D: Child-Caregiver relationship

- Link between child development, the caregiver's well-being and nutritional status
- The significance of the child-caregiver relationship in the Baby tents/IYCF-E

E: Sustainability

- Factors of success, to keep the activity going when the emergency response is over
- Added value to the community in a longterm perspective

F: Knowledge and skills of the delegate

- Skills and competencies needed to give psychosocial support to caregivers with young children and the link to support feeding practices - what do the staff need to know?
- Additional skills, knowledge and training needed for a delegate without knowledge in nutrition to support feeding practices for young children (< 2 years)
- Baby tent: PSS/Nutrition and division of responsibilities and tasks
- Nutrition and PSS - a common area of expertise?

G: The role of the community volunteers in giving psychosocial support and supporting feeding practices

- How to involve the network of community volunteers and use their potential in psychosocial support activities and in nutrition activities
- Training, supervision and support of volunteers

H: Important agency documents guiding the practice of Baby tents/IYCF-E/ appropriate feeding practices in emergency response

- Any documents of particular importance giving guidance on how run the Baby tents and IYCF-E activities (for example handbooks, strategies, guidelines)
- Accordance between guiding documents and your experiences from the field

Thank you

Your contribution to this public health master thesis is very much appreciated. Thank you for sharing your valuable knowledge and experiences. I hope it will be okay if I contact you again if there is a need to follow up on something discussed in the interview.

On the behalf of the Norwegian University of Life Sciences and the Norwegian Red Cross Disaster Management Unit, thank you for your cooperation!

Josefine Vacker

Appendix 3. Letter of consent

Request for your participation in a master's thesis assignment

"Psychosocial support, infant and young child feeding and Baby Friendly tents in disasters"

Background and study objective

This assignment is a part of my master's degree in Public Health at the Norwegian University of Life Sciences. The thesis will be published at the Department of International Environment and Development studies and conducted in cooperation with the Norwegian Red Cross Disaster Management unit, International Department.

The aim of the study is to investigate how to combine psychosocial support activitites and the practice of Baby Friendly tents into the Psychosocial Support component of the Red Cross Emergency Response Unit (ERU).This study will also explore the role of the Red Cross Red Crescent community volunteer within nutritional and psychosocial interventions in disaster settings.

The results might be used to gain a wider understanding in how to successfully implement interventions in a disaster affected community with the aim to:

- Strengthen psychosocial well-being among caregivers to small children and enhance child development.
- Support child survival by appropriate feeding practices.

The data will be collected trough a study of central agency documents containing technical guidance, frameworks for implementation and instruments for action **and** interviews with informants with expertise in Infant and Young Child Feeding in Emergencies [IYCF-E], Baby Friendly tents and Psychosocial Support in Emergencies.

Implications of your participation

The interviews will be conducted via Skype or face-to-face in the time period of December 2013 to January 2014. The interviews will be tape recorded and the student will be taking notes during the interviews. Estimated time for each interview is 1-1.5 hours. The interviews aim to highlight constraints and possibilities when combining nutritional and psychosocial interventions, if practical field experience is in accordance with technical guidance found central agency documents, what considerations and contextual factors that need to be taken into account when implementing interventions in disaster affected populations and the role of the community volunteers regarding psychosocial support and nutrition. On request, the interview theme guide can be sent in advance of the interview.

How to protect personal details and information?

All personal information and details about you will be handled confidentially. Only the student and supervisors will have access to personal information about study informants. The interview recordings and personal information will be stored separately and be deleted after completion of the master's thesis.

The master's thesis assignment is expected to be completed 15th of May 2014 and published in June 2014.

Voluntary participation

Participation in this study is voluntary and you have the right to withdraw from the study at any time. Information about you and collected data from your interview will then be deleted. The study is approved by the Norwegian University of Life sciences and the Norwegian Social Science Data Services (NSD).

If you do agree to be interviewed, please sign the **Declaration of study participation** (see below) and send it to josefine.vacker@gmail.com. Please specify your availability for the interview in the email. Preferably from December 11th, 2013 - February 7th, 2014.

If you have any questions about the study, do not hesitate to contact me or my supervisors.

Supervisor and project responsible

Esben Leifsen
Associate Professor
University for Life Sciences
email: esben.leifsen@umb.no
cellphone: +4793049705

Co-supervisor

Tonje Tingberg
Coordinator- Public Health in emergencies
Norwegian Red Cross
Disaster Management Unit
email: tonje.tingberg@redcross.no
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Kind Regards

Josefine Vacker

Asalveien 8
3118 Tønsberg, Norway
email: josefine.vacker@gmail.com
cellphone: +4741374023
Skype: josefinevacker

Declaration of study participation

I have received information about this master's thesis assignment on how to combine psychosocial support with nutritional interventions in Red Cross emergency response, and give my consent to participate in the study

---(Date, signature)

Appendix 4. NSD approval

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
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www.nsd.uib.no
Org.nr. 985 321 884

Esben Leifsen
Institutt for internasjonale miljø- og utviklingsstudier (Noragric) UMB
Boks 5003
1432 ÅS

Vår dato: 13.11.2013 Vår ref: 35925 / 2 / MSS Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 15.10.2013. Meldingen gjelder prosjektet:

35925	*How to respond to nutritional needs and promote child survival trough psychosocial support in disasters*
Behandlingsansvarlig	*Universitetet for miljø- og biovitenskap, ved institusjonens øverste leder*
Daglig ansvarlig	*Esben Leifsen*
Student	*Josefine Vacker*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 19.06.2014, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Marie Strand Schildmann

Kontaktperson: Marie Strand Schildmann tlf: 55 58 31 52
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / *District Offices*:
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 35925

Formålet med prosjektet er å undersøke hvordan man kan svare på ernæringsmessige behov og fremme barns overlevelse gjennom psykososial støtte i katastrofer.

Datamaterialet innhentes gjennom personlige intervju av fagpersoner.

Ifølge prosjektmeldingen skal det innhentes skriftlig samtykke basert på skriftlig informasjon om prosjektet og behandling av personopplysninger. Personvernombudet finner informasjonsskrivet tilfredsstillende utformet i henhold til personopplysningslovens vilkår, forutsatt at det påføres navn og kontaktopplysninger til daglig ansvarlig/veileder.

Innsamlede opplysninger registreres på privat pc. Personvernombudet legger til grunn at veileder og student setter seg inn i og etterfølger Universitetet for miljø- og biovitenskap sine interne rutiner for datasikkerhet, spesielt med tanke på bruk av privat pc til oppbevaring av personidentifiserende data.

Prosjektet skal avsluttes 19.06.2014 og innsamlede opplysninger skal da anonymiseres og lydopptak slettes. Anonymisering innebærer at direkte personidentifiserende opplysninger som navn/koblingsnøkkel slettes, og at indirekte personidentifiserende opplysninger (sammenstilling av bakgrunnsopplysninger som f.eks. yrke, alder, kjønn) fjernes eller grovkategoriseres slik at ingen enkeltpersoner kan gjenkjennes i materialet.

Norwegian University
of Life Sciences

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