Nutrition

This chapter explains how to integrate gender equality into nutrition programming. You can find information on why it is important to incorporate gender equality in nutrition programming as well as key standards and resources for future reference.

The chapter begins with an overall checklist which explains key actions for a nutrition programme which need to be carried out at each stage of the Humanitarian Programme Cycle (HPC). After this checklist, you can find more detail on how to undertake gender equality programming in each phase of the HPC. This includes practical information on how to carry out a gender analysis, how to use the gender analysis from the design through to implementation, monitoring and review and how to incorporate key approaches of coordination, participation, GBV prevention and mitigation, gender-adapted assistance and a transformative approach into each one of those phases. Relevant examples from the field are used to illustrate what this can look like in practice.

Why is it important to incorporate gender equality in nutrition programming?

Humanitarian crises have different impacts on the levels of nutrition available to women, girls, men and boys. Gender inequality for women and girls hampers their ability to access adequate and consistent amounts of nutritious food to meet their own needs as well as those of their families. Prevailing social norms mean that where food is in short supply, women and girls are likely to reduce their food intake, while men and boys are favoured. During a humanitarian crisis, the links between nutrition and risk of GBV can become more pronounced. Constraints on women's mobility can also hamper their access to food distribution sites.

Pregnant or lactating women may be disproportionately affected by undernutrition due to their increased physiological nutritional needs. Single men and boys who have been separated from their families can also be at risk of undernutrition if they are unable to cook or access food distribution.

Increased availability of nutritious food coupled with improved access to adequate health and water, sanitation and hygiene (WASH) services reduces levels of acute and chronic malnutrition for women, girls, men and boys.

Effectively integrating gender equality into nutrition will achieve the following goals:

- **Protect the right to security, nutrition and dignity for all and build safer communities.** By meeting the nutrition needs of all women, girls, men and boys, programmes reduce the need for crisis-affected people to engage in risky coping strategies such as reducing their nutritional intake or undertaking transactional sex. This in turn reduces associated risks of GBV, exploitation, social stigma, unwanted pregnancies and sexually transmitted infections such as HIV/AIDS.
- **Improve outcomes for children born in crisis contexts.** Prioritising nutrition support for pregnant and lactating mothers and advocating breastfeeding practices provides the best nutritional and developmental prospects for children born in crisis contexts. In addition, helping families to meet their household nutrition needs can reduce the practice of forced child marriage for girls, a coping strategy to access more food for girls and their families.
- **Respect the right to meaningful participation.** Consulting women, girls, men and boys without discrimination on the provision of nutrition services and facilities upholds rights and ensures appropriate service provision. For example, consultation can lead to the creation of infant and young child feeding centres that provide private spaces for breastfeeding mothers and offer a safe haven from harassment and violence.

Integrating gender equality and nutrition in the Humanitarian Programme Cycle

This section outlines the necessary actions front-line humanitarian actors such as United Nations agencies, local and international NGOs and government agencies need to take to promote gender equality in the nutrition sector at each stage of the HPC.

KEY GENDER EQUALITY ACTIONS FOR NUTRITION PROGRAMMING AT EACH STAGE OF THE HUMANITARIAN PROGRAMME CYCLE

1 Needs assessment and analysis

- Collect and analyse sex-, age- and disability-disaggregated data on needs, priorities and capabilities relating to nutrition.
- Conduct a gender analysis as part of nutrition needs assessments and analyse the findings.

2 Strategic planning

- Integrate gender equality into nutrition programme design for the response, utilizing the findings from the gender analysis and other preparedness data.
- Ensure a demonstrable and logical link between the gender-specific needs identified for the nutrition sector, project activities and tracked outcomes.
- Apply gender markers to nutrition programme designs for the response.

3 Resource mobilization

- Apply gender markers to nutrition programmes in the response.
- Include information and key messages on gender and the nutrition sector for inclusion in the initial assessment reports to influence funding priorities.
- Report regularly on resource gaps on gender within the nutrition sector to donors and other humanitarian stakeholders.

4 Implementation and monitoring

- Implement nutrition programmes which integrate gender equality and inform women, girls, men and boys of the available resources and how to influence the project.
- Develop and maintain feedback mechanisms for women, girls, men and boys as part of nutrition projects.
- Apply gender markers to nutrition programmes in the response.
- Monitor the access to nutrition assistance by women, girls, men and boys and develop indicators designed to measure change for women and girls or men and boys based on the assessed gaps and dynamics.

5 Gender operational peer review and evaluation

- Review projects within the nutrition sector and response plans. Assess which women and girls, boys and men were effectively reached and which were not and why.
- Share good practices around the usage of gender markers and address gaps.

1 Needs assessment and analysis

Gender analysis takes place at the assessment phase and should continue through to the monitoring and evaluation phase with information collected throughout the programme cycle. The rapid gender analysis tool in section B, pages 30–39 provides a step-by-step guide on how to undertake a gender analysis at any stage of an emergency. In addition to using sex- and disability-disaggregated dates (SADD), depending on the context, it can be important to disaggregate the data based on other diversity factors, such as ability, ethnicity, language spoken, level of income or education.

Gender analysis is key for the nutrition sector. In some contexts, the decision to bring a child to medical/nutrition consultation or have a child hospitalized (with often implied disruption in the family's life, as the mother or elder children will need to stay by the child's side) is often taken by the head of household (father) or elders (mother-in-law or mother of the head of household), without the mother of the child being able to express her own will on the matter. Yet, it is mothers who mostly benefit from health education sessions and are capacitated to detect health or nutrition issues. To tackle this issue, it is therefore crucial to empower women in these communities to have a say on these issues, and to include decision makers at the household level in information/awareness-raising sessions on health and nutrition.

SADD are a core component of any gender analysis and essential for monitoring and measuring outcomes. To be effective, SADD must be both collected and analysed to inform programming. In circumstances where collection of SADD is difficult, estimates can be provided based on national and international statistics, data gathered by other humanitarian and development actors or through small sample surveys. When SADD are not available or very outdated, there are methods can be used to calculate it (see section B, page 43). For the nutrition sector, it is important to gather information on the functioning of the health system as food responses are often delivered through existing health structures. Data should be disaggregated by gender and age, e.g., for infants 0–6 months, 6–12 months and 12–24 months and for people over age 60, as older men and women can be at high risk of malnutrition but are often excluded from nutrition programmes. These data can be used to develop an overview of nutrition issues in the affected area by age and gender (including populations at higher risks).

The following table summarizes the key moments during an emergency response where gender analysis should be carried out and what kind of deliverables should be produced. These should be produced at the level of the cluster (with the cluster lead accountable) and/or individual agency (with the emergency response coordinator accountable).

KEY ASSESSMENT TOOLS:

- IASC Gender Marker Tip Sheet: https://tinyurl.com/bodlmcg

KEY ACTIVITIES FOR GENDER ANALYSIS DURING A HUMANITARIAN RESPONSE

TIMEFRAME	ACTIVITY	DELIVERABLE
Preparedness	Develop gender snapshot/overview for the country; review pre-existing gender analysis from NGOs, the government and United Nations agencies.	Snapshot (6 pager) https://tinyurl.com/ycwk3r7z Infographic
First week of a rapid-onset emergency	Review of gender snapshot prepared before the emergency and edited as necessary. Circulate to all emergency response staff for induction. Identify opportunities for coordination with existing organizations working on gender issues. Carry out a rapid gender analysis, which can be sectoral or multisectoral, integrating key questions for the nutrition sector (see later on in this chapter for examples). Conduct sectoral or multisectoral rapid analysis and consult organizations relevant to the sector.	Briefing note (2 pager) identifying strategic entry points for linking humanitarian programming to existing gender equality programming https://tinyurl.com/yao5d8vs Map and contact details of organizations working on gender in the country Rapid gender analysis report https://tinyurl.com/y9fx5r3s
3 to 4 weeks after the rapid analysis	Carry out a **sectoral gender analysis** adapting existing needs analysis tools and using the types of questions suggested later on in this chapter. Carry out a gender-specific analysis of data collected in the needs assessment.	Sectoral gender analysis report https://tinyurl.com/y9xt5h4n

TIMEFRAME	ACTIVITY	DELIVERABLE
2 to 3 months after the start of the emergency response	Identify opportunities for an integrated **comprehensive gender analysis** building on pre-existing gender partnerships. Ensure there is a baseline that captures SADD, access to humanitarian assistance, assets and resources and level of political participation. Analyse the impact of the crisis, changes in ownership patterns, decision-making power, production and reproduction and other issues relating to the sector. Use the gender analysis inputs to inform planning, monitoring and evaluation frameworks including M&E plans, baselines and post-distribution monitoring. Carry out an analysis of internal gender capacities of staff (identify training needs, level of confidence in promoting gender equality, level of knowledge, identified gender skills).	Concrete questions into (potentially ICT-enhanced) questionnaire. Comprehensive gender assessment report https://tinyurl.com/ybyerydk and https://tinyurl.com/ybsqzvjz Inputs to planning, monitoring and evaluation-related documents 1-page questionnaire Survey report Capacity-strengthening plan
6 months after the response (assuming it is a large-scale response with a year-long timeline)	Conduct a gender audit/review of how the humanitarian response is utilizing the gender analysis in the programme, campaigns and internal practices. The report will feed into a gender learning review half way through the response.	Gender equality review report with an executive summary, key findings and recommendations.
1 year or more after the humanitarian response	Conduct an outcome review of the response looking at the response performance on gender equality programming. This needs to be budgeted at the beginning of the response. The report is to be shared in the response evaluation workshop and to be published.	Gender equality outcome evaluation with an executive summary, findings and recommendations. https://tinyurl.com/p5rqgut

Sources for a gender analysis include census data, Demographic and Health surveys, gender analysis reports, humanitarian assessment reports, protection and GBV sector reports, as well as gender country profiles such as those produced by UNICEF, WFP, Save the Children, International Medical Corps and others. These should be supplemented with participatory data collection from women, girls, men and boys affected by the crisis and/or the programme such as through surveys, interviews, community discussions, focus group discussions, transect walks and storytelling.

When collecting information for the nutrition sector, the analysis questions should seek to understand the impact of the crisis on women, girls, men and boys. Standard nutrition assessments can be adapted to put emphasis on gender and the particular experiences, needs, rights and risks facing women, girls, men and boys, LGBTI individuals, people with disabilities, people of different ages and ethnicities and other aspects of diversity. The assessment should ask questions about the needs, roles and dynamics of women, girls, men and boys in relation to the nutrition sector and how the other dimensions of diversity (e.g., disability, sexual orientation, gender identity, caste, religion) intersect with them. Ensure that they align with good practice and key standards on coordination, women's participation and GBV prevention and mitigation as per the table on pages 284–286 on "Key approaches and standards for needs assessment and analysis in nutrition programming".

THE GENDER ANALYSIS FOR THE NUTRITION SECTOR SHOULD ASSESS:

- **Population demographics:** What was the demographic profile of the population disaggregated by sex and age *before the crisis*? What has changed since the crisis or programme began? Look at the number of households and average family size, number of single- and child-headed households by sex and age, number of people by age and sex with specific needs, number of pregnant and lactating women. Are there polygamous family structures?
- **Gender roles:** What were the roles of women, girls, men and boys relating to nutrition before the crisis? How have the roles of women, girls, men and boys relating to nutrition changed since the onset of the crisis? What are the new roles of women, girls, men and boys and how do they interact? How much time do these roles require?
- **Decision-making structures:** What structures did the community use to make decisions relating to nutrition before the crisis and what are these now? Who participates in decision-making spaces? Do women and men have an equal voice? How do adolescent girls and boys participate?
- **Protection:** What protection risks did specific groups of women, girls, men and boys face before the crisis? What information is available about protection risks since the crisis began or the programme started? How do legal frameworks affect gender and protection needs and access to justice?
- **Gendered needs, capacities and aspirations:** What are the nutrition-related needs, capacities and aspirations of women, girls, men and boys in the affected population and/or programme? This should include an assessment of whether nutritional requirements are being met for specific groups, for example, women and girls sometimes eat only after the men and boys and if there is not much food available, they reduce their consumption or go without. It should also include an assessment of breastfeeding practices. Women may fail to breastfeed due to perceptions that breast-milk substitutes are better or because they have neither time nor support.

POSSIBLE QUESTIONS FOR A GENDER ANALYSIS FOR NUTRITION:

- Do sex- and age-disaggregated data on nutritional status or mortality data indicate that women, girls, boys or men are disproportionately affected by poor nutrition? Have women, girls, men or boys been affected differently by the crisis? How do other factors that intersect with gender such as caste or disability have an impact on nutrition status?
- How does household control over resources impact on who decides what is eaten and how much within the family? Do certain members of the family eat first and most? Who determines household spending on food? How do socio-cultural practices affect the nutritional status of women, girls, men and boys? Are there differences in breastfeeding practices for girl or boy babies?
- What are the distinct roles of women, girls, men and boys in food collection, storage and cooking? What has changed since the crisis?
- Who is most at risk for nutritional problems? Are the specific nutritional requirements of infants, older people, persons with disabilities, pregnant and lactating women and HIV/AIDS patients being met? What are child feeding practices? What has changed due to the crisis? Do food baskets meet specific needs?
- Are there secluded spaces for breastfeeding, especially in crowded locations or camps? Are they safe to access?
- Do women, girls, men and boys have equal access to food? Are female-headed households accessing sufficient food? Are there any social norms which prevent access for certain genders or ages?
- What are the cooking fuel needs of women, adolescent girls and other at-risk groups?

KEY APPROACHES AND STANDARDS FOR NEEDS ASSESSMENT AND ANALYSIS IN NUTRITION PROGRAMMING

Coordination

GOOD PRACTICE

» Work with women's rights and LGBTI organizations and inter-agency/intersectoral gender working groups (if established) to understand what approaches and solutions other agencies are adopting to provide gender equality in nutrition programming.

» Levels of nutrition among an affected population concern not only food security but are also dependent on the provision of and access to WASH, health (including HIV/AIDS), education, protection and many other humanitarian services.

BE AWARE!

» Be aware of possible biases in information collection and analysis. For instance, if women were not consulted, the identified priorities do not reflect the needs and priorities of the whole community.

Participation

GOOD PRACTICE

» Ensure an equal balance of men and women on the nutrition assessment team to ensure access to women, girls, men and boys. Where feasible, include a gender specialist and protection/GBV specialist as part of the team.

» Look for particular expertise or training by local LGBTI groups where possible to inform the analysis of the particular needs of these groups relating to nutrition.

» Undertake a participatory assessment with women, girls, men and boys. Set up separate focus group discussions and match the sex of humanitarian staff to the sex of the beneficiaries consulted to better identify their capacities and priorities. This approach facilitates a clearer understanding of the differing levels of the beneficiaries consulted to better identify their needs, capacities and priorities relating to nutrition.

» Adopt community-based approaches that build on existing community structures to motivate the participation of women, girls, men and boys in the response.

» Ensure access to childcare to enable the participation of women and girls, who often carry responsibility for care work, throughout the programme cycle.

Participation (continued)

BE AWARE!

» Advertise meetings through accessible media for those with disabilities, low literacy and from linguistic minority groups. Engage female and male translators to assist beneficiaries.

» Be mindful of barriers and commitments (child care, risk of backlash, ease of movement, government ban of open LGBTI population in some cultures, etc.) that can hinder the safe participation of women, girls and LGBTI individuals in community forums.

» Where women, girls, men and boys participate in mixed groups, address any barriers that stem from gender norms such as men's voices carrying more weight.

» Ensure that meeting spaces are safe and accessible for all. Where women's voices cannot be heard, look for other ways to get their opinions and feedback.

» In some contexts, it may be necessary to negotiate with community leaders prior to talking with women community members in order to avoid backlash.

GBV prevention and mitigation

GOOD PRACTICE

» Use this handbook together with the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.

» Train staff on how to refer people to GBV services.

BE AWARE!

» Don't collect information about specific incidents of GBV or prevalence rates without assistance from GBV specialists.

» Be careful not to probe too deeply into culturally sensitive or taboo topics (e.g., gender equality, reproductive health, sexual norms and behaviours, etc.) unless relevant experts are part of the assessment team.

» Always be aware of the ethical guidelines in social research when directly collecting information from vulnerable groups and others.

Gender-adapted assistance

GOOD PRACTICE

» Identify groups with the greatest nutritional support needs and the underlying factors that potentially affect nutritional status, disaggregated by sex and age.

» Assess the barriers to equitable access to nutrition programmes/services, disaggregated by sex and age.

BE AWARE!

» To identify the differentiated needs of women, girls, men and boys, be aware of potential barriers to their participation in the needs assessment (see participation section on pages 284–285 for further advice on this).

Transformative approach

GOOD PRACTICE

» Identify opportunities to challenge structural inequalities between women and men, and to promote women's leadership.

» Invest in targeted action to promote women's leadership, LGBTI rights and reduction of GBV.

BE AWARE!

» Ensure that any negative effects of actions within the nutrition programme that challenge gender norms are analysed in order to mitigate them and to ensure the programme upholds the "do no harm" principle (see section B, page 88 for more information on this concept).

2 Strategic planning

Once the needs and vulnerabilities of all members of the crisis-affected population have been identified during the needs assessment and analysis phase of the HPC, this data and information can be used to strategically plan the response intended to address them.

Using the information and data gathered through the gender analysis process, the programme planner can establish a demonstrable and logical link between the programme activities and their intended results in the nutrition sector, thus ensuring that the identified needs are addressed.

The strategic planning should also take into account the key approaches explained in the previous HPC phase (needs assessment and analysis) of coordination, participation, GBV prevention and mitigation and transformative approach. If these have been considered adequately in that phase together with the gender analysis, the planning should be adequately informed.

Gender markers should also be applied at this phase (see section B, pages 52–53 for more information).

At the strategic planning stage, indicators should be developed to measure change for women, girls, men and boys.

Use sex- and age-sensitive indicators to measure if all groups' needs are being met. Check the following: expected results; provision of quality assistance with respect to gendered needs; monitor rates of service access; satisfaction with the assistance provided; how the facilities were used; and what has changed due to the assistance, for whom and in what timeframe. Compare the different rates by sex and age of the respondents.

The following table shows examples of the development of objectives, results and activities with associated indicators based on the outcomes of a gender analysis:

GENDER ANALYSIS QUESTIONS	ISSUES IDENTIFIED	SPECIFIC OBJECTIVES *What specific objective is the operation intended to achieve?*	SPECIFIC OBJECTIVE INDICATORS *Indicators that clearly show the specific objective of the operation has been achieved*
Do women, girls, men and boys have equal access to sufficient and culturally appropriate nutrition, health and WASH programmes and services?	Barriers to women's mobility affect their ability to attend nutrition and health services or distribution sites or water points. Elderly people, persons with disabilities and young or sick children cannot walk to the nutrition and health services or water points. Opportunity cost of using services perceived as too high (e.g. lost revenue due to planting season).	Increased access to nutrition services either via direct attendance or through delivery of services among the most vulnerable.	Number and percentage of at-risk groups that gain access to nutrition services via one of the distribution channels
What gender/age and other diversity-linked beliefs and practices such as food taboos prevent access?	In some contexts, certain groups (people with disabilities, infants) lack access to specific nutritious foods (eggs, meat, etc.) due to social and cultural beliefs and taboos.	Increased access to nutrition services due to elimination of social beliefs and cultural taboos.	Percentage of women, girls, men and boys who access nutrition services as a result of elimination of social beliefs and cultural taboos
What is the nutritional status of pregnant and lactating women?	Nutritional status of girls and women of reproductive age deteriorates leaving both them and any foetus at increased risk of miscarriage, birth defects, pre-term labour, low-birth weight, etc.	Improved nutritional status of women of childbearing age, pregnant and lactating women and their babies. Improved expectations of taking the pregnancy to term.	Percentage of women and babies with health results within the margins of accepted nutrition standards e.g. Sphere Project Number and percentage of assisted pregnant women who take the pregnancy to term

EXPECTED RESULTS *The outputs of the intervention that will achieve the specific objective*	EXPECTED RESULTS INDICATORS (OUTPUT INDICATORS) *Indicators to measure the extent the intervention achieves the expected result*	GENDER-ADAPTED PROGRAMMING ACTIVITIES
Low attendance barriers are addressed and solutions are offered to reach the most vulnerable. Women, girls, men, boys and people with disabilities are more aware of the importance of proper nutrition interventions.	Number of distribution channels identified to reach at-risk groups Percentage of women, girls, men and boys and people with disabilities who report being aware of the importance of proper nutrition interventions	Develop special transportation arrangements and service delivery methods to ensure access for beneficiaries identified as facing barriers to access. Develop and deliver a communication campaign on the importance of accessing nutrition services.
Women, girls, men and boys are aware of the non-scientific justification of cultural beliefs and taboos.	Number and percentage of people participating in activities addressing food taboos Women, girls, men and boys report (in focus group discussions) being convinced that cultural beliefs and taboos are not supported by scientific justification	Develop and deliver a communication campaign addressing harmful traditions and/or taboos.
High-risk groups have regular access to fortified food, vitamins and other micronutrients.	Number and percentage of women and adolescent girls in high-risk groups who have access to fortified food, vitamins and micronutrients	Regular distribution of foods fortified with iron, vitamins and other micronutrients for high-risk groups, including women of childbearing age and pregnant and lactating women.

3 Resource mobilization

Following the strategic planning phase and the production of a results-based framework (log frame) based on the needs assessment and analysis, the next phase in the HPC is resource mobilization.

Key steps to be taken for effective resource mobilization include:

- Humanitarian actors need to engage in advocacy and partnership with donors to mobilize funds for addressing gaps in the particular needs, priorities and capacities of women, girls, men and boys.
- To mobilize resources around priority actions, support the nutrition cluster with information and key messages on the distinct needs of women, girls, men and boys and plans developed to meet these needs.
- Use **gender markers** to assess how well a programme incorporates gender equality into planning and implementation and provide guidance on how to improve the process. There are several different but related markers (see section B, pages 52–53 for more information).

Examples of commitments, activities and indicators that donors typically look for can be consulted in the IASC Gender Marker Tip Sheets. In the nutrition tip sheet, examples of commitments include:

- Analyse the impact of the crisis on women, girls, men and boys, ensuring that all strategies include a gender analysis, i.e., identification of the differences in nutritional requirements, feeding practices and access to nutritional services for women, girls, men and boys;
- Take specific actions to prevent GBV;
- Ensure that women and men benefit equally from training or other skills development;
- Ensure that father and mothers are targeted equally by food education activities.

4 Implementation and monitoring

Once the resources have been mobilized, the next stage of the HPC cycle is the implementation and monitoring of the programme.

Implementation

In order to ensure that nutrition programmes integrate gender equality throughout, the following key actions need to be taken into consideration:

- Tailor programme activities to the specific nutrition-related needs, capacities and priorities of all women and girls, men and boys.
- Inform women, girls, men and boys of the available resources and how to influence the programme.
- Develop and maintain feedback mechanisms for women, girls, men and boys as part of nutrition programming.

Note that the ability to safely access these mechanisms can be different for women, girls, men and boys and as such provisions should be made to facilitate their inclusion. Other diversity factors such as caste, age and disability should also be taken into account to ensure access to all aspects of the nutrition programme.

To ensure that the programme adheres to good practice, several key standards relating to gender equality should be integrated across the planning, implementation and monitoring stages. These standards relate to the following areas (and are explained in the more detail in the table that follows).

- Coordination
- Participation
- GBV prevention and mitigation
- Gender-adapted assistance
- Transformative approach

KEY MONITORING TOOL:

- IASC Gender Marker Tip Sheet https://tinyurl.com/bodlmcg

KEY APPROACHES AND STANDARDS FOR PLANNING, IMPLEMENTATION AND MONITORING IN NUTRITION PROGRAMMING

Coordination

GOOD PRACTICE

» Identify local women's rights groups, networks and social collectives — in particular informal networks of women, youth, people with disabilities and LGBTI groups — and support their participation in programme design, delivery and monitoring, and ensure they have a role in coordination.

» Coordinate with other humanitarian service providers to ensure that gender-related nutrition considerations are included across all sectors.

» Support the Humanitarian Needs Overview and Humanitarian Response Plan using a gender analysis of the situation of women, girls, men and boys relating to nutrition, and sex- and age-disaggregated data.

BE AWARE!

» Be aware that the experiences and needs of LGBTI people may be very different and so coordination with local groups that represent these individuals is important to fully understand their needs and how to tailor a response.

Participation

GOOD PRACTICE

» Implement a representative and participatory design and implementation process that is accessible to women, girls, men and boys to develop community-based and sustainable nutrition-related services and distribution of supplies.

» Strive for 50 per cent of nutrition programme staff to be women, including health workers at therapeutic feeding centres at facility and community levels.

» Ensure that women, girls, men and boys participate meaningfully in nutrition sector programmes and are able to provide confidential feedback and access complaint mechanisms by managing safe and accessible two-way communication channels.

» Women, girls, men and boys must be able to voice their concerns in a safe and open environment and if necessary speak to female humanitarian staff.

» Consult diverse women, girls, men and boys in assessing the positive and possible negative consequences of the overall response and specific activities. Include people with mobility issues and their care providers in discussions.

» Be proactive about informing women about forthcoming meetings, training sessions, etc. and support them in preparing well in advance for the topics.

» Ensure access to childcare to enable the participation of women and girls, who often carry responsibility for care, throughout the programme cycle.

Participation (continued)

BE AWARE!

» Ensure that women at heightened risk have a mechanism to raise their concerns and participate in decisions, while guaranteeing confidentiality regarding their personal situations and without exposing them to further harm or trauma. Some mechanisms such as confidential hotlines run outside the community, are more effective.

» Avoid placing women in situations where the community is simply responding to the expectations of external actors and there is no real, genuine support for their participation.

» Be mindful of barriers and commitments (childcare, risk of backlash, ease of movement, government ban of open LGBTI groups in some cultures, etc.) that can hinder the safe participation of women, girls and LGBTI individuals in community forums.

» Where women, girls, men and boys participate in mixed groups, address any barriers that stem from gender norms such as men's voices carrying more weight.

» Ensure that meeting spaces are safe and accessible for all. Where women's voices cannot be heard, look for other ways to get their opinions and feedback.

» In some contexts, it may be necessary to negotiate with community leaders prior to talking with women community members in order to avoid backlash.

GBV prevention and mitigation

GOOD PRACTICE

» Follow the guidance provided on nutrition in the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.

» Prevention and response to GBV is a key cross-cutting priority in nutrition programming and requires a coordinated effort across planning, implementation and monitoring of response efforts.

» Given that most nutrition programmes in emergencies target vulnerable groups, including pregnant and lactating women, adolescent girls and children under five, nutrition actors are particularly well-positioned to monitor the safety needs of women, girls and other at-risk groups, as well as refer survivors to the support services they need.

» Do no harm: identify early potential problems or negative effects by consulting with women, girls, men and boys, using complaint mechanisms, doing spot checks and where appropriate, using transect walks around distribution points. (See section B, page 88 for more information on this concept.)

» Where possible, locate nutrition facilities next to women-, adolescent- and child-friendly spaces and/or health facilities.

» Employ and retain women and members of other at-risk groups as staff members.

» Train staff on how to orient people towards GBV referral services. Include a caseworker who is specialized in GBV case management as part of nutrition staff.

» Reduce protection risks by ensuring that nutrition services such as outpatient/inpatient care at therapeutic feeding centres are not located near areas that present security risks.

KEY APPROACHES AND STANDARDS FOR PLANNING, IMPLEMENTATION AND MONITORING IN NUTRITION PROGRAMMING (CONTINUED)

GBV prevention and mitigation (continued)

BE AWARE!

» Don't share data that may be linked back to a group or an individual, including GBV survivors.

» Avoid singling out GBV survivors: Speak with women, girls and other at-risk groups in general and not explicitly about their own experiences.

» Don't collect information about specific incidents of GBV or prevalence rates without assistance from GBV specialists.

» The environment in which assistance is provided should, as far as possible, be safe for the people concerned. People in need should not be forced to travel to or through dangerous areas in order to access assistance.

Gender-adapted assistance

GOOD PRACTICE

» Analyse, share with relevant actors and use the results and data to inform humanitarian response priorities and target the right people. Assess all nutrition programming to ensure that gender-related considerations are included throughout.

» Support, protect and promote exclusive breastfeeding through training of providers and information campaigns.

» Train community nutrition health workers on the gender dimensions of health and nutrition and gender-sensitive service delivery.

» Give priority to pregnant and breastfeeding women to access food and integrate skilled breast-feeding counselling in interventions that target pregnant and breastfeeding women and children aged 0–24 months.

» Be aware that some groups may have different dietary needs.

» Include actions to address infrastructure and services (such as separate lines (queues) for women and men).

BE AWARE!

» Do not assume that all will benefit equally from nutrition programming. Use the distinct needs, roles and dynamics for women, girls, men and boys (as per the gender analysis) to define specific actions to address each need and consider options suggested by women, girls, men and boys. For example, ensure equal access to micronutrient-rich foods and vitamin A supplementation.

» Special measures to facilitate the access of vulnerable groups should be taken, while consider-ing the context, social and cultural conditions and behaviours of communities. Such measures might include the construction of safe spaces for people who have been the victim of abuse such as rape or trafficking, or putting in place means that facilitate access for people with disabilities. Any such measures should avoid the stigmatization of these groups.

Transformative approach

GOOD PRACTICE

» Challenge structural inequalities. Engage men, especially community leaders, in outreach activities regarding gender-related nutrition issues, and work together to demonstrate the collective benefits of nutrition for the whole community when women have improved nutritional outcomes.

» Promote women's leadership in all nutrition committees and agree on representation quotas for women with the community prior to any process for elections.

» Work with community leaders (women and men) to sensitize the community about the value of women's participation.

» Raise awareness with and engage men and boys as champions for women's participation and leadership.

» Engage women, girls, men and boys in non-traditional gender roles in the nutrition programme.

» Support women to enable them to build their negotiating skills and strategies and support them to become role models within their communities by working with them and encouraging them to take on leadership roles within the nutrition programme.

BE AWARE!

» Attempting to change long-held gender dynamics in a society can cause tensions. Keep lines of communication open with beneficiaries and ensure that measures are in place to prevent backlash.

» Powerful refugee and displaced men often feel most threatened by strategies to empower women in the community, as they see this as a direct challenge to their own power and privilege (even if limited).

Monitoring

Monitor the access to and quality of nutrition sector assistance by women, girls, men and boys as well as the changes relating to meeting women's strategic needs. The monitoring should also look at how the nutrition programme has contributed through meaningful and relevant participation and a transformative approach including promotion of women's leadership. **Sex- and age-disaggregated data** (SADD) are a core component of any gender analysis and essential for monitoring and measuring outcomes. Use **gender markers** to assess how well a programme incorporates gender equality into planning and implementation and provide guidance on how to improve the process (see section B, pages 52–53 for more information).

Monitor whether the nutrition programme adheres to the **"do no harm"** principle (see section B, page 88 for more information on this concept): conduct ongoing consultation with women, girls, men and boys and undertake observation/spot checks to identify early potential problems or negative effects. Where possible, use transect walks around nutrition centres and/or distribution sites and ask the following: Is the route enclosed or far, and is visibility affected by overgrown vegetation? Is it too crowded? Feedback mechanisms as part of monitoring are also critical (see section B, pages 84–87 for more information). These measures allow early identification of negative effects of the programme so that they can be addressed in a timely manner so as to prevent GBV or further abuse of women's rights.

5 Gender operational peer review and evaluation

The primary purpose of the operational peer review and evaluation stage is to provide humanitarian actors with the information needed to manage programmes so that they effectively, efficiently and equitably meet the specific needs and priorities of crisis-affected women, girls, men and boys as well as build/strengthen their capacities (see section B, page 60 for more information). Evaluation is a process that helps to improve current and future programming to maximize outcomes and impacts, including analysing how well the transformative approach has been integrated and whether women's leadership has been promoted, ensuring that strategic as well as practical needs have been addressed.

To ensure people-centred and gender-responsive impacts, it is necessary to review methodologies and processes to determine good practice in providing equal assistance to women and men. Programmes need to be reviewed based on equal participation of and access to services by women, girls, men and boys from the onset of programme planning to implementation. It is necessary to assess gaps in programming, focusing on which women, girls, men or boys were not effectively reached. The use of the gender markers collectively helps to identify gaps to improve programming and response.

KEY STANDARDS

1. The Sphere Project. "Minimum Standards in Food Security and Nutrition." *Humanitarian Charter and Minimum Standards in Humanitarian Response*. 2011. https://tinyurl.com/yapnzyn3

2. IASC. "Nutrition." *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*. 2015. https://tinyurl.com/y9ynutoj

KEY RESOURCES

1. Global Food Security Cluster, Global Nutrition Cluster. *Mainstreaming Accountability to Affected Population & Core People-Related Issues in the HPC through the Cluster System*. 2014. https://tinyurl.com/y75vcqd9