**MODULE 22**

**Gender**-**Responsive Nutrition in Emergencies**

## PART 2: TECHNICAL NOTES

The technical notes are the second of four parts contained in this module. They provide an overview of the steps needed for gender-responsive programming in humanitarian nutrition interventions. Information in this module was drawn from key resources including: the IASC *Gender Handbook in Humanitarian Action*; the UNICEF *Operational Guidance on Gender*; and the *Sphere Handbook*: *Humanitarian Charter and Minimum Standards in Disaster Response* (*Sphere Handbook*) developed by a group of NGOs, the Red Cross/Red Crescent Movement.

**Summary**

This module, *Gender-responsive nutrition in emergencies*, aims to contribute to improved gender-responsive programming in nutrition emergency response. It explains why gender-responsive programming is needed and how it can be implemented to improve the effectiveness of nutrition interventions.

The *Sphere Handbook* explicitly recognizes the rights of women and men, and boys and girls in its Humanitarian Charter. The Charter applies to all the nutrition-related standards that have been addressed throughout this Harmonized Training Package (HTP).

**Introduction**

*“*Gender equality in humanitarian action is simply about good, common-sense programming*.*”

Jan Egeland, Emergency Relief Coordinator,

IASC Gender Handbook in Humanitarian Action, Women, Girls, Boys and Men – Different Needs, Equal Opportunities (2006)

The core message of this module is that *Gender equality in humanitarian action is simply about good, common-sense programming.* It demystifies and simplifies the concept of gender, which many of the actors involved in humanitarian action still find unclear and/or uncomfortable. Some of these actors believe that gender concerns women only or is synonymous with women, or that it addresses their reproductive needs; others believe that gender roles are an integral cultural part of a society that outsiders should not try to change, even if they lead to an unequal balance of privileges and power, which is usually to the detriment of women. Definitions of gender and related terminology used in this module are presented in Annex 1.

Gender equality does not require that girls and boys, and women and men, be the same, eat the same, or that they be treated exactly alike, but rather implies an absence of bias or discrimination and therefore equal access to food and nutrition services. Equality between women and men is both a human rights issue and a precondition for, and indicator of, sustainable, people-centered development.

Source: Adapted from the Office of the Special Adviser on Gender Issues and Advancement of Women, *Gender Mainstreaming: Strategy for Promoting Gender Equality*, United Nations, New York, 2001.

Gender equality in nutrition emergencies ensures that women, girls, boys and men have equal access to nutrition services and the foods they need to live a healthy life.

**Gender-responsive programming for an adequate response**

During humanitarian crises, promoting and protecting gender equality through gender-responsive programming should not be considered an option that can be postponed, but rather, a requirement for an adequate humanitarian nutrition response. Gender-responsive programming improves the effectiveness and sustainability of nutrition interventions in humanitarian emergencies. It better addresses the distinct nutritional risks and vulnerabilities that women, girls, boys and men face in humanitarian crises. To achieve this, all groups must be consulted and actively participate in needs assessments and decision-making. Accordingly, evidence-based nutrition programmes can be designed to meet the needs of all, ensuring their safe and equal access to effective humanitarian nutrition assistance.

**Failing to address gender in emergencies**

Nutrition interventions may fail to reach the most vulnerable and, in some cases, may actually lead to further harm. For example, if sanitation facilities or water points are poorly lit or situated in a remote location, the vulnerability of girls and women to sexual violence could increase, or water use may be limited, which could cause problems in hygiene and food safety. If food distribution systems do not have a provision for unaccompanied adolescent boys, who may not have cooking skills, these boys may be at risk of malnutrition. Failing to address gender may also lead to reduced access to nutrition services, which results in lower admission and attendance rates. The range of humanitarian action must be designed to meet the different needs of women, girls, boys and men, and also to ensure their equal access to relevant services.

Source: Adapted from *Promoting Gender Equality through UNICEF-Supported Programming: Special Considerations in Humanitarian Action*. Available at: http://www.unicef.org/mdg/files/Emergency\_2Pager\_Web.pdf

Targeted actions usually focus on women and girls; however, in order to improve gender equality, boys and men must also be considered because boys and men may also be negatively affected by their gender roles. For example, in some communities, boys are expected to herd animals all day far away from home and may be without food or water, which places them at more risk of malnutrition than girls.

Boys and men should also be engaged in nutrition related projects because they have a role to play in influencing attitudes and shaping gender roles and power relations between men and women, and boys and girls. Failing to involve them carries risks and reduces effectiveness. Threats or risks facing men may not be adequately understood or addressed. Men may lose some of their status and authority because emergencies destroy traditional family and clan structures. It is important to obtain their support for women’s involvement in nutrition interventions.

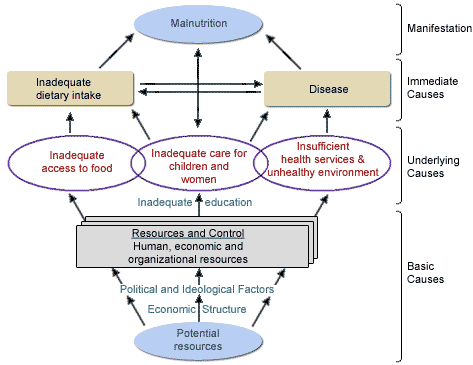
**2. Rationale**

In the context of humanitarian crises, women, girls, boys and men face distinct risks with respect to a deterioration of their nutritional status. This is linked to their different age- and sex-related nutritional requirements as well as to gender-related socio-economic and cultural factors.

**The gender dimensions of malnutrition**

Taking the UNICEF conceptual framework (Figure 1) as a starting point, the immediate causes of malnutrition are disease or inadequate dietary intake, which in turn are caused by household food insecurity and/or inadequate care, preferential feeding practices that favour males within households, and/or an unhealthy environment or insufficient access to health services.

Figure 1: UNICEF Conceptual Framework of Malnutrition



These partly overlapping and interacting underlying causal factors are gender-sensitive and negatively affect nutritional status during humanitarian crises. Cultural factors impact on these underlying causes, as the framework shows; for example, the tradition in some cultures that women and girls eat their meals only after the men and boys do, places them at an increased risk of malnutrition, particularly in emergencies when quality and quantities of food distribution rations are limited. In Yemen, children with severe acute malnutrition (SAM) with complications are denied treatment in inpatient stabilization centres, since cultural norms do not allow mothers to spend the night away from home. (See Annex 2 for more information on the role of culture.)

**Household food insecurity**

Livelihoods may be destroyed or undermined by natural or man-made disasters that reduce both food availability and access to food. Women and girls, who are usually the main food providers, have more constraints to accessing food security than men and boys because they are subject to the increased risk of GBV. They may also face cultural discrimination, which reduces their access to productive resources and limits their mobility.

Women of child-bearing age require more dietary iron than men, and when pregnant or breastfeeding, should also consume more protein. Still, they typically eat a lower quantity and a limited variety of nutritious foods than men. Furthermore, men and boys are favoured and eat better than women and girls in many societies. There are cultural practices, for example, that deny women and girls the right to eat food with the necessary nutritional value; some cultures prohibit them from consuming liver/gizzards or dictate that women and girls should eat last after everyone else has eaten, thus limiting their access to nutritious and protein-rich foods.

*“*Women eat last. In almost every society in the world, women gather the food, prepare the food, serve the food. Yet most of the time, women eat last. A woman feeds her husband, then her children, and, finally – with

whatever is left – she feeds herself. Even pregnant women and breast feeding women often eat last when, of all times, they should eat first*.”*

– Statement by Catherine Bertini, Executive Director of World Food Programme, Fourth World Conference on Women, September 1995, Beijing, China.

Iron-deficiency anemia increases maternal mortality, and a general lack of nutrients during pregnancy leads to increased numbers of babies with low birth weight who start their lives malnourished. When food is in short supply during emergencies, women and girls may reduce their intake even further as a coping strategy in support of other household members. Some individuals have special nutritional needs, which are exacerbated in crises. PLW as well as children and the chronically ill may be disproportionately affected by undernutrition due to their increased physiological requirements. If the household depends on general food distribution (GFD), the rations may not provide all the nutrients to meet the requirements of all household members, and opportunities to access additional and fresh foods for supplementary feeding and for pregnant and lactating women may be limited. Ready to use food e.g. ready-to-use therapeutic foods (RUTFs) for children with severe acute malnutrition, ready-to-use supplementary food (RUSFs) for moderately malnourished children as well as blended foods such as Corn Soya Blend (CSB) and other products for acutely malnourished children, PLW and chronically ill individuals may not be available at the onset of an emergency. In addition, another issue to take into consideration is whether the rations are packaged in such a way that women, PLW and children are able to carry them.

Also, people living with HIV/AIDS (PLWHA) are of special concern since their nutritional requirements increase by 10 per cent before they display any symptoms of HIV. In addition, during the illness, these requirements increase to 50–100 per cent and they also suffer from severe weight loss (see HTP Module 18). Moreover, the chronically ill may not be able to eat normal foods due to reduced appetite and/or mouth or throat problems.

**Care practices**

Care practices may be compromised by women’s lack of time and impaired health during crises, as well as their reduced access to support services, networks and information. Thus, their livelihoods opportunities can be affected, which may result in lower pay for more working hours and/or reduced production. Their well-being can be affected by the crisis and GBV incidents, which may leave them depressed and unable to fulfill their normal caregiving role, with a possible negative impact on nutrition including breastfeeding practices. In emergency situations, women may need to dedicate more time to collect food, water and cooking fuel, which negatively affects the well-being and nutritional status of infants and children, older people, the disabled and chronically ill people who all depend on their care.

During emergencies, if men who are single heads of households do not know how to cook or care for young children and are removed from their normal social support structures, their children will be at a greater risk of undernutrition. Also, adolescent males who have lost their families may be at risk if they do not know how to cook. Similarly, older, disabled, and chronically ill people may not be able to collect food, water and cooking fuel to cook for themselves.

**The health environment and access to health care services**

When water, sanitation and hygiene are negatively affected, the health environment may be compromised, especially at the onset of humanitarian crises and in protracted emergencies. In emergencies, in particular, women and girls may spend long hours to fetch water or may have to use less clean water sources when the distances are too great, which has detrimental effects on nutrition and health. Women are often not consulted when decisions are taken on the location and type of water points. In addition, health care may be lacking or disrupted, or become less accessible or inaccessible due to displacement.

Pregnant women as well as young children, older people and the chronically ill may be disproportionately affected by inadequate health services due to their increased health care needs.

**Socio-economic and cultural factors underlying causes of malnutrition**

The social, cultural, economic and political situation determines how income and assets are distributed between men and women, and between different socio-economic and cultural groups; the degree to which the rights of women and girls are protected by law and custom indirectly affects their nutritional status and that of their families. Emergencies may exacerbate gender inequality and increase GBV. **Case 1** provides an example of the gender dimensions of food insecurity and malnutrition in Zimbabwe.

***Case 1: Specific gender dimensions of malnutrition in Zimbabwe***

* More boys than girls under five years of age are classified as stunted (31.2% of boys, 27.6% of girls).
* Less girls than boys are fed four or more times per day among children over 23 months (26.1% and 34.9%, respectively).
* According to the 2009 *Internally Displaced Persons Assessment* (preliminary data), women are more likely to consume less food than men when there is a food shortage.
* According to the same assessment, there are reports of girls being forced into early marriage as a coping strategy when there is a food shortage.
* Sex- and age-specific data on nutritional issues for children over five years of age are scarce.

Source: Adapted from *Best Practices 1 – Tools from 2009 Gender Marker Pilot, 2009*

**Gender and malnutrition prevalence rates**

It is estimated that 60 per cent of the world’s chronically hungry are women and girls, and 20 per cent are children under five years of age;[[1]](#footnote-1) 20 per cent are men and boys over the age of five. This is the result of the combined effects of increased nutritional requirements and gender inequality.

Most anthropometric measurements of nutritional status (weight/height, height/age and weight/age) are gender-sensitive since different reference tables are used for boys and girls to determine whether they are malnourished. The middle upper arm circumference (MUAC) measurement, however, uses the same cut-off to determine malnutrition in boys and girls. This method is easy and fast to apply, and is commonly used for screening in emergency settings – children need not undress, and only a measuring tape is required. The method is accepted and recommended for both sexes; however, it may lead to a slightly higher number of girls being admitted to feeding programmes because of their different growth pattern than that of boys.[[2]](#footnote-2)

There is no clear evidence of a disparity in prevalence of malnutrition between girls and boys under five years of age at the global level. However, there have been reports of a discrepancy in some regions between the prevalence of acute malnutrition among boys and girls measured by anthropometric surveys and the proportion of boys and girls actually admitted to feeding programmes. Boys in southern Africa often have a higher prevalence of wasting than girls, while more girls are admitted in therapeutic care. This issue is not well understood and needs to be further analysed in light of the debate on the current use of separate admission standards[[3]](#footnote-3) for boys and girls. These standards are based on the 2006 World Health Organization (WHO) child growth standards and other factors such as the mortality rate of boys and girls in the same areas and socio-economic issues including gender discrimination. Currently, separate 2006 WHO growth standards for boys and girls are recommended and used to determine admission for treatment of SAM. Previously, admission was based on a unisex standard derived from the National Center for Health Statistics (NCHS) growth charts, which led to the inclusion of approximately the same numbers of boys and girls with the same mortality risk. With the new standard, it has been observed that more boys than girls are admitted to receive treatment. Since girls with the same weight as some of the admitted boys are denied treatment, some scientists argue that these new admission standards actually discriminate against girls, and that it would be better to use the boys’ standards as a unisex standard for the admission of both.

There is a significant relationship between child malnutrition and the mother’s socio-economic status; many nutrition surveys have shown that low maternal literacy and education levels are associated with a poor nutritional status of young children. Since the low status of women is considered one of the primary determinants of malnutrition, addressing gender inequalities is key to improving the nutritional status and the lives of mothers and their children.

**Gender equality improves the outcome of humanitarian nutrition interventions**

Recent reports have shown that, in practice, most humanitarian sectoral responses, including nutrition interventions, remain gender-blind, and thus fail to consider the differences within and among crisis-affected populations. The 2011 report *IASC* *Gender Marker in CAPs and Pooled Funds*: *Analysis of Results and Lessons Learned* identified that boys are more systematically affected by malnutrition, which has influenced the orientation of the Nutrition Cluster. The Cluster had earlier focused only on children under five years of age without considering the gender gap.

The Global Nutrition Cluster (GNC) and humanitarian agencies are committed to promoting gender equality in all their actions. This is also becoming a key requirement for accessing funds through the Consolidated Appeals Process (CAP). The *Nutrition Gender Marker Tip Sheet*, which includes the ADAPT and ACT Framework, guides humanitarian nutrition workers towards achieving this (see chapter 4 of this module).

Gender-responsive programming in humanitarian action aims at effectively reaching all segments of the affected population. It leads to emergency nutrition interventions that better address the different needs of women, men, girls and boys through:

* gender-responsive needs assessments;
* greater participation of women, girls, boys and men;
* improved understanding of the needs of different groups in a crisis;
* improved targeting of those with the greatest needs;
* improved use of potential of beneficiaries and natural and community resources;
* equal benefits for all beneficiaries;
* higher effectiveness and sustainability;
* improved accountability to the beneficiaries and various beneficiary groups.

Moreover, humanitarian crises provide an entry point for changing gender roles and the power balance between men and women. Social and traditional systems are disrupted or challenged as women need to take up different roles in the absence of male heads of households. Men may be cut off from their livelihood opportunities, which may undermine their traditional role as head of the household. Such changing roles and socio-cultural norms provide a fertile ground to improve gender equality, which not only results in better programming, but also supports long-term development (see **Case 2**).

***Case 2: Emergencies as an entry point for improving gender equality***

In 2003, Netherlands Red Cross (NLRC) implemented a project in Primary Health Care services for internally displaced persons (IDPs) in Kassala State, eastern Sudan. It extended the project in 2007 to support income-generating activities for IDPs, especially women, towards their economic self-sufficiency. In Hamashkorieb, the conservative socio-cultural norms forced women to stay mostly inside their homes and always relegated to the female area of the village. In the IDP camps, the Sudanese Red Crescent, supported by the Netherlands Red Cross, provided skills training on leather and rubber work to produce shoes, sowing, and beadwork for clothes and decoration for which special women’s centres were built. The training provided an opportunity for interaction with other women and was also used as an entry point to numeracy classes, small businesses management, and awareness raising on health, hygiene and sanitation.

Source: End of Project Evaluation, Kassala Livelihoods Project, Netherlands Red Cross (NLRC)/Spanish Red Cross (SRC), 2010. Available at: http://www.alnap.org/pool/vacancies/dutch-rc-tor.pdf

**Normative framework, accountability and international commitments**

The *Sphere Handbook* provides the basis and the standards for humanitarian action and for accountability to affected populations, donors, national governments in humanitarian action. Although none of six Sphere Core Standards specifically focuses on gender, gender is a cross-cutting issue relevant to each of them and features in their *Guidance Notes* (see Annex 3 for an overview of relevant standards).

**Accountability**

As pointed out by the Harmonised Training Package (HTP) Module 21, *Standards and accountability in humanitarian response*, accountability can be understood as a way of reducing the power differential in the relationship between the aid provider and the affected population. The Module also points out that the GNC and its members should increase their efforts to be accountable to their beneficiaries against the adopted standards. The basic elements of accountability aim towards a more equal power balance, facilitated by participation and a mutual communication between humanitarian project staff and affected populations.

Accountability is important because humanitarian agencies must report on their progress in ensuring that women, girls, boys and men have equal access to and equally benefit from their nutrition assistance. Girls and women encounter specific problems when dealing with public services that make it especially difficult for them to hold service providers or authorities accountable. These problems concern women’s access to services, the extent to which women are visible and esteemed, and providers’ knowledge of and conduct towards women.

In addition, gender-responsive programming requires increased participation and facilitated communication between all the different affected groups. In emergency nutrition interventions, this includes, for example, clear communication on entitlements of food rations, monitoring of the adequacy of rations (food basket monitoring) and the establishment of a complaint procedure for food and nutrition interventions. When programmes and projects become more gender-responsive, the quality of their performance and their accountability will be automatically improved.

**United Nations commitments and mandates**

*“*Understanding gender differences, inequalities and capacities improves the effectiveness of our humanitarian response. We must work together to promote gender equality – this is a shared responsibility of all humanitarian actors*.”*

– IASC Gender Handbook in Humanitarian Action, 2006

United Nations agencies and the GNC partners have formulated their gender policies based on the United Nations Charter, United Nations Resolutions and international human rights law, such as the Convention on the Elimination of All Forms of Discrimination Against Women.[[4]](#footnote-4) In 1997, the United Nations adopted gender mainstreaming as a strategy to ensure integration of gender issues and objectives in all elements of their work, programmes and projects. **Box 1** shows how gender features in and contributes to achieving the Millennium Development Goals (MDGs) that guide many of today’s programmes.

Since 1999, the IASC has required all member organizations that provide humanitarian assistance in emergencies to formulate specific strategies to mainstream gender issues, collect and analyse data from a gender perspective, build capacity for gender mainstreaming, and develop reporting and accountability mechanisms that ensure attention to gender.[[5]](#footnote-5) During humanitarian crises,[[6]](#footnote-6) all sectors are required to take specific actions to prevent and respond to GBV (see Annex 4). The Resource List in Part 4 of this module includes references to recent guides and manuals related to GBV and protection.

***Box 1: Gender equality and the United Nations Millennium Development Goals***

The third goal of the MDGs is to **“Promote gender equality and empower women”**. It sets a target of eliminating gender disparity in all levels of education by 2015. Gender equality can also help the international community to achieve other important MDGs:

**MDG1**: Eradicate extreme poverty and hunger.

Increasing rural women’s agricultural production and participation in the labour force helps to reduce poverty, stimulate economic growth and reduce malnutrition.

**MDG4**: Reduce child mortality.

Rural women’s lack of access to education and assets is directly linked to high rates of child and infant malnutrition and mortality.

**MDG5**: Improve maternal health.

The vast majority of maternal deaths – estimated at half a million a year – could be prevented through better access for women to reproductive health services, which includes provision of micro-nutrient supplementation.

**MDG6**: Combat HIV/AIDS, malaria and other diseases.

Gender inequality is recognized as one of the driving forces behind the spread of HIV infection and AIDS having severe implications for nutrition. Women are more at risk of anaemia, which can be exacerbated by malaria and which poses serious risks to their children.

**MDG7**: Ensure environmental sustainability.

As farmers and household providers, rural women manage natural resources daily. Their participation in programmes for the sustainable management of land, water and biodiversity is essential.

Source: Adapted from FAO, Bridging the Gap: FAO’s Programme for Gender Equality in Agriculture and Rural Development, 2009.

**Gender-responsive programming**

Gender-responsive programming in humanitarian action aims to effectively reach all segments of the affected population. This section provides an overview of gender-responsive programming and on how to integrate gender in the project cycle of nutrition emergency interventions, from needs assessment to monitoring and evaluation.

**What is a gender analysis?**

*Gender analysis* focuses on understanding and documenting the differences in gender roles, activities, needs, and opportunities in a given context through the disaggregation of quantitative data by sex. It highlights the different roles and learned behaviour of women and girls, boys and men based on gender attributes, such as access to resources, activities, control of assets and decision-making powers, how labour is divided and valued, among others.

Gender analysis is the systematic attempt to identify key issues contributing to gender inequalities so that they can be properly addressed, thus providing the basis for gender mainstreaming. It is a tool for understanding social processes and responding with informed and equitable options.

In emergencies, gender analysis makes it possible to understand who is affected among the population by the crisis – where they are, what they need, and what they can do for themselves using their abilities or capacities. It enables nutrition practitioners to identify the prevailing gender dimensions of malnutrition in the nutrition emergency by applying a gender lens to the UNICEF conceptual framework for malnutrition.

The gender needs identified in the gender analysis will inform all aspects and phases of the response. Gender needs can be categorized into practical and strategic needs (see **Case 3**).

**Practical needs** concern who needs which kind of assistance. **Practical gender needs** do not challenge women’s position in a particular culture, but rather, respond to immediate necessities., If in a household, for example, it is the usual role of the woman to fetch water, then providing a well close to the village is a gender-based activity even though the whole community benefits.

**Strategic gender needs** refer to the needs related to the promotion of the equal and meaningful participation of boys, girls, men, and women in their family and community. As women and girls are usually in a subordinate position when compared to men and boys in their societies, addressing strategic needs often entails working towards the empowerment of women and girls. Strategic needs vary according to the particular social, economic and political context in which they are formulated. Clearly, addressing these needs will require specific actions, often outside the nutrition and food security domain.

Where possible, humanitarian nutrition action that addresses practical needs should also support and integrate actions that address strategic gender needs. Some of these strategic needs can be incorporated in staff or volunteer training of emergency nutrition interventions, or in information, education and communication (IEC)/social and behaviour change communication (SBCC).

***Case 3: Integrating strategic needs in communication: involving men in child care***

A study in Mexico published in *Salubritas* (1982) showed that when both men and women appeared in printed materials that promote sanitation and oral rehydration, none of those surveyed thought that it was unusual or silly for men to be involved in the associated activities; however, when the printed materials showed only women, 63 per cent of the surveyed mothers and 70 per cent of the surveyed fathers thought that only mothers should be involved in these activities. The exposure of individuals to different gender roles facilitates their acceptance and may eventually contribute to a more equal balance of tasks and duties between women and men, boys and girls.

Source: Adapted from UNICEF, *Promoting Gender Equality through UNICEF-Supported Programming in Young Child Survival and Development: Operational Guidance,* 2011

**IASC’s** **ADAPT and ACT Framework**

This frameworkpresents nine key elements that guide nutrition professionals in how to mainstream gender in nutrition emergencies throughout the project cycle (see Annex 5).

Inter-cluster linkages are important to systematically address GBV. Nutrition staff should participate in multi-sectoral working groups on GBV prevention and protection to support the development of codes of conduct and disciplinary measures for any violations. Nutrition interventions should also integrate Protection from Sexual Exploitation and Abuse (PSEA), and how to refer and report cases in staff training, and complaint procedures should be established. Coordination of GBV and child protection issues in emergencies fall under the Protection Cluster. (**Case 4** provides an example of sexual exploitation in food distribution in Burundi.)

***Case 4: Sexual exploitation and food distribution***

In light of various irregularities uncovered in beneficiary lists by field teams, CARE conducted a study between October 2004 and June 2005 in Burundi to document whether sexual favours were demanded as a means to access food aid, and if so, to identify the underlying reasons and mechanisms, and develop strategies to reduce the risk to beneficiaries. In focus group discussions and semi-structured interviews, both victims and perpetrators confirmed that sexual harassment and exploitation occurred in the food aid process. Sexual exploitation occurred secretly and was never discussed openly, certainly not during the public validation of beneficiary lists when irregularities were to be identified. Widows and other single women, either without husbands or without adult sons, were found to be particularly vulnerable, because they had no adult males in the household to protect their reputation and no money to bribe the village heads to include them on the beneficiary lists. The main factor that led women to submit to requests for sexual favours was fear that they would be excluded from the lists. Perpetrators were generally those who established the lists.

Source: Zicherman N., *‘It is difficult to escape what is linked to survival’: Sexual exploitation and food distribution in Burundi*, *Humanitarian Exchange*, No. 35, 2006.

What is **gender mainstreaming?**

United Nations [Economic and Social Council](http://en.wikipedia.org/wiki/United_Nations_Economic_and_Social_Council) formally defined the concept:

*Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve*[*gender equality*](http://en.wikipedia.org/wiki/Gender_equality).

Gender mainstreaming takes into consideration the needs, abilities and opportunities, as well as the impact of all policies and programmes on women, girls, boys and men at every stage of the programme cycle – from planning to implementation and evaluation, as advocated in the ADAPT and ACT Framework.

What is **targeted action?**

In order to achieve gender equality, women and girls may need different treatment so that they can benefit from equal opportunities; consequently, some interventions exclusively target them. For example, school feeding programmes encourage girls’ enrolment and attendance in schools in order to alleviate gender inequalities found in many developing countries. However, not every intervention that targets only women or girls contributes to gender equality: breastfeeding promotion activities or iron supplementation for women and girls, for example, do not aim to overcome gender imbalances or obstacles to gender equality.[[7]](#footnote-7)

A good gender analysis should help stakeholders identify who the most vulnerable and disadvantaged groups is because of their gender and gender roles Specific interventions may also target men and boys where they are found to be discriminated against because of their gender or negatively disadvantaged because of their gender roles. For example, in some nomadic communities, it is expected that boys spend their days in the fields tending and herding cattle. This activity means that boys and men may be away from the home for long periods of time without food or water. Hence, a nutritional program in that community may need to have some targeted interventions to address boys and men’s nutritional needs.

Targeted actions usually focus on women and girls; however, in order to improve gender equality, boys and men must also be engaged because failing to involve them carries risks and reduces effectiveness. Critical issues relating to survival and health can be marginalized and relegated as being “women’s issues”, such as child feeding and the treatment of acute malnutrition where only mothers are targeted. Threats or risks facing men may not be adequately understood or addressed. Men may lose some of their status and authority because emergencies destroy traditional family and clan structures. They may resent the interference of women in the male domains of providing security to the family, bringing food to the household or engaging in economic activity. It is important to obtain their support for women’s involvement in nutrition interventions. It is important to obtain their support for women’s involvement in nutrition interventions.

**Practical guidance on gender-responsive nutrition needs assessment, targeting, communication and monitoring**

The section above provided an overview of gender-responsive programming throughout the project cycle, from emergency nutrition needs assessments to monitoring and evaluation based on the ADAPT and ACT Framework. Some aspects require more attention here, particularly the gender-responsive needs assessment, which is of key importance to effective humanitarian nutrition response. This section provides more in-depth, detailed practical guidance. First, it explains how to assess the prevailing gender dimensions of malnutrition. It then elaborates on how to consider the identified issues in targeting, communication and monitoring.

**Minimum gender requirements in emergency nutrition assessments**

All nutrition interventions are based on a needs assessment, be it an Initial Rapid Assessment or a more comprehensive nutrition assessment. Most anthropometric tools used to measure nutritional status are gender-sensitive.

Assessments and analyses are key to the development of effective interventions. The following actions should be taken to fulfill minimum gender requirements within humanitarian nutrition needs assessments:

**Preparation**:

* Review secondary data while taking into account gender roles, responsibilities and vulnerabilities.
* Interview representatives of the health, food security and water sanitation and hygiene sectors to assess gender sensitivities and gaps in the way services had functioned prior to the disaster.
* Select assessment teams, which should, as far as possible, be composed of both women and men, generalists and specialists, including those with skills in the collection of gender-sensitive data and communicating with children. Teams should include people familiar with the language(s) and area who are able to communicate in culturally acceptable ways. Also, translators, if needed, should be composed of both of women and men.
* Brief the team and translators on gender sensitivities in single- and mixed-sex discussion groups.

**During assessment**

* Collect all nutrition, morbidity and mortality data per age group and by sex.
* When a detailed breakdown by sex/age may not be possible in the very initial stages of an emergency, immediately differentiate the needs of adults/children and men/women.
* At the earliest opportunity, further disaggregate the data by sex and age: 0 to less than six months of age (male/female), six to less than 12 months of age (male/female), 12 to less than 24 months of age (male/female), 2-5 years of age (male/female), 6-12 years of age (male/female), 13-17 years of age (male/female); and then in 10-year brackets and by sex, specifying numbers of pregnant and lactating women.
* Hold key informant interviews, for example, with local authority representatives (male and female), government staff, various relevant health facility staff, operational agencies, traders, male and female community representatives (religious leaders, teachers, etc.) and/or community organizations.
* Ensure an adequate involvement of representatives of the whole community in the assessment process, especially women and other marginalized and possibly less visible groups, particularly ethnic groups and chronically ill, disabled and older people.
* To determine their needs and potential, create separate men/women focus groups. Here, particular attention should be paid to coping strategies. When time is available, specific focus groups can be joined with other groups, such as youth, and disabled and older people.
* Integrate HIV-related issues into all sectoral initial rapid assessments and the data should be disaggregated by age and sex.

**Analyses**

* Ensure that there are mixed teams to analyse and report on assessments.
* With the community, analyse the impact of the crisis on women, girls, boys and men in order to identify nutrition-related needs and ensure equal access to health, water, food and nutrition services.

**In-depth needs assessments: include a gender analysis**

By integrating the minimum gender requirements presented above in nutrition assessments, will allow to determine the nutritional needs of different vulnerable groupsand contribute to the identification and design of nutrition interventions**.** When there is sufficient time, it is strongly recommended to incorporate additional qualitative methods to obtain sufficient information for a gender analysis. Applying a gender lens to the UNICEF conceptual framework for malnutrition of the humanitarian crisis will lead to a more in-depth understanding of the gender dimensions of food security and nutrition; this would lead to more gender-responsive and therefore more effective humanitarian nutrition interventions.

**How to integrate a gender analysis in the nutrition assessment?**

In order to integrate gender analysis in the nutrition assessment, the gender roles of women and men, and boys and girls need to be examined. Focus should be placed on their abilities and skills related to nutrition, their access to and control of food, productive resources and appropriate technology, and their respective gender constraints, including their nutritional vulnerabilities.

The analysis should proceed as follows:

* Ask women and men about their major issues and concerns.
* Determine the norms and practices that discriminate against sex and age*.*
* Adapt qualitative nutrition assessment tools to determine the gender disparities

between women, girls, boys and men in terms of food security and nutrition, and access to food and services.

* Perform a participatory assessment with women, girls, boys and men together and

separately, and consider different socio-economic or cultural groups.

* Analyse the above information and use it to implement programmes.

As discussed above, in addition to applying the minimum gender requirements to the assessment, more qualitative data should be collected to enable a gender analysis and to answer the following sets of questions:[[8]](#footnote-8)

* What are the gender dimensions of food security,health and nutrition?
* What are the gender disparities in nutrition outcomes?

**What are the gender dimensions of food security and nutrition?**

* Are there socio-cultural practices, social norms, cultural beliefs and/or caring practices that affect the nutritional status of women, girls, boys and men in different ways? Are there any differences in feeding and care practices for young girls or boys? How do men and women view feeding and care of young children and maternal nutrition? Who is responsible for the young children – what is needed, and what should or should not be done for them or given to them? Who decides what, and who controls and who influences the children? How has this changed as a result of the crisis?
* How does the socio-economic status of women differ within a country and how does this influence the nutritional status of children? How has this changed as a result of the crisis?
* Is there a correlation between maternal education and child nutritional status?
* Are there differences for women, girls, boys and men in terms of access to food? How is food distributed within the household? Are men traditionally given priority in food allocation because of their heavier workloads, or simply due to their gender?
* Who in the household controls the resources, and does this have a different impact on access to food or the feeding habits of women, girls, boys and men? If women are heads of the households and/or family groups, do they have access to sufficient food, especially when pregnant or lactating?
* What are the differences between women’s and men’s roles and responsibilities with regard to nutrition?
* What is the gender division of labour, tasks and duties? Who does what and when?
* Is there a change in work patterns (e.g. due to migration, displacement or armed conflict) resulting in a change of roles and responsibilities in the household, and inhibiting or preventing certain women or men from accessing food?
* How does the gender division of labour and decision-making patterns in the household affect the nutrition of women, girls, boys and men within the household?
* In crises and in situations of widespread and severe poverty where food security is poor, do women and girls reduce their food intake as a coping strategy in favour of other household members?
* What other coping strategies are used by women, girls, boys and men?
* Are there any adverse changes in caring practices, such as having less time for child care due to the need to forage for wild foods and difficulties in finding drinking water and fuel wood?
* If boys and men are separated from families, can they prepare and cook food for themselves? Are there any support structures for orphans, and for men who lack child feeding and caregiving skills?
* How do older women and men access food, and does the food basket meet their specific needs?
* How do women, girls, boys and men with disabilities access food, and does the food basket meet their specific needs?
* Is the environmental health situation affected, including hygiene, sanitation and access to clean water? Liaise with the responsible clusters such as camp coordination and camp management, health, as well as the global water, sanitation and hygiene (WASH).

* Are prevention and protection measures in place, or are women and girls at risk of violence when obtaining food, water and fuel? Liaise with the responsible clusters.

**What are the gender disparities in nutrition outcomes?**

* Do any of the available disaggregated data indicate that women and girls, boys and men, or older people are disproportionately affected? If so, why?
* What are the characteristics of populations with a poor nutritional status who are not provided with nutrition services or inadequate food? Is there a gender issue? Determine which groups are hard to reach (physical and social access) and/or marginalized, and the barriers that prevent access.

**What are the gender disparities in health and nutrition services?** (Team up with the Health Cluster to determine this.)

* What nutrition interventions were in place before the current emergency? How were they organized and did they affect women, girls, boys and men differently?
* Did women, girls, boys and men have equal access to these services and were these services used by all?
* Map the location and indicate the capacity and functional status of health facilities and nutrition and public health programmes, including gender-specific, essential services for women and men (e.g. reproductive health services).
* Are there any gender sensitivities with respect to the health provider?
* Identify trained health professionals in the community (keeping in mind they may not be working due to family responsibilities) and enable them to return to work through the provision of transport, security, child care and flexible work schedules, as needed.
* Compile an inventory of local groups and key stakeholders in the health sector, including gender theme groups (traditional healers, women’s organizations) in order to discover what is being done – where, by whom and for whom.
* Conduct qualitative assessments to determine perceptions about health and nutrition services provided to the community and identify recommendations to address the community’s concerns.

**The following considerations should be taken into account:**

* Childcare support needs to be provided in order to enable women and men, especially those from single parent-headed households, to participate in meetings.
* Women and girls are often at increased risk of violence and may be unable to access assistance and/or make their needs known. They may be insufficiently included in community consultation and decision-making processes, and thus their health needs may not be met. Men may have to suffer other disadvantages due to gender differentiation, e.g. their role as protectors may result in risk-taking during and after an emergency.
* GBV, mental health and psychosocial issues will also impact on the nutritional status of infants, young children and PLW, and should be assessed.

**Tools for gender analysis:** Participatory tools, such as focus group discussions and in-depth interviews, are especially useful in assessing gender dimensions of nutrition in emergencies. Activity calendars and clocks are useful to assess gender roles, duties and tasks, and can be included in focus group discussions which then should comprise women and men in separate groups. **Annex 6** presents an overview of participatory tools that can be used to answer the above sets of questions.

**Gender-responsive and community (or participatory) targeting**

Effective targeting is crucial to the success of any nutrition intervention. There are various ways of targeting, for example, in gender-responsive humanitarian assistance programmes, utmost care should be taken to ensure that the vulnerable, disadvantaged and less mobile members of communities are also targeted and will benefit from the assistance. Although it should be recognized that community leaders may not always be the best representatives for the poor in their communities, participatory or community targeting has many advantages (see **Box 2**). It is important that an effective system for monitoring of targeting effectiveness be established to detect and correct possible discrimination and inappropriateness. Ensure that community leaders/representatives, both men and women, should be engaged in participatory processes.

***Box 2: Advantages and disadvantages of******community (or participatory) targeting***

In community (or participatory) targeting, decisions are made by community members or their representatives, including the potential beneficiaries, and criteria selection is based on their subjective judgment of need or vulnerability. This targeting method relies on the knowledge and understanding of one’s neighbours’ situation. It is also a low-cost procedure and overcomes difficulties in data collection while exploiting the deeper knowledge on the community’s vulnerability. Women are a good asset in this process. Coverage of all households, or at best, based on household size, may result from applying this targeting mechanism. Alternatively, given customary systems of exchange and loans, assistance might be shared beyond targeted beneficiaries, regardless of the assessment performed by outside agencies.

**Gender-related advantages:** People can become familiar with democratic decision-making processes and reinforce the community’s responsibility towards its vulnerable members. Also, the participation of communities who often know best their most vulnerable members is promoted. Kinship-support systems are less prone to be undermined. This targeting also contributes to developing grassroots initiatives and encouraging gender-balanced representation, which is often imposed on from outsiders. Moreover, more refined targeting is possible (wealth, family size, family members, workloads, etc.). Finally, it usually ensures an improved complaint system.

**Gender-related disadvantages:** Community leaders are not always the best representatives for the poor in their society. In addition, the lack external supervision might reinforce the community gender imbalance. If the targeting is biased, it may have negative effects on the community.

Source: Adapted from *Socio-Economic and Gender Analysis (SEAGA) in Emergency and Rehabilitation Programmes*, FAO/WFP, 2007.

Gender-related targeting issues are most applicable to GFD and the livelihoods interventions discussed below, because other emergency nutrition interventions select their target groups based on age and biological vulnerability (children under five years of age, or PLW) or based on the gender-neutral basis of their nutritional status, which determines admission to therapeutic care and supplementary feeding programmes (SFPs).

**Social and Behaviour Change Communication (SBCC)**

Telling people what to do is not an effective approach for communication. SBCC was developed as a more effective strategy, which is based on community engagement. Most nutrition interventions use this strategy, allowing the population to voice their issues and take ownership. Behaviour change is not a “*luxury in an emergency. It is a necessary component of efforts to ensure the survival, health, development, protection and psychological recovery of an affected population*.”[[9]](#footnote-9) Nutrition SBCC can be widely used and is helpful in:

* + promoting good behaviour and discouraging poor practices;
  + familiarizing communities with the use of new products or services;
  + raising awareness in the community and investigating barriers to service uptake.

In the past, many programmes were gender-blind or failed to target men for communication on nutrition, and were therefore less effective. While women are usually responsible for taking care of young children and providing food for families, it is often the men who have more power and take the decisions. For example, they usually determine how to distribute the food, especially the more expensive protein-rich foods, and also have a say in when to start and to stop breastfeeding.

It is recommended to set up a central Health Education and Communication Coordination Unit soon after the onset of an emergency so that all agencies will use the same messages and materials. In particular, effective gender-responsive SBCC is important for infant and young child feeding in emergencies (IYCF-E). The first step is to determine the major barriers and beliefs related to infant feeding and other aspects of nutrition (see Module 17).

**Barrier analysis** is a rapid assessment tool that can help to identify why recommended healthy behaviours are reluctantly adopted or not adopted at all.[[10]](#footnote-10) Food for the Hungry, a Swiss NGO, developed this approach to identify and overcome barriers to healthy behaviour. There are seven steps in the analysis. After tabulating or organizing the data from the analysis, decisions should be taken on what changes are needed in programme design and in the behaviour change messages used, and which groups to target. Changes in the determinants should be monitored during the life of the project. Although this tool is not designed specifically for gender, it can be used effectively to assess and address gender barriers. By working with communities, messages are more likely to be heard.

UNICEF has produced a toolkit on SBCC specifically for use in emergencies,[[11]](#footnote-11) which together with HTP Module 19, *Working with communities in emergencies*, provide more information on how to develop effective evidenced-based, gender-responsive communication in emergencies. When the content for the SBCC strategy has been developed and target groups defined, a **rapid and gender-responsive analysis of the most suitable channels** **for communications** needs to be undertaken. SBCC can include oral channels, such as radio and interpersonal communication through community networks, community workers and religious channels. Innovative means of communication include the press and mobile phone text messages. For example, during the Haiti earthquake response in 2010, radio messages, plays performed by local theatre groups, and an ‘advertising’ car with loud speakers were used to communicate key IYCF messages in Haitian Creole.

When developing SBCC messages and choosing the type of communication channels (e.g. oral, leaflets, posters), it is important that they reach and appeal to the target group. **Rapid field testing** is needed in emergencies. Since in many emergency situations, children take care of their younger siblings, SBCC on health and nutrition promotion should include them as a target group. When messages and or communication materials are developed, they should be clear and simple enough for them to understand. There may also be more male caregivers of young children who should therefore be targeted; messages that address mothers will not appeal to them and vice versa. In order to address children, a different tone and illustrations than those used for adults should be used.

If gender-related barriers to optimal nutrition practices and to the use of services are identified, they should be included in the communication strategy as appropriate. Moreover, SBCC also provides a potential entry point to addressing strategic gender needs. For example, messages involving boys and men performing domestic chores or taking care of young children together with women and girls will eventually contribute to changing gender roles and a more even distribution of tasks and chores among the sexes. (See **Box 3** for a summary of the rationale behind SBCC in humanitarian response.)

***Box 3: Social and Behavior Change Communication*(*SBCC*) *in humanitarian response***

Preparing and responding successfully to emergencies require that evidence-based social and behaviour change communication (SBCC) strategies become an integral part of emergency preparedness plans and training. Communication efforts will result in improved health, hygiene, protective and caring practices. It will also lead to positive collective action and informed demand among affected communities for emergency assistance, supplies and services. All of these actions are crucial in protecting and promoting the

well-being of children, women and their families when a disaster strikes.

Experience has shown that affected members of communities can become effective agents of behaviour change and mobilizers for disaster preparedness and response. The participation of adults, children and young people in recovery, relief and rehabilitation is integral to any strategic communication action plan. Participation has proven to promote psychosocial healing and cohesion among affected community members during times of crises. It is a truism that affected communities are too shocked or helpless to assume responsibilities for their own survival and recovery; on the contrary, many affected people, especially children, find strength and are able to return to normal life faster when they help others during and after an emergency.

Source: Adapted from UNICEF, BehaviourChange Communication in Emergencies: A Toolkit’, Foreword, 2006. See http://www.unicef.org/ceecis/BCC\_full\_pdf.pdf

**Gender-responsive monitoring and evaluation**

Monitoring the different needs of women, girls, boys and men, and vulnerable groups in the target population, and monitoring whether and to what extent interventions are addressing these needs can improve the quality and impact of nutrition in emergencies if this information is used appropriately. It will also improve accountability, especially when monitoring and evaluation results are shared with the beneficiaries, allowing for a two-way communication.

Monitoring and evaluation systems should avoid the use of too many indicators, complex indicators that are not understood by the staff, and indicators that do not contribute to measuring effectiveness of interventions.

**Minimum** **gender-sensitive indicators**

At a minimum, the indicators listed in the ADAPT and ACT Framework and checklists in the IASC *Gender Handbook* should be used for monitoring and evaluation in nutrition in emergencies.

* Collect sex- and age-disaggregated data on nutrition programme coverage, including:
* percentage of girls and boys aged 6-59 months treated for acute malnutrition (SAM and MAM cases presented separately;
* percentage of girls and boys under five, PLW in the target group covered by supplementary feeding programmes and treatment for moderate acute malnutrition;
* percentage of boys and girls under five covered by nutrition surveillance;
* percentage of women, girls, boys and men who are still unable to meet nutritional requirements in spite of ongoing programming;
* exclusive breastfeeding rates and other relevant Infant Young Child Feeding in Emergency (IYCF-E) indicators for girls and boys.
* percentage of men and women benefitting from nutritional behaviour change interventions
* Implement plans to address inequalities and ensure access and safety for the entire target population.

**Participatory monitoring**

In participatory monitoring, beneficiaries are involved in measuring, recording, collecting, processing and communicating information to assist both operation management staff and the beneficiary group members in decision making. Participatory monitoring is recommended (**Box 4**) to improve gender equality because it places beneficiaries at the heart of the response, allows their views to be taken into account and increases accountability towards them. Staff and beneficiaries involved in setting up monitoring systems and in evaluation teams should ideally comprise women and men from the various socio-economic groups and, if possible, gender equality experts.

***Box 4: Participatory monitoring***

## Adapting a more participatory approach in monitoring and evaluation requires greater involvement of community members, women, girls, boys and men at all steps of the project cycle. Community members can become involved in the initial design of the intervention by collecting and analysing data through more qualitative approaches and by ensuring that the findings are shared. Qualitative approaches to monitoring and evaluation are of particular value, allowing voices to be heard and community members to tell their story in a culturally appropriate and non-threatening way. Including project participants in the impact assessment process can create an opportunity to develop a learning partnership involving the donor, the implementing partner and the participating communities.

Source: Adapted from HTP Module 20; and *Participatory Impact Assessment: A Guide for Practitioners*, 2008, Tufts University/Feinstein International Centre.

An additional advantage of using a participatory approach in monitoring and evaluation while using gender-sensitive indicators is that it contributes to awareness and better understanding of gender equality among the beneficiary community. During interventions, a useful method for generating participatory information and redefining policies and objectives is to organize participatory workshops with all stakeholders, with an adequate and balanced representation of the beneficiaries. Gender should be included in the workshop agenda by asking such questions as: Does gender affect the use of services? Is the targeting gender-responsive? Which practical and strategic gender needs should still be addressed?

**Disaggregation of data by age, gender and/or diversity provides more visibility to vulnerable groups.** If vulnerable groups are visible at the data collection stage, then it is more likely that their specific needs will be incorporated into programme planning and implementation. Disaggregating data by age and sex can reveal biases and aspects that might not have surfaced otherwise, as presented in **Case 5** on the Democratic Republic of the Congo.

***Case 5: Incorporating gender considerations into nutrition programming: Democratic Republic of the Congo***

|  |
| --- |
| Experience shows that when sex- and age-disaggregated data (SADD) data are available, they can improve overall programme quality and effectiveness. For example, previous national demographic and health surveys conducted in the Democratic Republic of the Congo showed that a larger proportion of boys than girls were classified with moderate or severe acute malnutrition. Selective feeding programme data, however, indicated that more girls were admitted than boys. Failure to consider boys’ increased vulnerability resulted in a lack of understanding of the causes of this situation as well as the necessary actions to reverse it. The Nutrition Cluster is now trying to address this gap by analysing the social dynamics that impact boys’ nutritional wellbeing. The results of this gender analysis will eventually inform programming.    The Nutrition Cluster also developed minimum commitments on gender in emergency nutrition. The commitments were the product of a dialogue with cluster members at provincial and national levels, who committed to:   * analysing the particular nutritional vulnerabilities of boys and, on that basis, take the adequate corrective measures; * ensuring that fathers and mothers are equally targeted by food education activities; * engaging fathers in taking care of malnutrition cases would be encouraged; * systematically consulting women in order to identify the opening hours and days that are most convenient for them; * ensuring a balanced representation of sex in care teams and community mediators; * disaggregating by sex the number of aid beneficiaries, recruited community mediators and care personnel targeted for training. |

Source: Adapted from Delphine Brun, GenCap Inter-Agency Advisor to Global Clusters, 2011

By integrating a gender dimension into monitoring and evaluation, it is possible to capture information leading to a better understanding of the different risks facing women, girls, boys and men in a given context and how to best address them in programming. It will also help measure to what extent a project has addressed the different needs of men and women and has made an impact on their overall lives. Taking GFD as an illustrative example,[[12]](#footnote-12) some specific questions or gender-sensitive programme performance indicators can be used to identify whether there is gender disparity in the way the intervention is implemented, as follows:

* Is food aid targeted to women and child-headed households?
* Is a household registered in the women’s name to ensure women have greater control over how food is used in the home and to encourage greater household food consumption?
* Is the provided food basket adequate to meet the nutrition needs of women and girls, boys and men, and the micronutrient needs of children and adolescent girls?
* Are pregnant and lactating women being targeted with food aid and supplements to meet their specific physiological requirements?
* To what extent are women participating in:
  + the assessment and targeting process, especially the identification of the most vulnerable;
  + the composition of the food baskets;
  + decision making on the timing and location of food distribution points on the size of the food basket and the frequency of distribution;
  + the assessment of cooking needs and the collection of firewood and water;
  + the assessment of their security at, and travelling between the distribution points and their homes;
  + food distribution committees – do they have an equal number of men and women?
* To what extent is equal access to services achieved?

**Interpreting Sex- and Age-Disaggregated Data**

Although SADD is now widely applied, the collected data are not always sufficiently used. Disparities in SADD in nutrition needs assessments require an analysis and sometimes an additional survey. For example, there may be need to assess why there are different exclusive breastfeeding rates for male and female babies, why there are different percentages of women, girls, boys and men who are malnourished in some of the age groups, or why older people suffer disproportionally. The causes may be related to any of the gender dimensions described in the rationale. Disparities observed during a humanitarian crisis may also be the result of gender bias or gender blindness in programme performance.

Gender-sensitive programme performance indicators also include the ratio between male and female service providers and volunteers because this can influence enrolment and attendance of services. (See **Box 5** for a useful gender-sensitive reporting system checklist.)

In conclusion, the aim of collecting SADD is to use this information in order to develop and implement plans to address any inequalities and ensure access and safety for all of the target population.

***Box 5: Reporting system checklist***

Determine whether the current reporting system generates information separately for men and women concerning:

* project staff at various levels;
* committees at each level;
* implementing agency staff;
* registration committees;
* numbers of entitled persons;
* distribution committees;
* category (internally displaced person, refugee, returnee);
* participants in reconstruction work;
* total persons receiving aid;
* heads of households.

Was the operation designed properly to focus on the differential effect of the disaster on women and girls, boys and men? Has their situation improved?

Did we use the available resources efficiently, measuring the outputs in relation to the inputs?

Did we achieve the expected results effectively?

How can we adjust assistance to the specific needs of women and girls, boys and men?

Was the type of aid provided truly tailored to the real and different needs of the affected women and men, girls and boys?

Could the needs of women and girls, boys and men have been met more efficiently following a different approach?

Does the reporting system incorporate a participatory approach among project staff at different levels to assess the progress?

Does the monitoring and evaluation system incorporate participatory feedback from women and girls, boys and men?

Source: Adapted from Module 10*, Monitoring and evaluation*, *SEAGA for Emergency and Rehabilitation Programmes*, FAO/WFP, 2007.

**Focusing on older people, the disabled and people living with HIV/AIDS**

The monitoring and evaluation of nutrition interventions should include an analysis of the situation of **older people** to better understand their specific needs, track their ability to access basic services and assess the appropriateness of food rations to meet their needs. Relevant questions to monitor and evaluate the interventions include:

* Are older men and women involved and consulted during the assessment phase?
* Is blended food provided as part of their ration?
* Is physical access to the general food ration sufficient (e.g. through decentralization of distribution sites and more frequent distributions in order to reduce the weight of the food rations)?
* Do older people have sufficient access to fuel and water for cooking? And are there any gender differences between older men and older women with regard to access?
* Are there any programmes assisting them? What are they and are they adequate?

One of the challenges in monitoring the nutrition situation of older people is the difficulty in assessing them anthropometrically.[[13]](#footnote-13) MUAC is mainly used to determine their nutritional status because an accurate measurement of height may be problematic due to a disability or the inability to stand up straight. Older people are the focus of HTP Module 23, *Nutrition of older people in emergencies*.

Similarly, the nutritional status of **people with disabilities** should be regularly monitored to ensure that needs are being met. Depending on the nature of the disability, this may be challenging due to difficulties in taking anthropometric measurements. It is also important to monitor the rate at which people with disabilities are receiving food rations and other supplies, and to take disability-appropriate measures to improve access to services where necessary.

In addition, monitoring the needs of **PLWHA** and how they are met by the response requires the necessary attention, as discussed in HTP Module 18.

**Gender-responsive programming for specific humanitarian nutrition interventions**

This section emphasizes gender considerations to factor in when planning and implementing specific humanitarian interventions to prevent and treat malnutrition. Please refer to the relevant sections in this module for guidance on gender-responsive needs assessment, targeting, design, training, SBCC and monitoring and evaluation in nutrition emergency response.

**General Food Distribution**

GFD now falls under the Food Security Cluster. Because the GNC’s role in GFD is to support adequate nutrition needs assessment and monitoring of GFD implementation (including food basket monitoring) and subsequent advocacy, it is important to present here some of the many gender-sensitive aspects related to GFD. Understanding these issues also facilitates the inter-cluster coordination between the nutrition and food security clusters, and an improved outcome for beneficiaries.

**Targeting food distribution**

The section above on targeting is especially relevant to GFD since this is the largest nutrition intervention both in terms of numbers of beneficiaries and budget, and much of its effectiveness depends on adequate targeting. Food aid will normally be distributed to women, because this is a World Food Programme (WFP) requirement for food assistance programmes. Targeting female-headed households on the basis that they are most vulnerable to food insecurity is another strategy often used by agencies.

For gender-responsive targeting:

* + ensure that each household ration card for free food distributions is issued in a woman’s name;
  + register households receiving food aid to facilitate equal distribution;
  + ensure that female- and adolescent-headed households, polygamous households and vulnerable groups are included in food distribution lists;
  + if polygamy is widely practised, ensure that women are recipients of food aid for themselves and their children;
  + facilitate priority access to GFD for women and older people, and provide support for transport of the rations;
  + consider, to the extent possible, direct/easily accessible distribution to the most vulnerable groups and/or provision of means of transportation to communities or groups of beneficiaries (e.g. community-owned wheelbarrows);
  + ensure that children under five years of age, ill or malnourished individuals, pregnant and lactating women, and other vulnerable groups are given priority for feeding and food aid programmes;
  + ensure available, appropriate foods for PLW, children and older people that will meet their nutrition requirements;
  + ensure that the type of ration does not require much preparation work.

Effective targeting depends on an adequate gender-responsive needs assessment. In addition, SBCC, monitoring and evaluation, and prevention of GBV are important since women and girls are easy victims of theft. For example, during the Haiti emergency, women collecting food were attacked and their food stolen after leaving distribution sites. In Sudan, during the Bahr El Ghazal crisis in 1998, WFP Food Monitors distributed food to the female headed households but the local authorities captured the food at a central location away from the WFP distribution site and then redistribute to the entire population after taking 25 percent of the food for the Sudan people’s Liberation Army (SPLA).

**Communication and accountability around food distribution**

Targeting criteria should be transparent and beneficiaries have the right to know their entitlements and the date or period when the next distribution will take place (see **Case 6**).

***Case 6: Transparency and Communication on General Food Distribution***

In order to avoid tension, communities – host communities, refugees and internally displaced persons (IDPs), etc. – must be informed about who qualifies for food aid, the selection criteria, the targeting and distribution arrangements (timing, composition and size of food rations) and entitlements per person or per household, among others, so that the intervention does not increase risks and insecurity. Consultations with various sectors of the population can help identify potential sources of risk and entry points to resolve tensions early on. During a focus group discussion in Colombia, for example, women reported tensions between people receiving food aid and other members of the community not receiving food aid who questioned their exclusion from food aid activities.

Source: Adapted from *IASC Handbook on Gender, Women, Girls, Boys and Men: Different Needs – Equal Opportunities,* 2006

Management and coordination of food distribution is the task of the Food Security Cluster; every effort should be made to include women in decision making and implementation of GFD. While it may be relatively easy to ensure that women have a presence in village or camp distribution committees and are the recipients of food aid, it is more difficult to ensure they actively participate in decision making and that their opinions and suggestions are given equal weight to those of men. Establishing quotas for women in leadership positions as well as using voting as a basis for decision making may mitigate gender imbalance. Guidance on GFD implementation is provided in HTP Module 11, *General food distribution*, and the *IASC Gender Handbook*.

**Monitoring and Evaluation of General Food Distribution**

The GNC partners will be involved in **food basket monitoring** to assess the adequacy of the provided food rations. Module 11 provides more information on nutrient requirements for GFD. For calculating and planning appropriate rations, certain gender-related elements apply:

* population structure in terms of sex and age to estimate energy requirements. A population composed exclusively of women and children will require approximately 6 per cent less energy than a standard population. Where boys and men constitute the total population, the average daily energy requirements would be increased by 6 per cent;
* micronutrient requirements for children, pregnant and lactating women, and adolescent girls;
* the need to provide ready to use foods and blended food including ready-to-use therapeutic foods (RUTFs)[[14]](#footnote-14) for children, PLW, and ill and older people (see Module 11).

If the women designated to receive food aid are not present at the time of distribution, the reasons for this should be investigated. Women should be interviewed specifically regarding their views on: the distribution system; how food is used at the household level; and how their involvement in the collection of food affects their ability to care for children and perform their other domestic responsibilities. (See also the GFD-related example of monitoring and evaluation questions above.)

In addition, the impact of the food aid programme on women, men, girls and boys (needs, access and control over physical and human resources) should be assessed in light of their current and future well-being and livelihoods. This can be assessed through focus group discussions with open questions and in-depth interviews with key informants of both sexes and all ages. Consultations should be held with women and men separately to anticipate and address any negative impact that food aid interventions may have on women and girls, boys and men.

**Cash transfers and food vouchers**

When food aid is replaced with cash transfers or food vouchers, additional gender aspects should be considered, such as the need to minimize the risk of theft and/or GBV, as well as the risk of male dominance over decisions on expenditures. Where cash has been specifically targeted at women, it has contributed to their decision-making power within the household.

In all cases, cash transfer and food voucher programmes need to be sensitive to underlying gender inequalities. When food vouchers are provided, there are nutritional benefits and income-generating opportunities for the whole family. There is evidence that cash can be as effective as food aid in meeting nutritional needs of women and girls. Cash can also have a positive influence on caring practices. In Ethiopia, Save the Children found that in households receiving cash transfers, mothers fed their children more frequently, giving them a wider variety of grains and pulses and an increased amount of livestock products, oil and vegetables. Furthermore, mothers spent less time collecting firewood or dung as an income source, thus enabling them to spend more time at home caring for their children.[[15]](#footnote-15)

**Infant and Young Child Feeding in Emergencies**

Gender programming guidance is relevant and should be applied to IYCF-E.[[16]](#footnote-16) In particular, the gender-responsive needs assessment presented above is paramount for identifying gender-related and other barriers to optimal infant and young child nutrition, health, feeding and care.

**For optimal IYCF-E, mothers and caregivers of infants up to six months of age need to**

immediately and exclusively breastfeed, and therefore require:

* + access to good maternal nutrition including safe drinking water;
  + access to adequate information and skilled support;
  + access to mental health and psychosocial interventions, as needed;
  + decision-making power;
  + privacy, especially in some cultures;
  + time to breastfeed feed and care for infants and themselves;
  + support by partner and wider community;
  + gender-responsive and evidence-based SBCC developed with the target group.

**For optimal IYCF-E, mothers and caregivers of infants from six months to two years of age need to** breastfeed and provide complementary feeding (in addition to the above), and therefore require:

* + access to micronutrient rich foods for complementary feeding;
  + kitchen equipment and eating utensils;
  + soap and safe drinking water for hygienic preparation;
  + safe and culturally appropriate water and sanitation facilities;
  + time to prepare food and to feed and care for infants and young children;
  + support by partner and wider community;
  + access to mental health and psychosocial interventions, as needed;
  + gender-responsive and evidence-based SBCC developed with the target group.

Availability and access to these factors should be the focus of the assessment and response. Assessment teams should include at least one person who has received basic orientation on IYCF-E and on gender. Gender inequality can undermine the mother’s choice or ability to breastfeed, e.g. by pressure or lack of support from her husband and extended family, lack of time due to the unequal distribution of tasks. These broader influences should be investigated to develop effective gender-responsive SBCC that empowers mothers, fathers, and the communities to make informed decisions. This will increase the possibility for better outcomes. For example, in Haiti, mothers and their partners/husbands believed that the shock of the earthquake had made their milk turn bad, and their partners insisted that the mothers feed the babies breast milk substitutes. This possible barrier to breastfeeding could be overcome through SBCC. Identified barriers to adequate IYCF-E practices need to be addressed in programme design and in corresponding SBCC in order to prevent acute malnutrition and improve access and uptake of treatment for acute malnutrition.

**Time constraints** for mothers often compromise caring practices during emergencies. They can negatively affect both breastfeeding and complementary feeding, such as hygiene and the quality of prepared complementary food, as well as reduce the frequency and duration of feeding. These time constraints can be reduced through a variety of strategies, including the provision of mills, fuel-saving strategies, the provision of water points in the vicinity, and community child care services. In addition, changing gender roles with respect to household chores and child care will achieve a more even balance of work and leisure time between women, girls, boys and men.

**Social and economic factors** may also critically influence IYCF practices in general and especially in emergencies, for example, if a mother needs to go out to work to earn money, this affects her capacity to breastfeed her infant. In addition, privacy is needed for breastfeeding in some cultures. Community awareness and socio-cultural factors also play an important role, as **Case 7** shows.

***Case 7: Socio-cultural practices that influence infant and young child feeding practices in Yemen***

During gender workshops in December 2010 with a Nutrition Cluster in Aden, Yemen, Cluster members noted that mothers-in-law and other older women in the family have control over a woman’s breastfeeding practices. They reported that, in some cases, older women stop mothers from breastfeeding and advise them to give secondary feed, believing that their milk will cause harm to the child. Furthermore, among affected community, some lactating women were advised by older women to stop breastfeeding because they believed that since the mother was not getting nutritious food, her milk had no value. This was considered one of the reasons for acute malnutrition among children under three months of age.

During another gender workshop with the Nutrition Cluster in Sa’ana, Yemen in March 2011, Cluster members partly attributed high rates of malnutrition of children under five years of age to socio-cultural practices. One Cluster member described a case in which a father did not support his child’s admission to a Stabilization Centre because the child’s mother would have to spend the night outside the home. Given the cultural norm that women should not appear in public, this was clearly not an option. Other Cluster members noted that women in this region generally have no control over family income, which influences their and their children’s nutritional status, because less is spent on buying nutritious food. Moreover, they reported that while women prepare the food, it is the men who distribute it, meat in particular, and women may be forbidden from eating certain types of food including protein-rich meats due to cultural norms.

Source: UNICEF Yemen, Mission Report, 2011

**Saving lives through breastfeeding**

Enabling women to breastfeed during emergencies is a life-saving measure that needs **skilled breastfeeding support (breastfeeding counselling**[[17]](#footnote-17)**) and psychological support** in addition to support from the community and adequate food intake. During emergencies, in particular, mothers lack the confidence to breastfeed, and myths about the inability to breastfeed due to stress and shock need to be counterbalanced through gender-sensitive communication (see Module 17, Annex).

The father, the husband or the relative of a mother who is breastfeeding or who has breastfed and has stopped during this crisis should encourage her to continue or restart. She should be reassured of how well she is equipped to nourish and protect her baby.

Breastfeeding is particularly critical among the most vulnerable infants – newborns, prematurely born babies, twins, ill or malnourished infants, and infants whose mothers who face physical, emotional or nutritional challenges. In particular, during antenatal care, the importance of exclusive breastfeeding as a life-saving measure should be addressed together with practical advice for early initiation of breastfeeding within one hour after birth.

This is even more crucial in populations where artificial feeding is widespread. In such populations, health and nutrition staff may need refresher training on the importance of breast feeding, especially in emergencies. Good results were achieved after the Haiti earthquake when over 100 baby-friendly tents were set up by different NGOs. Mothers and caregivers with children up to two years of age came to the tents to receive infant and young child feeding counselling.[[18]](#footnote-18)In Indonesia, following the earthquake, breastfeeding counselling helped to reduce the negative stigma in using donated infant formula by households with infants and young children. Breastfeeding support actually improved early initiation and exclusive breastfeeding rates to greater than pre-emergency levels.[[19]](#footnote-19)

Clearly, it is essential that **training on breastfeeding and IYCF**, an important part of emergency preparedness, be developed and integrated in all levels of nutrition programming and healthcare. (Annex 7 describes the **ten steps** to successful breastfeeding that should be implemented by all facilities providing maternity services and care for newborns and infants, including services providing malnutrition treatment.)

Services should be established to provide nutrition and care for **orphans and unaccompanied infants and young children.** Additional guidance can be found in Module 17, *Infant and young child feeding*, which also presents guidelines on breastfeeding and breast milk replacements in the context of HIV/AIDS.

**Gender-responsive Management of Acute Malnutrition**

In the HTP modules on supplementary feeding programmes (Module 12, *Management of moderate acute malnutrition*) and on outpatient and inpatient therapeutic care (Module 13, *Management of severe acute malnutrition*), relatively little attention is paid to gender. Gender considerations that are specifically related to malnutrition treatment interventions will be presented here. The preceding IYCF-E section should also be consulted.

**Supplementary feeding programmes**

SFPs are usually established for the management of moderate acute malnutrition (MAM) and to prevent deterioration into SAM. These targeted SFPs use anthropometric admission criteria for children under five years of age and sometimes also for PLW.

Blanket supplementary feeding is generally used as a preventive measure among a specific target group for a specific period of time in order to prevent MAM in the population. Targets groups should be based on nutritional vulnerability and usually include children under five years of age and pregnant and breastfeeding women as priority target groups, but could also include ill and disabled individuals, older people and orphans.

Women leaders and mothers in particular should be involved in decision making on the design of both types of SFPs, the locations where they will be held and the opening hours. The gender barriers identified in the needs assessment or barrier analysis should be taken into account. For example, Module 12 states that one of the advantages of dry take-home rations is that it is less time-consuming for mothers and caregivers to attend weekly or every fortnight instead of daily. This leads to bettercoverage and lower default rates. SFPs may face a lower attendance rate in the rainy season or during the labour-intensive peaks in the agricultural cycle. Possible solutions include the distribution of double rations, decentralization of distribution sites, and mobile distribution teams that deliver care closer to homes. Other possible barriers to overcome are related to privacy in the areas where children are weighed and measured, and the gender of the service provider.

**Therapeutic care**

SAM is now mainly treated in outpatient therapeutic care as part of community-based management of acute malnutrition (CMAM) for which children have to present themselves weekly to receive RUTF as a take-home ration, and to have their health and nutritional status monitored. As in SFPs, it is important that women be involved in its design and implementation. Only children who present complications (e.g. general oedema and/or lack of appetite) will need to be admitted to inpatient therapeutic care, and usually for only a few days or 1-2 weeks. This is a major improvement over the therapeutic feeding centres (TFCs) that would admit all SAM children for long periods and had a lower cure rate. Long-term admission in TFCs disrupted family life because mothers were admitted with their children. Nevertheless, mothers or other caregivers need to accompany the now-reduced number of children that need to be admitted to the inpatient therapeutic care facility; this can be a barrier that may prevent the child’s admission and treatment (see **Case 7**).

Another related concern is that when a child is admitted with his or her mother in the inpatient therapeutic care, the rest of the family depends on support from neighbours or other family members, or on the father’s cooking and caregiving skills. To prevent a deterioration of the nutritional status of the family members who remain behind, consultations can be held with the caregiver and the family to identify serious problems and refer to community support services if needed and available. A guest facility next to the hospital ward where the mothers can cook for themselves and their families should be established (See Modules 11, 12 and 13).

It is important that therapeutic care programmes are able to provide skilled breastfeeding assistance to support the caregivers of malnourished infants and young children, as discussed in more detail in Module 18, *HIV & AIDS nutrition*, and under IYCF-E above.

**Treatment of infants under six months of age**

Malnourished infants under six months of age have increasingly been the focus of new developments in IYCF-E for the treatment of MAM and SAM. The main strategy is to establish or re-establish breastfeeding by mothers or caregivers (wet nurses) (see Module 12).

**Sex-disaggregated data management**

According to HTP Module 20, *Monitoring and evaluation*, “Where possible, indicators should be disaggregated to reflect differences according to gender, age or other relevant factors.” However, tracking sex-disaggregated data from admission in – to discharge from – SFPs (or default, referral or non-response) and outpatient therapeutic care effectively doubles the reporting work. Researchers of the Minimum Reporting Project[[20]](#footnote-20) acknowledge this as well as the fact that sex-disaggregated data in these interventions are seldom analysed and if so, rarely show any significant differences. In order to address this lack, monitoring and registration of SADD are recommended. Any substantial gender discrepancies at admission could be the result of gender discrimination, unequal access or differences in prevalence rates between boys and girls, and should be further investigated and addressed. Current recommendations in Module 12 on SFPs therefore recommend only reporting sex-disaggregated data for new admissions, which will identify gender-related differences in access and/or vulnerability (see also section *Interpreting SADD* above).

**Emergency School Feeding**

Both in development and in humanitarian assistance, school feeding programmes are seen as opportunities to meet the food needs of vulnerable children. These intervention should be jointly prepared with the Food Security and Education Clusters.

Girls are usually the first to drop out of schools in emergencies. In many cases, school feeding programmes aim to reduce gender disparities by encouraging families to send girls to school, providing a school meal or take-home ration as an incentive. Where only girls or boys (based on the situational context) receive the meal or ration, this is an example of a *targeted gender intervention*.

In other school feeding programmes, both boys and girls will receive food to address low enrolment and attendance in schools in certain geographical areas or where schools are located at long distances from the households. When food is provided as school meals, it will contribute to attendance, concentration and scholastic performance. If home rations are provided, they may be shared with other family members. In both cases, school feeding programmes contribute to reducing short-term hunger and nutritional deficiencies.

**Micronutrient Interventions**

Micronutrient deficiencies can easily develop during an emergency or exacerbated. This occurs because livelihoods and food crops are lost; food supplies are interrupted; diarrhoeal diseases break out, resulting in malabsorption and nutrient losses; and infectious diseases suppress the appetite while increasing the need for micronutrients to help fight illness. For these reasons, it is essential to ensure that the micronutrient needs of people affected by a disaster are adequately met. To achieve this, it is critical that general food-aid rations are adequate and well-balanced to meet nutrient needs, and that they are distributed regularly and in sufficient quantities. Micronutrient deficiencies in populations affected by an emergency can be prevented and controlled through multiple vitamin and mineral supplements for PLW and for children aged 6 to 59 months. (HTP Module 12 presents sex- and age-specific micronutrient requirements. Some micro-nutrient interventions focus on pregnant women and girls only, such as supplementation of folic acid and iron.)

**Livelihood Interventions**

Guidance on gender-responsive programming should be applied to livelihoods interventions. While livelihood interventions may not be the primary concern of the Nutrition Cluster, they do have nutrition and gender implications; they aim to address some of the underlying causes of malnutrition, usually during the rehabilitation phase. Additional information can be obtained in

GFSC website.[[21]](#footnote-21) The HTP Module 16, *Livelihood interventions*, which presents a variety of interventions:

* Cash for work
* Cash grants
* Microfinance
* Commodity vouchers
* Cash vouchers
* Monetization and subsidized sales
* Market infrastructure
* Destocking
* Agriculture, livestock and fishing support.

Food-for-Work programmes are another type of livelihood support, which is described in Module 11. Various income-generating activities, which often include skills training and provision of inputs to start up a small business, also aim to strengthen livelihoods.

In both emergency and development settings, it is important to ensure that women as well as men are targeted for livelihood support interventions. At the same time, programme designers and implementing agencies need to realize that women’s involvement in cash- or food-for-work activities will reduce their time for taking care of children and other vulnerable family members. Female-headed households, therefore, cannot always be expected to participate in such schemes or other activities that aim to replace GFD. Therefore, blanket SFP or other parallel support programmes targeting female and child-headed households will be required in emergency settings where there is no GFD.

Women are often encouraged to return to subsistence farming in the aftermath of an emergency with the provision of seeds and tools. However, there are gender implications if only women are targeted. It is equally important to obtain the full participation of women, girls, boys and men in all subsequent steps such as project design, implementation, and monitoring and evaluation. It has been argued that by focusing on women’s livelihoods to meet a food security agenda, there is a risk of ignoring potentially more successful opportunities for livelihood development outside agriculture.

Gender-responsive needs assessments for livelihoods interventions during rehabilitation must focus in greater detail on productive roles and access to productive assets – i.e. focus on who owns, uses and controls these assets, on how roles are divided, and on who makes the decisions. During crises, women very often assist with or completely take over activities that are normally performed by men. Special attention should therefore be given to allow women access to services such as credit, extension, training on appropriate technologies, supply sources, transport and mobility because, in many cases, these may have been targeted to men. Women’s access to land is not only a legal matter or a customary issue, but also, a question of power. In some cases, emergency interventions may negatively affect women’s control of crop production and land cultivation. For example, when new techniques are introduced and revenues increase, men might be attracted and take responsibility for the introduced activity.

Here, caution should be used regarding the potential negative impact of only targeting women for livelihood projects because this increases the burden on women to be the sole provider for their families and alleviates men of their responsibilities for their families. Opportunities for engagement in livelihood projects should also, therefore, consider the involvement of men.

Time- and energy-saving technologies should be specifically considered and designed for women who often carry the burden of major workloads, because this extra time will benefit care and nutrition of families. The FAO/WFP Socio-Economic and Gender Analysis Programme (SEAGA) materials,[[22]](#footnote-22) among others, provide guidance including practical steps on how to use specific participatory rural appraisal (PRA) tools to identify needs and opportunities to improve livelihoods of women, girls, boys and men during recovery and rehabilitation. Daily Activity Clocks and Gender-disaggregated Seasonal Calendars are extremely useful in this context (see Annex 6 for a description and user guide) .

**Nutrition Surveillance**

Nutrition surveillance is the continuous collection and analysis of nutritional status data in order to give warning of an impending crisis or to make policy and programmatic decisions that will lead to improvement in the nutrition situation of the population.

For nutrition surveillance and food security early warning systems that forecast and monitor food and nutrition insecurity, refer to Modules 9 and 10. **Case 8** illustrates how gender is mainstreamed in the FAO/Food Security and Nutrition Analysis Unit (FSNAU).

***Case 8. Gender-responsive nutrition surveillance***

Since 2011, the Food Security and Nutrition Analysis Unit (FAO/FSNAU) in Somalia has been working closely with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Gender Adviser and its Gender Analyst to integrate gender in nutrition analysis. Their publications provide nutrition data disaggregated by sex, and where possible, on maternal nutritional status. This information is available for Somali regional programming and is therefore imbedded in each relevant chapter of FSNAU publications. Inclusion of sex-disaggregated data in the Consolidated Appeal for Somalia is now mandatory; hence, the sex-disaggregated information provided by FSNAU is being linked to programme design of the Consolidated Appeal. OCHA works with the response agencies to ensure that gender is embedded in their programmes.

Source: Ahono Busili, Nutrition Manager, FAO/FSNAU, 2011

**Challenges, Coordination and Support**

Gender-responsive programming is growing and becoming increasingly common in humanitarian assistance policies and strategies. Some examples include the WFP Gender Policy and Strategy 2009 as one of the priorities in the programme *Promoting Positive Gender Relations and Supporting Sustainable Livelihoods through Food for Work and Food for Training*,[[23]](#footnote-23) and the central strategy of United Nations High Commissioner for Refugees’ (UNHCR) Age, Gender and Diversity Mainstreaming, which is having a positive impact on accountability within the Organization.[[24]](#footnote-24) However, despite the gender-sensitive wording in policies and strategies, much more should be done in practice to achieve gender-responsive programming in humanitarian nutrition interventions. Some of the remaining challenges are the effective use of common gender-responsive programming measures, and time and funding constraints.

**Effective use of gender-responsive programming measures**

While many programmes and projects currently apply the widely agreed measures to improve gender equality to a certain extent, there is a risk that they miss their goal. Collection and analysis of SADD data are crucial to inform humanitarian nutrition programming. However, there is no use in collecting SADD data if they are not used to design or to adjust interventions.

Pursuing a gender balance in the participation of women, from staff recruitment to management positions and beneficiary committees is a common goal today in humanitarian response. However, it should be realized that this is not a guarantee for equality in decision making. Increasing the representation of women in food-related programmes and in project design does not automatically result in equal participation in decision making. In many traditional cultures, in particular, male dominance in the public domain prevents women from giving their opinions in mixed forums. Additional measures are required, such as voting to take decisions instead of listening to the loudest voice, and quotas for women to be elected in leadership positions.

**Time, funding and capacity constraints in emergencies**

Time constraintsin emergencies may prevent conducting a gender analysis within the first rapid needs assessment. This should be corrected after the first needs have been addressed in order to ensure that the response is adequate in meeting the needs of women, girls, boys and men, and that it does not perpetuate or even exacerbate gender inequality.

In a WFP survey in 2007, the gender focal points identified **inadequate funding and capacity**, and **limited practical tools for gender mainstreaming** as challenges for implementing the gender policy.[[25]](#footnote-25)

**Coordinating efforts and supporting gender equality in emergencies**

This can be promoted through the establishment of a Gender Support Network (GenNet). The IASC recommends that GenNets be established both at the local and national level in which government representatives, civil society, United Nations agencies and NGOs would collaborate to increase gender equality in society and in emergency response. Participation of the nutrition sector in GenNets is important for coordinating activities and sharing information. In all emergencies, nutrition staff should work with the United Nations Development Programme (UNDP) and/or the Office for the Coordination of Humanitarian Affairs (OCHA) Gender Focal Point and with other sectors/clusters. This is needed also to ensure gender-sensitive humanitarian programming mechanisms for GBV prevention and response (see Annex 4).

**Technical support**

The IASC Gender Task Force now continues as a Sub-Working Group and supports the strategy for integrating gender as a crosscutting issue into the Cluster Approach and into other elements of the humanitarian reform. At the same time, the IASC Gender Standby Capacity (GenCap) project seeks to build capacity of humanitarian actors at the country level to mainstream Gender-responsive programming, including prevention and response to GBV in all sectors of humanitarian response. Its standby GenCap roster can provide support to humanitarian country teams through its pool of gender advisers.[[26]](#footnote-26)

The IASC offers the online course, *Different needs, equal opportunities; increasing effectiveness of humanitarian action for women, girls, boys and men*,[[27]](#footnote-27) which is based on the highly useful *Gender Handbook* referenced throughout this module. To address poor performance on gender and to ensure that projects and programmes are gender-responsive, the IASC developed the “Gender Marker” (see **Box 6**).

***Box 6. The IASC Gender Marker***

The IASC Gender Marker is a tool that codes, on a 0‐2 scale, whether or not a humanitarian project is designed well enough to ensure that women, girls, boys and men will benefit equally from it or that it will advance gender equality in another way. If the project has the potential to contribute to gender equality, the marker predicts whether the results are likely to be limited or significant.

Source: The IASC Gender Marker.

See www.globalprotectioncluster.org/en/areas-of-responsibility/age-gender-diversity/gender/the-iasc-gender-marker.html

The inclusion of sex-disaggregated data and a gender-responsive approach in project proposals is currently mandatory for obtaining funding through CAP. This forces project designers to formulate gender-responsive projects that lead to more effective humanitarian outcomes; the *Gender Marker Tip Sheet* for nutrition,[[28]](#footnote-28) which includes the ADAPT and ACT Framework/checklist, assists agencies to achieve this. It also provides donors with a detailed assessment of the gender-responsiveness of projects that seek funding. The Resource List, Part 4 of this module, includes additional guidelines and manuals to assist humanitarian nutrition professionals in gender-responsive programming.

**Annex 1: Key definitions**

**⚫*Gender*** refers to the social attributes and constraints associated with being male and female, and the relationships between women and men and girls and boys, as well as the relations between women and those between men. Gender determines what is expected, allowed and valued in a women or a man in a given context.

**⚫*Gender analysis*** is a systematic way of looking at the different impacts of development, policies, programmes and legislation on women and men that entails, first and foremost, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others.

**⚫*Gender balance*** means the equal participation of men and women in decision-making bodies, including those managing community facilities, infrastructure and programmes such as food distribution. Achieving a gender balance in staff recruitment improves the overall effectiveness of policies and programmes, and the capacity to better serve the beneficiaries.

**⚫*Gender-based violence*** (GBV) is an umbrella term for any harmful act that is perpetrated against a person’s will that is based on socially ascribed gender differences. Some examples are: sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; trafficking; forced/early marriage; harmful traditional practices such as female genital mutilation; honour killings; and widow inheritance.

**⚫*Gender equality*,** or equality between women and men, refers to the equal enjoyment by women, girls, boys and men of rights, opportunities, resources and rewards. Equality does not mean that women and men are the same, but rather, that their enjoyment of rights, opportunities and life chances are not governed or limited by whether they were born female or male.

**⚫*Gender mainstreaming*** is a strategy, an approach, and a means to achieve the goal of gender equality. It involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities – policy development, research, advocacy/ dialogue, legislation, resource allocation, and planning, implementation and monitoring of programmes and projects.

Source: Adapted from IASC *Gender Handbook in Humanitarian Action, Women, Girls, Boys and Men: Different Needs, Equal Opportunities*, 2006;

UN Women website, see <http://www.un.org/womenwatch/osagi/gendermainstreaming.htm>;

FAO website, see <http://www.fao.org/gender/gender-home/gender-why/en/>;

IGWG, *A Practical Guide for Conducting and Managing*

*Gender Assessments in the Health Sector*, see <http://www.igwg.org/igwg_media/gender-assessment-guide-2012.pdf>

**Annex 2: The role of culture, social norms and behaviour**

Culture shapes *how* things are done in a society and provides explanations as to *why* they are done that way.[[29]](#footnote-29) Culture can seemnatural and immutable because it conditions not just what people do, but also how they think about and understand what they do. At the same time, a culture is not fixed, but is continually changing; what is culturally acceptable or even desirable today may be unacceptable tomorrow. A culture is also not monolithic; many of its aspects are highly contested within the culture itself. For example, some segments of society may be keen to change a cultural practice, while others – particularly those who benefit from it – may fight hard to maintain it. It is, therefore, unwise to assume the existence of a true cultural consensus. Men traditionally enjoy a privileged position over women, with greater power and voice. As a result, they are frequently able to ensure that their cultural preferences and values prevail. Similarly, socially elite groups have more power than marginalized groups to define and maintain prevailing cultural values.

Development practitioners are sometimes reluctant to take actions that they fear may be perceived as interfering with another culture. For ethical reasons, they may feel reluctant to impose ideas about women’s rights that may be perceived as Western, or they might wish to avoid being accused of cultural insensitivity. However, it is advisable to assess social norms and practices with regard to universal human rights.

It is critical for development and emergency response practitioners to approach others’ practices and beliefs in a spirit of openness and respect, with a view to understanding the fundamental, underlying values that motivate such practices and beliefs; this is not the same thing, however, as uncritically accepting them. For instance, understanding that parents who supported female genital mutilation were concerned that, without such actions, their daughters would be unmarriageable and thus face a lifetime of severe economic insecurity was vital to the development of an effective approach to ending the practice. This approach consisted of a community-wide mass abandonment of the practice that lead to all girls (and thus all potential wives) being uncut, putting them on equal footing in the marriage market. Understanding that parents were motivated by concern for their daughters’ long-term futures rather than by an irrational adherence to a harmful practice was the first step in finding a lasting solution.

**To understand culture and promote gender equality, the following is important:**

* Listen to how people understand and talk about discrimination in the society: Is it a taboo topic or is it readily discussed? This gives a sense of the degree to which social change is taking place.
* Keep in mind that the dominant group does not speak for everyone. If men are speaking for women, or elites for the marginalized, it is necessary to help create forums in which people can speak for themselves;
* Refer to national commitments on gender equality, as set out in instruments such as the Beijing Platform for Action and the Convention on the Elimination of All Forms of Discrimination Against Women, and to organizations and individuals within a country who are working for a gender-equal society;
* Learn about the ways in which girls, women and socially marginalized or minority groups understand and work to shape and change their culture;
* Understand the values that underlie harmful practices rooted in cultural tradition in order to better support alternative practices;
* Use science and evidence to convey the benefits that gender equality brings to health and

development outcomes;

* When an act of sex discrimination is justified as being rooted in culture, ask if this discrimination would be acceptable if it were applied to a member of a racial or ethnic minority group.

**Annex 3: Overview of relevant Sphere Standards for Gender**

**and Nutrition in Emergencies**

Source: ‘*Humanitarian Charter and Minimum Standards in Humanitarian Response; Chapter 3: Minimum Standards in Food Security and Nutrition’*, Geneva: The Sphere Project, 2011.

The Sphere standards specify the minimum acceptable levels to be attained in a humanitarian response. The Food Security and Nutrition Standards cover assessment, infant and young child feeding, management of acute malnutrition and food security (food transfers, cash transfers and livelihoods). There are six Sphere Core Standards that are relevant to all sectors: (a) People-centred humanitarian response; (b) Coordination and collaboration; (c) Assessment; (d) Design and response; (e) Performance, transparency; and (f) Aid worker performance. Although none of the Sphere Core Standards focus on gender as such, gender as a cross-cutting issue is relevant to each of the six core standards and features in their Guidance Notes:

**Six Core Standards**

1. People-centered humanitarian response
2. Coordination and collaboration
3. Assessment
4. Design and response
5. Performance, transparency and learning
6. Aid worker performance.

The relevant **Sphere Minimum Standards** are:

1. Minimum Standards in Water Supply, Sanitation and Hygiene Promotion
2. Minimum Standards in Food Security and Nutrition
3. Minimum Standards in Shelter, Settlement and Non-Food Items
4. Minimum Standards in Health Action.

The first, second and fourth minimum standards include important gender implications that need to be taken into account for successful gender-responsive programming.

Moreover, there are four basic **Protection Principles** that should be applied by all humanitarian action to support gender-responsive programming:

1. Avoid exposing people to further harm as a result of your actions.
2. Ensure people’s access to impartial assistance in proportion to need and without discrimination.
3. Protect people from physical and psychological harm arising from violence and coercion.
4. Assist people in claiming their rights, accessing available remedies, and recovering from the effects of abuse.

|  |
| --- |
| **Sphere standards relevant to nutrition in emergencies**  **Food security and nutrition assessment standard 1: Food security**  Where people are at increased risk of food insecurity, assessments are conducted using accepted methods to understand the type, degree and extent of food insecurity, to identify those most affected and to define the most appropriate response.  **Food security and nutrition assessment standard 2: Nutrition**  Where people are at increased risk of undernutrition, assessments are conducted using internationally accepted methods to understand the type, degree and extent of undernutrition, and identify those most affected, those most at risk and the appropriate response.  **Infant and young child feeding standard 1: Policy guidance and coordination**  Safe and appropriate infant and young child feeding for the population is protected through implementation of key policy guidance and strong coordination.  **Infant and young child feeding standard 2: Basic and skilled support**  Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimizes risks and optimizes nutrition, health and survival outcomes.  **Management of acute malnutrition and micronutrient deficiencies standard 1: Moderate acute malnutrition**  Moderate acute malnutrition is addressed.  **Management of acute malnutrition and micronutrient deficiencies standard 2: Severe acute malnutrition**  Severe acute malnutrition is addressed.  **Management of acute malnutrition and micronutrient deficiencies standard 3: Micronutrient deficiencies**  Micronutrient interventions accompany public health and other nutrition interventions to reduce common diseases associated with emergencies and address micronutrient deficiencies.  **Food security standard 1: General food security**  People have a right to humanitarian food assistance that ensures their survival and upholds their dignity, and as far as possible prevents the erosion of their assets and builds resilience.  **Food security – food transfers standard 1: General nutrition requirements**  Ensure the nutritional needs of the disaster-affected population, including those most at risk, are met.  **Food security – food transfers standard 2: Appropriateness and acceptability**  The food items provided are appropriate and acceptable to recipients so that they can be used efficiently and effectively at the household level.  **Food security – food transfers standard 3: Food quality and safety**  Food distributed is fit for human consumption and of appropriate quality.  **Food security – food transfers standard 4: Supply chain management (SCM)**  Commodities and associated costs are well managed using impartial, transparent and responsive systems.  **Food security – food transfers standard 5: Targeting and distribution**  The method of targeted food distribution is responsive, timely, transparent and safe, supports dignity and is appropriate to local conditions.  **Food security – food transfers standard 6: Food use**  Food is stored, prepared and consumed in a safe and appropriate manner at both household and community levels.  **Food security – cash and voucher transfers standard 1: Access to available goods and services**  Cash and vouchers are considered as ways to address basic needs and to protect and re-establish livelihoods.  **Food security – livelihoods standard 1: Primary production**  Primary production mechanisms are protected and supported.  **Food security – livelihoods standard 2: Income and employment**  Where income generation and employment are feasible livelihood strategies, women and men have equal access to appropriate income-earning opportunities.  **Food security – livelihoods standard 3: Access to markets**  The disaster-affected population’s safe access to market goods and services as producers, consumers and traders is protected and promoted. |

**Annex 4: Guidelines for Gender-based Violence Interventions in Humanitarian Settings**

Source: Adapted from IASC *Guidelines for Gender-based Violence Interventions in Humanitarian Settings, Action Sheet 6.1: Implement safe food security and nutrition programmes*, 2005.[[30]](#footnote-30)

**Background**

Women and girls often face a different set of risks from men and boys during an emergency, such as food insecurity. Effective food security and nutrition strategies require an understanding of the gender dimensions of crises in order to identify and assess gender-specific relief needs (See Action Sheet 2.1, *Conduct coordinated rapid situation analysis*). The participation of women in decisions on how to best implement food security and nutrition programmes is critical to reducing the risks that women and girls face in emergency situations. Gender-based violence (GBV) prevention requires the application of the following principles in planning and conducting food distributions:

• The community is entitled to specific food aid benefits.

• There must be active participation of the community.

• All actions must be transparent, open and clear to all.

• All actors must facilitate access to food aid.

• All actors must ensure safety from violence and abuse.

**Key actions**

The following actions apply to the food security and nutrition sector; i.e organizations implementing food distribution and nutrition programmes. The food security and nutrition sector identifies a focal point who participates regularly in the GBV Working Group and reports on the sector’s achievement of the key actions. The food security and nutrition sector focal point(s) participate in cross-cutting functions led by the GBV coordinating agencies and working groups, as described in *Action Sheets for Coordination, Assessment and Monitoring, Human Resources, and Information Education Communication*.

1. Collect sex-disaggregated data for planning and evaluation of food security and nutrition strategies.

2. Incorporate strategies to prevent sexual violence in food and nutrition programmes at all stages of the project cycle (including design, implementation, monitoring, and follow-up), giving special attention to groups in the community that are more vulnerable

to sexual violence.

• Target food aid to women- and child-headed

households. Women and children who are the

sole providers of the household are often at

greater risk of discrimination and violence. In

times of food shortage, they are often at heightened risk of food insecurity and malnutrition. Registering household ration

cards in the names of women rather than men

can help to ensure that women have greater

control over food and that it is actually consumed.

• Give special attention to pregnant and

lactating women, addressing their increased

nutritional needs.

• For polygamous families, issue separate ration

cards for each wife and her dependents. Often,

the husband will be considered a member of

one of the wives’ households. Traditionally,

many polygamous men and their wives believe

that the husband is entitled to meals from

each wife. Carefully consider how to

assign the husband’s food ration and give clear

information to all members of the family (i.e.

all wives).

3. Involve women in the entire process of implementing food security and nutrition strategies. Establish frequent and consistent communication with women in order to understand the issues that need to be addressed and resolved. Women should participate in:

• the assessment and targeting process, especially

in the identification of the most vulnerable;

• discussions on the desirability and appropriateness of potential food baskets;

• decisions on the location and timing of

food distributions, including both general

ration distributions and supplementary feeding;

• the assessment of cooking requirements and

additional tools, their availability within the

community, and the strategies in securing

access to non-food-items. Special attention

should be given to this point since women

could be exposed to sexual violence in the

process of collection of these items (e.g. the

collection of firewood can put them in a vul- nerable position if they have to travel very far

away or outside the camp).

4. Enhance women’s control of food in food distributions by making them the household food entitlement holder.

• Issue the household ration card in the woman’s

name.

• Encourage women to collect the food at the

distribution point.

• Give women the right to designate someone to

collect the rations on their behalf.

• Encourage women to form collectives to collect

food.

• Conduct distributions at least twice per month

to reduce the amount of food that needs to be

carried from distribution points.

• Introduce funds in project budgets to provide

transport support for community members

unable to carry rations from distribution

points.

5. Include women in the process of selecting the

location of the distribution point. Consideration

should be given to the following aspects:

• The distance from the distribution point to the

households should not be greater than the distance from the nearest water or wood source

to the household.

• The roads to and from the distribution point

should be clearly marked, accessible and frequently used by other members of the community.

• Locations with nearby presence of large numbers of men should be avoided, particularly

those where there is liberal access to alcohol

or where armed persons are in the vicinity.

6. Establish gender-balanced food distribution committees that allow for the meaningful and equal participation of women. Attention should be given to the following aspects:

• Ensure that food is distributed by a gender- balanced team. Provide packaging that facilitates

handling and can be re-used for other domestic activities.

• Select the time of distribution according to

women’s activities and needs in order to permit the organization of groups that can travel together

to and from the distribution point.

• Distribute food during the day. Leave enough

time for women to return to their homes during

daylight hours.

7. Provide enough information about distributions using a variety of methods to ensure communication to everyone, especially women and girls. Inform the community about:

• the size and composition of the household

food rations;

• beneficiary selection criteria;

• distribution place and time;

• the fact that they do not have to provide services or favours in exchange for receiving

rations;

• the proper channels available to them for

reporting cases of abuse linked to food distribution.

8. Reduce security risks at food distributions. Create ‘safe spaces’ for women at distribution points.

• Appeal to men in the beneficiary community

to protect women and ensure safe passage of

women from distribution sites to their homes.

• Ensure that there is a sex balance in the food distribution teams.

• If necessary, segregate men and women receiving rations, either by having distributions for

men and women at different times, or by

establishing a physical barrier between them

during the distribution.

• Assure that food distribution teams and all

staff of implementing agencies have been

informed about appropriate conduct, prevention

of sexual abuse and exploitation, and

mandatory reporting.

• Create ‘safe passage’ schedules for child household heads.

• Begin and end food distribution during daylight

hours.

• Consider placing two women guardians (with

vests and whistles) to oversee off-loading, registration, distribution and post-distribution of

food. These women can signal to the security

focal point if there are problems.

9. Monitor security and instances of abuse in the

distribution point as well as on departure roads.

• Ensure that there are women staff from the implementing agency present during food distributions.

• Establish a community-based security plan for

food distribution sites and departure roads

in collaboration with the community.

• Establish a security focal point at each of the

distribution sites.

• Monitor security on departure roads and

ensure that women are not at an increased risk

of violence by carrying the food commodity.

**Annex 5: IASC Gender Handbook in Humanitarian Action; ADAPT and ACT Framework for Gender Equality Programming**

**in Humanitarian Action**

**Analyse** gender differences

• Use participatory assessments to gather information about nutritional needs and cooking skills of women, girls, boys and men, and on the resources that they control.

• Analyse the reasons for inequalities in malnutrition rates between women, girls, boys and men, and then address them through programming.

• Collect information on cultural, practical and security-related obstacles faced by women, girls, boys and men in accessing nutritional assistance and take measures to overcome them.

• Reflect the gender analysis in planning documents and situation reports.

**Design** services to meet needs of all

• Design nutritional support programmes according to food culture and nutritional needs of women (including pregnant or lactating women), girls, boys and men in the target population.

Ensure

**Access** for all

• Routinely monitor access to services by women, girls, boys and men through spot checks and discussions with communities, and promptly address obstacles to equal access.

Ensure equal

**Participation**

• Involve women and men equally and meaningfully in

decision-making and programme design, implementation and monitoring.

**Train** all equally

• Offer training on nutrition and gender issues for women, girls, boys and men.

• Train an equal number of women and men from the

community on nutrition programming.

• Employ an equal number of women and men in nutrition programmes.

**Address** gender-based violence

• Include both women and men in the process of selecting safe distribution points.

• Ensure that a gender-balanced team distributes the food.

• Create ‘safe spaces’ at distribution points and ‘safe passage’ schedules for women and children heads of households.

• Make special arrangements to safeguard women to and from the distribution point (e.g. by providing an armed escort if necessary).

• Monitor security and instances of abuse.

**Collect**, analyse and report programme

Monitoring data

• Collect and repot sex- and age-disaggregated data on nutrition programme coverage, including:

* percentage of girls and boys under five, pregnant and lactating women in the target group covered by supplementary feeding programmes and treatment for moderate to acute malnutrition;
* percentage of boys and girls under five covered by
* nutrition surveillance;
* percentage of women, girls, boys and men who are

still unable to meet nutritional requirements in spite of ongoing programming; and

* exclusive breastfeeding rates for girls and boys.

• Implement plans to address inequalities and ensure access and safety for all of the target population.

**Target** actions based on analysis

• Address unequal food distribution and nutrition rates within the household through nutritional support.

• Ensure that programmes address the underlying reasons for discrimination.

• Empower those discriminated against.

**Collectively** coordinate actions

• Ensure that actors in nutrition liaise with actors in other areas to coordinate on gender issues, including participating in regular meetings of the gender network.

• Ensure that the nutrition area of work has a gender action plan and routinely measures project-specific indicators based on the checklist provided in the Inter-Agency Standing Committee (IASC) *Gender Handbook*.

• Work with other sectors/clusters to ensure gender-sensitive humanitarian programming.

**Annex 6: Participatory tools for gender analysis**

Participatory tools for gender analysis includes focus group discussions and key informant interviews. Guidelines for these tools are provided in the form of handouts in the last two exercises of the Trainer’s Guide in Module 19, *Working with communities in emergencies*.

This annex gives an overview of the following tools that are presented in the 2008 FAO/WFP Socio-Economic and Gender Analysis (SEAGA) for emergency and rehabilitation programmes[[31]](#footnote-31) and in other SEAGA publications:

* the **Livelihoods Analysis tools,** which address the flow of activities and resources through which different people make their living;
* the **Context Analysis** **tools**, which address economic, environmental, social and institution patterns that pose support or constraints to development.

**Livelihoods Analysis tools**

The following is a full description of two of the livelihood analysis tools presented by SEAGA, which are very effective in gender analysis:

* Daily Activity Clocks
* Gender-disaggregated Seasonal Calendars.

**Daily Activity Clocks**

**Purpose:** Daily Activity Clocksillustrate all the different kinds of activities carried out in one day. They are particularly useful for looking at relative workloads between different groups of people in the community, e.g. women, men, the rich, the poor, children and older people. Comparisons between Daily Activity Clocks show who works the longest hours, who concentrates on a small number of activities, who must divide their time among a variety of activities, and who has the most leisure time and sleep. They can also illustrate seasonal variations. This exercise will help you better plan your programme and services according to the schedule of the busy beneficiary, especially women.

**Process:** Organize separate focus groups of women and men. Make sure that each group includes people from the different socio-economic groups. Explain that you would like to learn about what they do in a typical day. Ask the groups of women and men to each produce their own clocks. They should first focus on the activities of the previous day. An outline of all the activities carried out at different times and how long they took should be drafted. Plot each activity on a circular pie chart (to look like a clock). Activities carried out simultaneously should be noted, such as child care and gardening.

When the clocks are completed, ask questions about the activities shown. Ask whether yesterday

was typical for the time of year. Note the present season, e.g. the wet season, and then ask the same participants to produce new clocks to represent a typical day in the other season, e.g. the dry season.

**Compare**: One of the best and often most entertaining ways to introduce the Daily Activity Clock tool is to start by showing what your own day looks like. Draw a big circle on paper and indicate what time you wake up, what time you go to work, and when you care for your children, and so forth. There is no need to go into great detail, but it is important to include **all** activities, such as agricultural work, wage labour, child care, cooking and sleeping.

**Gender-disaggregated Seasonal Calendars**

**Purpose:** Seasonal calendarsare tools that help to explore changes in livelihood systems taking place over the period of a year. They can be useful in counteracting time biases because they are used to determine what occurs in each seasons; otherwise, there is a tendency to discuss only what occurs during the time of the rapid appraisal (RA). This exercise will help you better plan your programme and services according to the schedule of the busy beneficiary, especially women.

Calendars can be used for many purposes, such as to learn about people’s workload at different times of the year, or how their incomes change in different periods. It can also be used to show the seasonality of other important aspects of livelihoods such as food and water availability.

**Process:** Work with one group of women and one group of men that produced the Daily Activity Clocks. Explain that, this time, you want to learn about what people do in a **year**. Find a large open space for each group. Calendars can be drawn on a large paper or can be traced in the sand or on a dirt floor using stones or leaves for quantification. Draw a line all the way across the top of the cleared space (or paper). Explain that the line represents a year and ask how people divide the year, i.e. months, seasons, etc. The scale to use is the one that makes the most sense to the participants. Ask the participants to mark the seasonal divisions along the top of the line. It is usually easiest to start the calendar by asking about rainfall patterns. Ask them to put stones under each month (or other division) of the calendar to represent relative amounts of rainfall (more stones equal more rain). Once the rainfall calendar is finished, you can draw another line under it and ask participants to make another calendar, this time showing their labour for agriculture (putting more stones over the periods of high labour intensity). Make sure that the labour calendar and subsequent calendars are perfectly aligned with the rainfall calendar. Different colours or different lines can be used to differentiate the tasks by men and women.

This process is repeated, one calendar below another, until all the seasonal issues of interest are covered. Be sure to include calendars for food availability, water availability, income sources and expenditures. Ask the participants to put a symbol or sign next to each calendar to indicate the topic. As much as possible, ask them also to describe the sources of food and income, and relevant details. Other issues may be added according to the needs and interests of the participants, such as animal diseases, fodder collection, fishing seasons, marketing opportunities and health problems, some of which must be divided by gender.

**SEAGA Matrix: Livelihoods Analysis Tools[[32]](#footnote-32)**

|  |
| --- |
| Livelihood Analysis focuses on how individuals, households and groups of households make their living and their access to resources to do so. It reveals the activities people undertake to meet basic needs and to generate income. Gender and socio-economic group differences are shown with respect to labour and decision-making patterns. Key questions include:   * How do people make their living? How do the livelihood systems of women and men compare? Of different socio-economic groups? * Are there households or individuals unable to meet their basic needs? * How diversified are people’s livelihood activities? Do certain groups have livelihoods vulnerable to problems revealed in the development context? * What are the patterns for use and control of key resources? By gender? By socio-economic group? * What are the most important sources of income? Expenditures?   **Resources Mapping – Farming Systems Diagram:**  for learning about household members’ on-farm, off-farm and non-farm activities and resources.  **Benefits Analysis Flow Chart:** for learning about benefits use and distribution by gender.  **Daily Activity Clocks:** for learning about the division of labour and labour intensity by gender and socioeconomic group.  **Seasonal Calendars:** for learning about the seasonality of women’s and men’s labour, and seasonality of food and water availability and income and expenditure patterns, and other seasonal issues of importance to the community.  **Resources Access and Control Matrix:**for learning about use and control of resources by gender and socio-economic group, often applied using proportional piling and picture cards.  **Income and Expenditures Matrices:**for learning about sources of income, sources of expenditures and the crisis coping strategies of different socio-economic groups.  **Wealth Ranking:** for determining the proportion of the population that is vulnerable. Proportional piling techniques can be used to determine proportions, e.g. of people that are poor. |

**SEAGA Matrix: Context Analysis Tools[[33]](#footnote-33)**

|  |
| --- |
| In any particular community, there are a number of socio-economic patterns that influence how people make a living and their options for development. Looking at the *context*helps us to understand these patterns. Key questions include:   * What are the important agro-environmental, economic, institutional and social patterns in the village? * What are the links between the field-level patterns and those at the intermediate- and macro-levels? * What is getting better? What is getting worse? * What are the supports for intervention? The constraints?   **Trend lines:** for learning about the *impact of disasters*(without and with the project) and the *vulnerability*of people in affected areas.   * Environmental *(deforestation, water supply)* * Economic *(jobs, wages, cost of living)* * Population *(birth rates, out-migration, in-migration)* * Other issues that are important to the community *(crop production:*good, bad and normal years over the past 5-10 years. *Area planted –*year 1, year 2, year 3, year 4*,*year 5. *Crop harvested*bags [units]: year 1, etc. *Food self-sufficiency*(months): year 1, etc. *Households food insecure (%)*: year 1, etc. *Prices*of main staple per bag (units): year 1, etc. *Terms of exchange*: e.g. exchange of 1 adult male sheep would bring how many kg of grain over year 1, year 2, etc..   **Village Resources Map:** for learning about the environmental, economic and social resources in the community.  **Transects:** for learning about the community’s natural resource base, land forms, and land use, location and size of farms or homesteads, and location and availability of infrastructure and services, and economic activities.  **Village Social Map:**for learning about the community’s population, local poverty indicators, and number and location of households by type (ethnicity, caste, female-headed, wealthy, poor, etc.).  **Venn Diagrams:** for learning about local groups and institutions, and their linkages with outside organizations and agencies. |

**Annex 7: Ten steps to successful breastfeeding**

The ten steps for health facilities to take towards ensuring successful breastfeeding are as follows:[[34]](#footnote-34)

1. Create and adapt a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women on the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk unless medically indicated.
7. Practise "rooming in" – allowing mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand whenever the baby is hungry.
9. Give no artificial teats or pacifiers (also called “dummies” or “soothers”) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The role of a father has been shown to be a powerful influence on a mother’s decision to breastfeed. To support and increase breastfeeding initiation and continuation, the father’s opinion, attitude and knowledge about breastfeeding and his relationship to his baby and the baby’s mother must be considered. Strong approval and support of breastfeeding by the father is associated with a high incidence of the decision to breastfeed. Mothers who perceive their partners to prefer formula or be ambivalent about the feeding method are significantly more likely to discontinue breastfeeding before discharge compared with those who perceive their partners as being supportive. Even if the mother thinks that the father has a negative attitude toward breastfeeding, she is more likely to bottle-feed, even if that perception was incorrect. Much of the focus on breastfeeding support is on the maternal-infant. This focus may lead some fathers to feel excluded and resentful of breastfeeding. Fathers’ negative perceptions of breastfeeding’s effects on such things as interference with sex or having a damaging effect on breast appearance can also lead the mother to bottle-feed.

1. WFP Gender Policy 2009. See www.wfp.org/content/wfp-gender-policy. [↑](#footnote-ref-1)
2. Further information is available at EN-NET: [www.en-net.org.uk/question/186.aspx](http://www.en-net.org.uk/question/186.aspx) [↑](#footnote-ref-2)
3. Based on the EN-Net contribution by M. Golden. See [www.en-net.org.uk/question/40.aspx](http://www.en-net.org.uk/question/40.aspx) [↑](#footnote-ref-3)
4. CEDAW, 1979. See [www.un.org/womenwatch/daw/cedaw/text/econvention.htm](http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm) [↑](#footnote-ref-4)
5. This complies with the Economic and Social Council (ECOSOC) Resolution signed in July 1998 that mandated all United Nations organizations to “ensure that a ensure that a gender perspective is fully integrated into humanitarian activities and policies*”* (E/1998/L.15 of 16 July 1998). [↑](#footnote-ref-5)
6. “Gender-based violence is a violation of universal human rights protected by international human

   rights conventions, including the right to security of person; the right to the highest attainable standard

   of physical and mental health; the right to freedom from torture or cruel, inhuman, or degrading treatment;

   and the right to life.” IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings, 2005. [↑](#footnote-ref-6)
7. *IASC Gender Handbook in Humanitarian Action: Women, Girls, Boys and Men – Different Needs, Equal Opportunities*,2006. [↑](#footnote-ref-7)
8. Questions and considerations have been adapted from UNICEF HTP Module 8*, Operational guidance for gender in young child survival and development* and the IASC *Gender Handbook for Humanitarian Action,* 2009. [↑](#footnote-ref-8)
9. United Nations Children’s Fund, Behaviour Change Communication in Emergencies: A Toolkit, New York, 2005. [↑](#footnote-ref-9)
10. Barrier analysis is a tool for BCC in child survival and community development programmes developed by Food for the Hungry. See http://barrieranalysis.fhi.net/ [↑](#footnote-ref-10)
11. *Behaviour**Change Communication in Emergencies: A Toolkit***.** UNICEF, 2006. <http://www.influenzaresources.org/files/BCC_in_Emerg_chap1to8_2006.pdf> [↑](#footnote-ref-11)
12. This example was taken from HTP Module 20, *Monitoring and evaluation*. [↑](#footnote-ref-12)
13. Young and Jaspers, ‘The meaning and measurement of acute malnutrition in emergencies’, HPN Network Paper, No. 56, 2006. [↑](#footnote-ref-13)
14. Newly developed blended foods include corn soy blend plus (CSB +/++), which is a reformulation of the original CSB to meet the additional energy density and micronutrient needs of some population subgroups. In the field, CSB and super cereal are used for 6-59 months and in development context, they are used for the 6-24 months specifically. [↑](#footnote-ref-14)
15. Save the Children UK, Impact of a cash for relief programme on child caring practices in Meket Woreda, 2005. [↑](#footnote-ref-15)
16. *Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers*.ENN/IFE Core Group, 2007. See [www.ennonline.net/pool/files/ife/ops-guidance-2-1-english-010307-with-addendum.pdf](http://www.ennonline.net/pool/files/ife/ops-guidance-2-1-english-010307-with-addendum.pdf); and UNICEF *IYCF Programming Guide*. See <http://www.unicef.org/videoaudio/PDFs/IYCF_programming_guide_May_26_2011.pdf> [↑](#footnote-ref-16)
17. Breastfeeding counsellors may be health professionals, community health workers or peer counsellors (e.g. mothers and grandmothers) who have undertaken relevant training. Assistance can be provided at health facilities, in safe breastfeeding corners and tents, and in mother-to-mother support or breastfeeding support peer groups in the community. [↑](#footnote-ref-17)
18. See HTP Module 17, Case 5: Skilled Support at a Baby-Friendly Tent in Haiti. [↑](#footnote-ref-18)
19. See HTP Module 17, Case study 1: Indonesia. [↑](#footnote-ref-19)
20. Emergency Nutrition Network (ENN) website for more information on the Minimum Reporting Project (MRP). See www.ennonline.net/research/sfp. [↑](#footnote-ref-20)
21. See <http://foodsecuritycluster.net>; http://www.unicef.org/nutritioncluster/index\_links.html http://foodsecuritycluster.net/sites/default/files/FSC%20Handbook%20draft%203%20final%20for%20web.pdf [↑](#footnote-ref-21)
22. SEAGA for Emergency and Rehabilitation Programmes, FAO/WFP 2007. [↑](#footnote-ref-22)
23. WFP Gender Policy 2009: Promoting Gender Equality and the Empowerment of Women in Addressing Food and Nutrition Challenges. See [www.wfp.org/content/wfp-gender-policy](http://www.wfp.org/content/wfp-gender-policy), 33, p. 12. [↑](#footnote-ref-23)
24. Thomas and Beck, Changing the Way UNHCR Does Business? An evaluation of the Age, Gender and Diversity Mainstreaming Strategy 2004-2009, 2010. See <http://www.alnap.org/resource/5852.aspx?tag=328>. [↑](#footnote-ref-24)
25. WFP *Gender Policy 2009: Promoting Gender Equality and the Empowerment of Women in Addressing Food and Nutrition Challenges*. See [www.wfp.org/content/wfp-gender-policy](http://www.wfp.org/content/wfp-gender-policy) [↑](#footnote-ref-25)
26. See <http://oneresponse.info/crosscutting/gender/Pages/Gender.aspx> information on GenCap. [↑](#footnote-ref-26)
27. The online course is available at: www.iasc-elearning.org/home. [↑](#footnote-ref-27)
28. *Gender Marker Tip Sheet*. See https://docs.unocha.org/sites/dms/CAP/NutritionGenderMarkerTipsheetJuly2011.pdf [↑](#footnote-ref-28)
29. UNICEF, *Promoting Gender Equality: An Equity-Focused Approach to Programming: Operational Guidance Overview*, 2011. See www.unicef.org/gender/files/Overarching\_Layout\_Web.pdf [↑](#footnote-ref-29)
30. Available at: http://www.google.it/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=3&ved=0CEMQFjAC&url=http%3A%2F%2Fwww.humanitarianinfo.org%2Fiasc%2Fdocuments%2Fsubsidi%2Ftf\_gender%2FGBV%2FGBV%2520Guidelines%2520AS6%2520Food.pdf&ei=pHpMUe31O8HG7Abe-4HwCw&usg=AFQjCNHtOSoZTGny02\_4eQi8uMAg5s0XbA&bvm=bv.44158598,d.ZWU [↑](#footnote-ref-30)
31. <http://www.fao.org/docrep/008/y5702e/y5702e00.htm> for a full description of each of the listed tools. [↑](#footnote-ref-31)
32. See ftp://ftp.fao.org/docrep/fao/008/y5702e/y5702e00.pdf [↑](#footnote-ref-32)
33. See ftp://ftp.fao.org/docrep/fao/008/y5702e/y5702e00.pdf [↑](#footnote-ref-33)
34. WHO/UNICEF, *Evidence for the Ten Steps to Successful Breastfeeding*. 1998, Geneva. [↑](#footnote-ref-34)