



Have you read section A ?

# GENDER AND NUTRITION IN EMERGENCIES

**E**mergencies are often characterized by a high prevalence of acute malnutrition and micronutrient deficiency diseases, which in turn lead to increased risk of death among the affected population and in particular among vulnerable groups. Women, girls, boys and men face different risks in relation to a deterioration in their nutritional status in emergency contexts. These different vulnerabilities are related both to their differing nutritional requirements and to socio-cultural factors related to gender. Good nutrition programming must take due account of gender issues at all stages of the project cycle — from participatory assessment and analysis through to surveillance, implementation of interventions, monitoring and evaluation.

### How do gender issues affect nutritional status?

- In crisis situations where food is in short supply, women and girls are more likely to reduce their food intake as a coping strategy in favour of other household members. This can contribute to under-nutrition among women and girls.
- Because of social traditions men and boys may be favoured and fed better than women and girls.
- Women may face constraints in accessing humanitarian services, including food, as a result of insecurity, cultural discrimination and limited mobility.
- Women, especially those who are pregnant or lactating, may be disproportionately affected by under-nutrition due to their increased physiological requirements. Teenage pregnancy can lead to poor health and nutritional status for both the baby and the mother.

### BREASTFEEDING CHALLENGES IN TRANSITION AND EMERGENCY CONTEXTS

Following the October 2005 earthquake in Kashmir, Pakistan, women frequently shared a shelter with distant male relatives and/or non-related men. The lack of privacy and support led many women to stop breastfeeding as they felt uncomfortable exposing their breasts in front of men. This emphasizes the urgent need for lactation corners in emergency settings to ensure continued breastfeeding.

- While remaining the main caretakers of children and other dependents within a household, women take on additional activities to support household food security especially in situations where male heads of households are absent. This often leads to disruption in infant and young child feeding practices and reduced caring capacities.
- Men who are single heads of households may be removed from their normal support structures during emergencies. If they do not know how to cook or care for young children, this will result in greater risk for under-nutrition for those children.
- Single men and boys separated from their families can be at risk of under-nutrition if they do not know how to cook or access food distribution.

### NO COOKING SKILLS – POOR NUTRITION FOR BOYS

In a refugee camp in northern Kenya southern Sudanese boys were separated from their families. Unsurprisingly, their nutritional status deteriorated because they did not know how to cook or access food distribution.

**NIGER AND UNDER-NUTRITION: WHY GENDER ANALYSIS MATTERS**

**Context:** For several decades, Niger has suffered from high levels of under-nutrition due to sub-optimal infant and young child-feeding practices rooted in longstanding beliefs about gender inequality and women's and girls' status, as well as food insecurity and chronic poverty. A series of environmental and economic shocks in the country over recent years exacerbated existing structural weaknesses, resulting in high levels of acute malnutrition among young children. In 2005, a nutrition survey showed that 22% of children under three years suffer from acute under-nutrition, which is five times higher than among older children (3-5 years old) in whom the prevalence of acute under-nutrition is only 4%. The Niger crisis was a crisis among infants and young children.

**The importance of a gender perspective in analysis and response:** Recent assessments and evaluations of the humanitarian response to the malnutrition crisis in Niger have highlighted poor analysis of the structural and proximate causes of malnutrition in the region. In particular, poor child-feeding practices, lack of access to health services, cultural practices and gender inequality in the country were inadequately incorporated into the national vulnerability analysis and subsequent programming. Within Niger's patriarchal society, women often do not have access to or control of food supplies. Seasonal cross-border labour migration patterns by male members of the household often leave women behind with limited access to granary stores.

**Lessons learned:** Humanitarian and development partners in the region are placing greater emphasis on understanding the impact of gender issues within vulnerability analysis and on appropriate programming, which enables women to continue to care for their infants and young children, access services and benefit from emergency interventions.

## WHAT DO WE NEED TO KNOW TO DESIGN AND IMPLEMENT GENDER-RESPONSIVE NUTRITION PROGRAMMES?

### What are the population demographics?

- Number of households.
- Number of women, girls, boys and men.
- Number of female-, male- and child-headed households.
- Number of persons by age and sex with specific needs (unaccompanied children, disabled, sick, elderly).
- Number of pregnant and nursing women.

### What is the social, political, cultural and security context? What has changed as a result of the emergency?

- What are the existing power structures within the community? Do women have their own structures?
- What are the differences between women's and men's positions/roles and responsibilities with regard to nutrition?
- Have women, girls, boys and men been affected differently by the emergency?
- Who were the most at risk for nutrition problems? What has changed due to the crisis?
- What factors (social, economic, political or security) limit access to and control over food to any members of the household/community/population?

### What is the gender-specific nutritional status, ill health and mortality picture?

- Do data on nutritional status (< -2 z-score weight for height) disaggregated by sex and age indicate that girls and boys are disproportionately affected? If so, what are the reasons for these differences?
- What is the nutritional status of women of reproductive age? What are the levels of anaemia?
- Do mortality data (crude mortality rate and under-5 mortality rate) disaggregated by sex indicate that women, girls, boys or men are disproportionately affected? If so, what are the reasons why this is so?

### What are the gender and social determinants of malnutrition?

- Are there any socio-cultural practices, taboos, cultural beliefs or caring practices that may affect women's, girls', boys' and men's nutrition status differently?
- How is food distributed within the home between women, girls, boys and men?
- Who within the household has controls over resources and does this impact on access to food and feeding habits?
- Are there any differences in breastfeeding practices for girl or boy babies? Is there a negative impact?
- What are the negative effects that the emergency situation may have had on traditional caring practices?

**What is the food and food security access and availability situation?**

- Are there differences for women, girls, boys and men in terms of access to food?
- If boys and men are separated from families do they have cooking skills? Can they prepare food for themselves?
- If women are heading households/family groups are they accessing sufficient food? How do elderly 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 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?
- What nutrition interventions were in place before the current emergency? How were they organized and did they affect women, girls, boys and men differently?
- How do school children access meals while in schools?
- Do households have access to micronutrients sources?

**ACTIONS TO ENSURE GENDER EQUALITY PROGRAMMING IN NUTRITION****Rapid assessment/baseline**

- Conduct a rapid participatory assessment with women, girls, boys and men of diverse backgrounds to ensure the integration of gender perspectives in the initial nutritional status analysis to identify groups most at risk.
- Obtain information on age- and sex-specific incidence of illnesses, nutrition indicators and health conditions.

**Address the nutritional and support needs of at-risk groups**

- Consult with key at-risk groups (e.g. pregnant and lactating women) to identify effective and accessible supplementary feeding programmes.
- Set up monitoring systems so that the different groups (by age and sex) benefit from the nutrition programmes.
- Support, protect and promote exclusive breastfeeding and appropriate young child-feeding practices through training of appropriate service providers and information campaigns, as well as the development and application of relevant policies and monitoring.

**Address micronutrient deficiencies and nutrition needs**

- Ensure that vaccination campaigns and vitamin A supplementation reach women, girls and boys equally.
- Promote fortification of food aid commodities to ensure equal access to micronutrient-rich foods.
- Involve women, girls, boys and men in the design, management and assessment/monitoring of nutrition-related services and control of distribution of supplies.

**Community mobilization and participation**

- Involve women, girls, boys and men in participatory assessments, defining health and nutrition priorities, planning solutions, policies, interventions and evaluation from the outset.
- Identify the capacities and skills among the affected population and work with them to build on their capacities and develop community-based sustainable nutrition programmes to avoid medium- and long-term dependence on external assistance.
- Develop community-based nutrition monitoring programmes, including the distribution and use of food within the home and train community nutrition workers on the gender dimensions of health and nutrition.

**Treatment of moderate and severe acute malnutrition**

- Establish therapeutic feeding centres at both facility and community levels and ensure a gender balance of health workers managing the centres.
- Implement targeted supplementary feeding programmes achieving maximum coverage for all through decentralized distribution.

**Technical support and capacity building**

- Incorporate in the team as many women and men as possible from the affected/displaced population where possible and appropriate.
- Train local health and nutrition workers on gender-sensitive service delivery.
- Review national guidelines on various aspects of nutrition to ensure gender sensitivity.
- Provide skills in emergency preparedness in relation to gender and nutrition.

**Conduct an in-depth nutrition survey**

- Ensure gender-balanced nutrition assessment teams, including female translators.

- Review existing data on nutrition and health to ensure it is disaggregated by sex and age, including statistical significance test.
- Carry out a nutrition survey and identify population groups that are hard to reach and/or marginalized and analyse the data by sex and age.

## CHECKLIST TO ASSESS GENDER EQUALITY PROGRAMMING IN THE NUTRITION SECTOR

The checklist below is derived from the action section in this chapter, and provides a useful tool to remind sector actors of key issues to ensure gender equality programming. In addition, the checklist, together with the sample indicators in the Basics Chapter, serves as a basis for project staff to develop context-specific indicators to measure progress in the incorporation of gender issues into humanitarian action.

NUTRITION – GENDER CHECKLIST	
<b>Analysis of gender differences</b>	
1.	Information on the nutritional needs, cooking skills and control over resources of women, girls, boys and men is gathered through participatory assessments.
2.	Reasons for inequalities in malnutrition rates between women, girls, boys and men are analysed and addressed through programming.
3.	Information is collected on the cultural, practical and security-related obstacles women, girls, boys and men could be expected to face in accessing nutritional assistance and measures taken to circumvent these obstacles.
4.	The gender analysis is reflected in planning documents and situation reports.
<b>Design of services</b>	
1.	Nutritional support programmes are designed according to the food culture and nutritional needs of the women (including pregnant or lactating women), girls, boys and men in the target population.
<b>Access</b>	
1.	Women's, girls', boys' and men's access to services is routinely monitored through spot checks, discussions with communities and obstacles to equal access are promptly addressed.
<b>Participation</b>	
1.	Women and men are equally and meaningfully involved in decision-making and programme design, implementation and monitoring.
<b>Training/ Capacity building</b>	
1.	Training courses on nutrition and gender issues are held for women, girls, boys and men.
2.	An equal number of women and men from the community are trained on nutrition programming.
3.	An equal number of women and men are employed in nutrition programmes.
<b>Actions to address GBV</b>	
1.	Both women and men are included in the process of selecting a safe distribution point.
2.	Food distribution is done by a sex-balanced team.
3.	"Safe spaces" are created at the distribution points and "safe passage" schedules created for women and children who are heads of households.
4.	Special arrangements are made to safeguard women to and from the distribution point (e.g. armed escort if necessary).
5.	Security and instances of abuse are monitored.

<b>Targeted actions based on gender analysis</b>
1. Unequal food distribution and nutrition rates within the household are addressed through nutritional support as well as programmes to address underlying reasons for discrimination and to empower those discriminated against.
<b>Monitoring and evaluation based on sex-and age-disaggregated data</b>
<p>1. Sex- and age disaggregated data on nutrition programme coverage is collected:</p> <ul style="list-style-type: none"> <li>• percentage of girls and boys aged 6-59 months who are covered by vitamin A distribution;</li> <li>• percentage of girls and boys under 5, pregnant and lactating women in the target group who are covered by supplementary feeding programmes and treatment for moderate acute malnutrition;</li> <li>• percentage of boys and girls under 5 who are covered by nutrition surveillance;</li> <li>• percentage of women, girls, boys and men who are still unable to meet their nutritional requirements in spite of ongoing nutritional programming; and</li> <li>• exclusive breastfeeding rates for girls and boys.</li> </ul> <p>2. Plans are developed and implemented to address any inequalities and ensure access and safety for all of the target population.</p>
<b>Coordinate actions with all partners</b>
<p>1. Actors in your sector liaise with actors in other sectors to coordinate on gender issues, including participating in regular meetings of the gender network.</p> <p>2. The sector/cluster has a gender action plan, has developed and routinely measures project-specific indicators based on the checklist provided in the IASC Gender Handbook.</p>

## RESOURCES

1. Inter-Agency Standing Committee (IASC). "Action Sheet 6.1: Implement Safe Food Security and Nutrition Programmes." *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergency*. Geneva. 2005. <http://www.reliefweb.int/library/documents/2005/iasc-gen-30sep.pdf>
2. The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response. "Chapter 3: Minimum Standards in Food Security, Nutrition and Food Aid." *The Sphere Handbook: 2004 Revised Version*. Geneva. 2004. <http://www.sphereproject.org/content/view/27/84/lang,English/>
3. Young, Helen, Borrel, Annalies, Holland, Diane, and Salama, Peter. Public Nutrition in Complex Emergencies. *The Lancet*, Volume 364, Issue 9448, Pages 1899-1909.